

SOURCE ISOLATION POLICY

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<p>Controlled document</p> <p>This document has been created following the Royal Devon and Exeter NHS Foundation Trust Policies, Procedures, Protocols, Guidelines and Standards Policy. It should not be altered in any way without the express permission of the author or their representative.</p>	

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

The Strategic Directions 2007-2012 were agreed by the Board of Directors in October 2007 to support the Trust's vision "Respond, Deliver, Enable". The Key Milestones below will ensure there is a shared understanding about what needs to be delivered.

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience		Waiting	
Assurance Framework		Privacy and Dignity	
Monitor/Finance/Performance		Efficiency and Effectiveness	
Healthcare Commission Core Standard numbers:		Delivery of Care Closer to Home	
		Infection Control	✓
NHSLA Risk Management Standards for Acute Trusts			
NHSLA CNST Maternity Clinical Risk Management Standards:			
Other (<i>please specify</i>):			
Note: This policy has been assessed for any equality, diversity or human rights implications			

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1. Introduction

Standard precautions are the principal strategy for the prevention and control of nosocomial infection. However, additional precautions are required for the care of patients who are known or suspected to be infected (or colonised) with highly transmissible or epidemiologically important pathogens. Such precautions are known as source isolation precautions.

The infected/colonised patient, as the source of infection, is segregated from unaffected patients, usually in a single room but, on occasions, within a cohort of similarly affected patients. Physical segregation, combined with other precautions such as the use of protective clothing, is aimed at reducing the likelihood of infections spreading via the airborne, droplet or contact routes.

The extent of isolation depends on:

- i The infecting organism and the route of transmission
- ii The physical and mental abilities of the patient.

These guidelines provide the information required to determine appropriate isolation precautions based on the route of transmission. However, consideration must also be given to an individual patient's mental or physical needs which often need to be balanced against the risk of transmission of infection. Care should be planned on an individual basis taking into account the needs of the patient and susceptibility of other patients. The Infection Control Team should be contacted for advice regarding individual patients.

2. Routes of Transmission

Knowledge of the possible route of transmission is necessary to apply isolation precautions appropriately and, in particular, to select appropriate protective clothing.

a) *Contact transmission*

This is the most important and frequent mode of transmission of nosocomial infection. This may be direct contact such as touching, biting and kissing. It also includes indirect contact via equipment (including sharp objects e.g. needles, blades), as well as the faecal oral route.

b) *Droplet transmission.*

Large droplets are generated from the source person primarily during coughing, sneezing, and talking, and during the performance of cough inducing procedures such as suctioning and bronchoscopy. Transmission occurs when droplets containing micro-organisms generated from the infected person are propelled a **short** distance (approximately 1 metre) and deposited on the host's conjunctivae, nasal mucosa, or mouth.

c) *Airborne transmission*

This route of transmission can be divided into two types, droplet nuclei and dust.

i Droplet nuclei.

Small respiratory droplets rapidly evaporate into small-particle residues [5 µm or smaller in size] known as droplet nuclei, that may contain micro-organisms. Droplet nuclei remain suspended in the air for long periods of time and may become inhaled by a susceptible host within the same room or over a longer distance from the source patient.

- ii Dust
Skin squames are shed from the skin surface at a rate of approximately 300 million a day and are the main component of dust. Some of the squames carry micro-organisms. Small dust particles may remain airborne for several hours and can be inhaled or settle in wounds.

3 Source Isolation Precautions

3.1 Communication

- a) Explain the rationale for isolation to the patient and, where possible, the duration of isolation anticipated. Where available provide a patient information leaflet.
- b) Place the appropriate isolation card on the door of the room/bay and indicate the appropriate precautions.
- c) Record in the patient's notes that isolation has been commenced and the reason why.
- d) Revise the nursing care plan accounting for infection control precautions to be maintained by staff, patient and visitors.
- e) Inform the Infection Control Team that there is a patient in isolation.
- f) Check whether the patient has a 'Notifiable Disease' and if so complete Notification Certificate. If a Notification Certificate Book is not held in your department, contact the Infection Control Dept within their normal working hours.

3.2 Accommodation

- a) Identify appropriate isolation facilities e.g. single room or cohort bay.
 - A side room with negative pressure ventilation may be required for airborne infections - refer Section 4 for details.
 - It is particularly important to keep the door closed when the side room is used for isolating a patient with an airborne infection.
 - If a single room is indicated it is preferable that it has *en-suite* toilet and washing facilities.
- b) Remove all inessential furniture and equipment.
- c) Ensure that appropriate equipment is available:

Inside the room

Hand cleansing facilities
Gloves & Aprons
Clinical waste bag holder/bin.
Linen receptacle with water soluble bag.
Sharps Bin (if safe to leave within room)
Thermometer
Sphygmomanometer, Stethoscope (if required)
Toileting and wash facilities (if no *en suite* bathroom).

Outside the room

Appropriate protective clothing
Alcohol hand rub.

NB The mental health of the patient may dictate that it is unsafe to leave some of this equipment within the room. Always undertake a risk assessment.

3.3 Hand Hygiene

- a) Within the room
Hands must be cleansed prior to leaving the isolation room. Hand hygiene must also be performed between different patient care activities to prevent cross contamination of different body sites. If the patient has diarrhoea soap and water should be used for hand hygiene rather than alcohol rub.
- b) Immediately after leaving the room
Cleanse hands..

3.4 Protective Clothing

It is often unnecessary and inappropriate to require every person entering an isolation room to wear protective clothing.

If worn, protective clothing must be removed immediately prior to leaving the room and must be disposed of inside the room into a clinical waste bag (except when leaving the room to dispose of used bedpans etc. when it is removed in the sluice after placing bedpan in macerator/bedpan washer).

The type of protective clothing required is dependent on the mode of transmission and the type of contact. All that is usually required is disposable gloves and aprons.

Guidance regarding the need for gloves and aprons is provided in the Index of Infections at Sections 4 and has been divided into the following three categories:

Limited to Standard Precautions (LSP)	If the infectious agent is transmitted in blood or other body fluids then protective clothing is only required when contact with such material is anticipated
Direct contact and cleaning (DCC)	For many conditions protective clothing is only required for direct patient contact and activities such as bed making and room cleaning. In this situation protective clothing is not required for social contact by staff or visitors.
All staff and visitors (ALL)	For a small number of conditions it is appropriate for all persons entering the room to wear protective clothing.

Occasionally additional protective clothing, such as masks and gowns, is required. Where this is appropriate it has been identified in the Index of Infection (Section 4). However, please note that masks are rarely necessary and are of limited value in protecting against infection spread by the airborne respiratory route. It is more important that staff caring for patients with airborne infections are immune.

3.5 Vulnerable Staff & Visitors

Some may be more vulnerable than others to infection. In particular:

- Pregnant women
- Immunocompromised people (for any reason)
- Staff with eczematous/psoriatic or similar skin lesions (particularly relevant with MRSA)
- Staff and visitors receiving antibiotics (relevant to C.difficile infection)

Must seek advice prior to caring for patients in isolation.

3.6 Equipment

Disposable equipment should be used whenever possible. Non disposable equipment must be decontaminated in accordance with the Decontamination Policy when removed from the room. Wherever possible equipment should be allocated for sole use of the patient and decontaminated when no longer required.

3.7 Linen

All laundry from isolation rooms must be managed as fouled/infected laundry and therefore be placed in water soluble bags within the room and then into an outer linen sack.

3.8 Waste Disposal

All waste must be disposed of into clinical waste bags inside the room. Double bagging is not necessary. The bag should be placed immediately at the designated collection point.

3.9 Excreta

Excreta can be disposed of directly into the toilet adjoining the room. If no *en-suite* facilities, cover commode/bed pan and take directly to the sluice. Pans and urinals must be heat disinfected in washer/disinfector or, if disposable, be placed directly into the macerator. Gloves and aprons should then be removed and discarded in clinical waste bin and hands washed.

3.10 Sharps

A sharps bin should be kept inside the room for sharps disposal, unless this will be a hazard to the patient.

3.11 Collection of Specimens

Specimens should be obtained within the room. Care must be taken to avoid contaminating the outside of the specimen container. All clinical specimens should be regarded as potentially infectious and handled as such. However, since it is National Health and Safety Policy, specimens from patients likely to have the following organisms have to be treated as 'high risk' and identified on the accompanying form, with a label to indicate this.

INFECTION SUSPECTED	ORGANISM	SPECIMEN
HEPATITIS	<i>Blood Borne Viruses</i> Hepatitis B&C	Blood and body fluids
HIV / AIDS	HIV I+II HTLV I+II	Blood and body fluids
TB	Mycobacterium tuberculosis (MTB)	Specimens from site of infection Eg: sputum, urine
TYPHOID	Salmonella typhi Salmonella paratyphi	Faeces & Blood Cultures
BRUCELLOSIS ("UNDULANT FEVER")	Brucella abortus/melitensis	Blood Cultures Bone Marrow
PLAGUE	Yersinia pestis	Specimens from discharging lesions Sputum

ANTHRAX	Bacillus anthracis	
YELLOW FEVER	Arboviruses	Blood

ON NO ACCOUNT SHOULD ANY SPECIMENS BE TAKEN FROM PATIENTS WITH SUSPECTED VIRAL HAEMORRHAGIC FEVER (eg: LASSA/EBOLA, etc., A POTENTIALLY LETHAL CROSS-INFECTION HAZARD) WITHOUT CONTACTING A MEDICAL MICROBIOLOGIST FIRST.

3.12 Management of Spillage

Refer to Decontamination Policy.

3.13 Crockery and Cutlery

Crockery and cutlery is adequately decontaminated by dishwasher. Return items to kitchen promptly.

3.14 Visits to other Departments

Wherever possible, the department should be notified in advance so that arrangements may be made to prevent possible spread of infection i.e. patients with infections spread by the airborne route should be seen at the end of a list/session. Ward staff should advise of any necessary precautions. The Infection Control Nurse can also be contacted for advice. After the investigation/treatment is completed, surfaces with which the patient has had contact should be cleaned with hot water and detergent or detergent wipes.

Portering staff and other staff accompanying the patient do not need to wear protective clothing but must clean their hands thoroughly after having direct contact with the patient.

Wheelchairs/trolleys used to transport patients to other departments must be cleaned with hot water and detergent or detergent wipes.

3.15 Transfer/Discharge of Patients

Patients can be transferred from one ward to another ward or unit, if clinical need dictates. The receiving area must be informed in advance of the nature of the infection to ensure that the appropriate facilities are available and the required precautions are applied. Movement for non clinical reasons, e.g. outlying medical patients who are in isolation rooms to surgical wards to increase bed availability in medicine, should be avoided.

On discharge ensure that receiving hospital/nursing home or community services are informed of any necessary precautions. If transport by ambulance is required, the Ambulance Service must be informed of any necessary precautions.

3.16 Visitors

Visitors must report to the nurses' station prior to entering the room. It may be necessary to ask about immunisation status prior to visiting. In some circumstances visiting may be restricted. If visiting is allowed it is usually unnecessary for visitors to wear protective clothing but they should be advised to wash/clean their hands when leaving the room. Visitors may need to be shown how to do this. Visitors should be advised not to visit other patients but if this is necessary they should do so before visiting the patient in isolation. They should be advised not to eat or drink whilst in the isolation room. Visiting by young children should be discouraged. If visitors insist on bringing young children they must be informed of any risks.

3.17 Routine Cleaning

Isolation rooms must be cleaned at least as frequently as other patient areas using standard cleaning procedures. Cloths must be disposable. Mop heads must be removed and should be laundered after use or disposable mop heads discarded.

3.18 Last Offices

Following death, the body may remain an infection risk to personnel and therefore isolation precautions must be maintained whilst Last Offices are performed.

Last Offices are performed in accordance with local Trust procedures.

All bodies should be sealed in a leak proof cadaver bag.

3.19 Terminal Cleaning

Terminal cleaning of the environment and furniture can be arranged via the housekeeping/domestic supervisor. However, when housekeeping services are not available it is the responsibility of the nursing staff to ensure the room is cleaned before reuse. The cleaning procedure below should be followed:

Procedure

- Clean thoroughly, and remove, patient equipment before terminal cleaning of the environment commences.
- Dispose of any contaminated disposable patient care items as clinical waste.
- Strip the bed linen and bag appropriately.
- Dispose of debris/rubbish into a clinical waste bag.
- Remove any dignity curtains for laundering.
- Arrange for removal of radiator covers (if appropriate)
- Clean the environment thoroughly using NaDCC sanitiser solution 1000ppm e.g. Chlor-clean or Actichlor plus.. Steam cleaners may be used for difficult to clean equipment.
 - Start with high cleaning - curtain rails, overhead light and bedside TV or phone equipment, high shelves/ledges.
 - Clean all other surfaces, including the inside of the bedside locker. Wall washing is not required but remove visible splash marks.
 - Clean bed frame and mattress.
 - Clean handwashing sink and any en-suite facilities - include cistern and door handles, light pulls etc.

- Clean patient equipment that could not be removed from the room.
 - Mop vinyl flooring. Place mophead in laundry bag and return for laundering or, if disposable mop head used, discard as clinical waste. If room is carpeted this must be vacuumed and then steam cleaned using a steam cleaner/extractor.
 - Dispose of cloths, gloves and aprons into a clinical waste bag. Remove waste bag from room. WASH HANDS
- .Replace radiator covers
 - Hang clean curtains

4 Tables of Communicable Diseases and Appropriate Precautions

Disease or Organism	Mode of transmission from person to person In the health care setting	Single room	Gloves	Apron	Other PPE	Visitor Restrictions	Duration of isolation	Comments
Anthrax Cutaneous Pulmonary	Contact with lesions Person to person spread unknown. * See comments	Yes Yes	ALL ALL	ALL ALL	See comments	-	Duration of disease	NOTIFIABLE DISEASE Infection Control Team must be informed if anthrax is suspected. *In the event of a deliberate release of anthrax spores the patient, his/her belongings and the environment may be contaminated. Refer to HPA guidelines www.hpa.org.uk
Bronchiolitis	Droplet	Yes	DCC	DCC	-	Exclude pre-school children	Clinical Recovery	
Brucellosis	No person to person spread	No	LSP	LSP				
Chickenpox (Varicella zoster)	Airborne via respiratory secretions and vesicle fluid Contact with vesicle exudate	Yes	DCC	DCC	-	Exclude non immune	1 week after onset or until lesions are dry	Non immune staff must be excluded. Negative pressure isolation room preferred Also refer Varicella Zoster information on Comex
Creutzfeldt Jakob Disease (CJD) and related disorders	Contact via instruments used for invasive procedures	No	LSP	LSP	-	-	Duration of hospital stay	Special precautions required for invasive procedures Also refer CJD guidance

Key to table

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PPE = Personal Protective Equipment

Modes of transmission

Contact – direct (touching, kissing, biting) or indirect via equipment/fomites (includes percutaneous exposure via used sharps)
Droplet - large respiratory droplets propelled a short distance only
Airborne - via droplet nuclei or skin scales – remain suspended in the air for long periods

Disease or Organism	Mode of transmission from person to person In the health care setting	Single room	Gloves	Apron	Other PPE	Visitor Restrictions	Duration of isolation	Comments
Croup	Droplet Contact via contaminated hands.	Yes	DCC	DCC	-	Exclude pre-school children	Clinical recovery	
Cryptococcus neoformans	No person to person spread	No	LSP	LSP				
Cytomegalovirus	Contact with saliva, blood, urine	No	LSP	LSP	-			
Dengue Fever	Contact via contaminated sharps	No	LSP	LSP			Clinical recovery	Always consider other communicable diseases when travelling from abroad. Isolate in s/r until diagnosis is confirmed.
Diarrhoea (suspected infective) See Section 5 for individual causes	Contact via faecal oral route	Yes	DCC	DCC		Variable	Variable see Section 4.1	Refer Section 5 of this policy
Diphtheria Respiratory	Droplet	Yes	ALL	ALL		Exclude non immune	Until swabs are repeatedly negative	NOTIFIABLE DISEASE. Inform infection control on suspicion.
Cutaneous	Direct contact with skin lesions	Yes	DCC	DCC				
Encephalitis (suspected infective)	Contact via faecal oral route	Yes	LSP	LSP				NOTIFIABLE DISEASE
Enterovirus (Echo and Coxsackie)	Contact via faecal oral route	Yes for infants only	DCC	DCC				
Epiglottitis	Droplet	Yes	DCC	DCC		Exclude pre-school	48hours after starting appropriate antibiotic therapy	Immunisation and prophylaxis of close contacts may be necessary

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Disease or Organism	Mode of transmission from person to person In the health care setting	Single room	Gloves	Apron	Other PPE	Visitor Restrictions	Duration of isolation	Comments
Gas Gangrene	No person to person spread	No	LSP	LSP				Infection is usually endogenous
Glandular fever	Contact via saliva (kissing)	No	LSP	LSP				
Gonococcal Infection								
Genito-urinary tract	Contact with exudate from mucous membranes of the GT	Yes, children only	LSP	LSP			24 hours of antibiotic therapy	NOTIFIABLE DISEASE
Ophthalmia neonatorum	Contact via unwashed hands	Yes	DCC	DCC				
Hepatitis Undiagnosed	Contact with blood, faeces and other body fluids (percutaneous exposure)	Yes	LSP	LSP				NOTIFIABLE DISEASE
Hepatitis A	Contact (faecal-oral)	Yes	LSP	LSP	LSP		7 days after onset of jaundice	NOTIFIABLE DISEASE
Hepatitis B, C & δ	Contact with blood and body fluids (usually percutaneous exposure via used sharps)	Not usually*	LSP	LSP	LSP			NOTIFIABLE DISEASE (if acute) *Single room required if bleeding uncontrollably or has large open wounds or receiving haemodialysis.
Herpes simplex Type I and II	Contact with lesions and via shared towels etc. Droplet	Not usually*	LSP	LSP			All lesions scabbed	* Single room may be required if patient has extensive lesions Also refer Herpes Simplex information on Comex.
Herpes zoster Refer Shingles								

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Disease or Organism	Mode of transmission from person to person in health care setting	Single room	Gloves	Apron	Other PPE	Visitor Restrictions	Duration of isolation	Comments
Human Immunodeficiency Virus	Direct or indirect contact with blood and body fluids (usually percutaneous exposure via used sharps)	No	LSP	LSP	LSP			Patients with AIDS may have infectious conditions that require isolation
Impetigo	Refer streptococcal infection							
Infestations								
Human Fleas	Contact with patient and bedding and clothing	Yes	ALL	ALL	Gowns DCC	Recommend limiting visitors to those who have already had contact until treated	Until patient, bedding and clothing are treated.	Human fleas are extremely uncommon.
Cat/dog fleas	N/A	No						Treat animals and environment
Lice (Body)	Contact with patients, clothing, bedding, towels etc	Yes	ALL	ALL	Gowns DCC	Recommend limiting visitors to those who have already had contact until treated	Until patient bedding and clothing are treated	Body lice live in the seams of clothing.
Lice (Head)	Contact (head to head) and via shared combs, head wear, pillows	Yes	DCC	DCC		Advise visitors to avoid head to head contact	Until treated	
Lice (pubic)	Contact (usually sexual)	No	LSP	LSP			Until treated	As this is usually STD consider referral to GUM clinic for screening

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Disease or Organism	Mode of transmission from person to person In the health care setting	Single room	Gloves	Apron	Other PPE	Visitor Restrictions	Duration of isolation	Comments
Infestations continued								
Scabies	Contact with skin (prolonged skin contact usually required)	Yes	DCC	DCC		None	Until treated	Itching may continue for several days/weeks Close contacts will need treatment
Crusted/atypical scabies	Contact with skin, bedding, clothing etc	Yes	DCC		Gown DCC	Recommend limiting visitors to those who have already had contact until treated	As advised by the ICT	Refer to dermatologist Contacts will need treatment. Also refer Scabies guidance
Worms	Contact via faecal oral route	No	LSP	LSP			Until treated	Family contacts or equivalent may need treatment
Influenza, Seasonal	Droplets	Yes	LSP	LSP		Advise elderly visitors to be immunised	3 days after onset	Alert ICT if more than one case on same ward
Legionnaires' Disease	No person to person spread	No	LSP	LSP			N/A	Microbiologist MUST be contacted to arrange for rapid diagnostic methods to be set up. NOTIFIABLE DISEASE
Leptospirosis (Weil's Disease)	Contact with blood and urine	No	LSP	LSP			N/A	NOTIFIABLE DISEASE
Lice Refer Infestations								
Listeriosis	Mother to baby in utero and during delivery Contact (faecal oral) although very rare	Yes in neonatal unit only	LSP	LSP			Clinical recovery	Microbiologists should be informed as potentially food borne

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Malaria	Contact via percutaneous exposure	No	LSP	LSP				NOTIFIABLE DISEASE Always consider the possibility of other tropical infections which may be infectious. Therefore until diagnosis confirmed a single room is advisable.
Measles	Airborne	Yes	DCC	DCC		Exclude non-immune	4 days after rash appears	NOTIFIABLE DISEASE. Also refer Measles information on Comex.
Meningitis Undiagnosed	? Droplet transmission ? Indirect contact (faecal oral)	Yes	DCC	DCC	Surgical masks		Variable depending on cause	NOTIFIABLE DISEASE Masks for airway management and close prolonged contact
Bacterial Meningococcal (<i>Neisseria meningitidis</i>)	Droplet	Yes	DCC	DCC	As above		48 hours of appropriate antibiotics	NOTIFIABLE DISEASE Antibiotic prophylaxis may be required for household and mouth kissing contacts. CCDC or Health Protection Nurse will advise. Refer Appendix 1.
Other bacterial causes e.g. pneumococcal, haemophilus influenzae	No person to person transmission	No	LSP	LSP				
Viral	Contact (faecal oral) +/- Droplet	Yes	DCC	DCC			Clinical recovery	NOTIFIABLE DISEASE Commonly caused by enterovirus

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Meningococcal Septicaemia – See Meningococcal Meningitis								
Multi-Resistant Gram Negative Organisms	Depends on site of colonisation. Contact via unwashed hands most significant route of transmission.	Possibly (Seek advice)	DCC	DCC			On the advice of the Infection Control Team	For ESBL and AMP C producing bacteria refer to ESBL/AMP C guidance.
Mumps	Droplet Contact with urine/saliva	Yes	DCC	DCC	Surgical mask for close contact /airway management	Exclude non immune	9 days after onset	NOTIFIABLE DISEASE
Mycoplasma pneumonia	Droplet	No	LSP	LSP			10 days after onset	Patients are usually no longer infectious by the time the diagnosis is confirmed.
Parvo virus (human) (Slapped Cheek)	Droplet	Yes	LSP	LSP		Exclude pregnant women	Usually once rash appears but see comments.	Patients in aplastic crisis may be infectious for 1 week after onset. Exclude pregnant members of staff.
Plague Bubonic	Contact with pus from buboes	Yes	ALL	ALL				NOTIFIABLE DISEASE Contact Infection Control Team immediately on suspicion.
Pneumonic	Airborne	Yes	ALL	ALL	Mask, Gown ALL	Exclude unless already exposed	Duration of disease	Person to person transmission is rare but the patient should be transferred to high security infectious disease unit.
Polio	Contact via faecal oral route Droplet	Yes	LSP	LSP		Exclude non immune	7 days from onset of symptoms	NOTIFIABLE DISEASE

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Source Isolation Policy

Approved by Infection Control Committee: 19th November 2009
Review Date: January 2012

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Psittacosis	Person to person spread very rare	No	LSP	LSP			N/A	
Pyrexia of Unknown Origin with recent travel abroad	As cause is unknown all modes of transmission must be considered	Yes	ALL	ALL		Limited to previous contacts and close family	Variable – clinical recovery if cause not confirmed	Malaria, typhoid and Hepatitis A are the commonest causes of PUO in returned travellers BUT always consider possibility of Viral Haemorrhagic Fever. Also refer VHF guidance.
Q-fever	No person to person spread	No	LSP	LSP				
Rabies	Contact via percutaneous exposure to saliva Droplets of saliva to conjunctiva/mucosa.	Yes	ALL	ALL	Masks and eye protection if coughing	Limited	Clinical recovery	NOTIFIABLE DISEASE Contact Microbiologist and Infection Control Team if suspected. Person to person transmission is only a theoretical risk but because of the implications of acquisition strict adherence to isolation precautions must be observed.
Ringworm (extensive)	Contact with skin scales, nail and hair and via associated equipment e.g. hair clippers, shavers	No	DCC	DCC			Variable	Own bath shower facilities desirable.
Rubella	Droplet	Yes	DCC	DCC		Exclude non immune	4 days after onset of rash.	NOTIFIABLE DISEASE

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Airborne – via droplet nuclei or skin scales – remain suspended in the air for long periods

Disease or Organism	Mode of transmission from person to person In the health care setting	Single room	Gloves	Apron	Other PPE	Visitor Restrictions	Duration of isolation	Comments
Smallpox	Contact with vesicles Airborne via respiratory droplet nuclei	Yes	ALL	ALL	Masks, gowns and eye protection ALL	Exclude unless already exposed	Until informed by the Infection Control Team	NOTIFIABLE DISEASE <u>CONTACT MICROBIOLOGIST AND INFECTION CONTROL IMMEDIATELY ON SUSPICION</u> Implement Major Incident Plan
Shingles	Contact with exudate Airborne via vesicle fluid (in disseminated shingles)	Yes	DCC	DCC		Exclude if non immune to chickenpox	1 week after onset or until lesions are dry	Exclude staff non-immune to chicken pox Also refer Varicella Virus (VZ), chickenpox and shingles information on Comex.
Streptococcal (Group A) Infection Including sore throat scarlet fever, impetigo, erysipelas, wound Infection, toxic shock syndrome, puerperal fever.	Contact with lesions Droplets	Yes	DCC	DCC		Recommend excluding children and any visitor with a wound.	48 hrs from commencing appropriate antibiotics	Scarlet Fever – NOTIFIABLE DISEASE Staff with sore throats should seek advice from Occupational Health
Streptococcal Group B (Neonatal)	Contact via faeces, skin sites	No	LSP	LSP			N/A	

Key to table

ALL = Applies to all persons entering the room
DCC = Required for direct contact or cleaning
LSP = Limited to standard precautions
N/A = Not applicable
PPE = Personal Protective Equipment

Modes of transmission

Contact – direct (touching, kissing, biting) or indirect via equipment/fomites (includes percutaneous exposure via used sharps)
Droplet - large respiratory droplets propelled a short distance only
Airborne - via droplet nuclei or skin scales – remain suspended in the air for long periods

Disease or Organism	Mode of transmission from person to person In the health care setting	Single room	Gloves	Apron	Other PPE	Visitor Restrictions	Duration of isolation	Comments
Syphyllis Early congenital Primary Secondary Latent & Late	Contact with lesions, secretions, blood No person to person spread	No No	LSP LSP	LSP LSP			24 hrs of effective therapy N/A	
Tetanus	No person to person spread	No	LSP	LSP			N/A	NOTIFIABLE DISEASE
Toxoplasmosis	No person to person spread	No	LSP	LSP			N/A	
Tuberculosis Pulmonary (open) ie sputum smear positive	Airborne via resp droplet nuclei	Yes	LSP	LSP	HEPA masks for cough inducing procedures	Limit to household/ family contacts	Usually 2 weeks treatment	NOTIFIABLE DISEASE Also Refer TB guidance Negative pressure ventilation preferable. MDRTB must be nursed in negative pressure isolation.
Pulmonary (closed)	No spread	No	LSP	LSP			N/A	
Extrapulmonary (excluding open abscess and other drainage lesions)	No spread	No	LSP	LSP			N/A	

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Modes of transmission

Contact – direct (touching, kissing, biting) or indirect via equipment/fomites (includes percutaneous exposure via used sharps)
Droplet - large respiratory droplets propelled a short distance only
Airborne - via droplet nuclei or skin scales – remain suspended in the air for long periods

Disease or Organism	Mode of transmission from person to person In the health care setting	Single room	Gloves	Apron	Other PPE	Visitor Restrictions	Duration of isolation	Comments
Typhoid & Paratyphoid	Indirect contact - faecal/urine/oral spread	Yes, with <i>en-suite</i> facilities	DCC	DCC		Advise visitors not to eat or drink in the isolation room	Variable	NOTIFIABLE DISEASE Ensure blood cultures and stools are labelled with risk of infection stickers
Typhus	Indirect contact via inoculation injury	No	Yes	LSP	LSP		Until any infestation is treated	NOTIFIABLE DISEASE Ensure patient is free of infestation.
Vancomycin Resistant Enterococcus (VRE)	Contact with colonised/infected sites	Yes	DCC	DCC	-	-	Until informed by Infection Control	Also Refer VRE/GRE Guidance
Varicella Zoster Refer Chicken pox or Shingles								
Viral Haemorrhagic Fever (eg Lassa, Ebola, Marburg)	Contact - percutaneous exposure to blood and body fluids ?Droplet - pharyngeal secretions	Yes	ALL	ALL	Masks Visors ALL	Immediate family/partner Exclude children.	As advised by Infection Control Team	NOTIFIABLE DISEASE <u>CONTACT INFECTION CONTROL IMMEDIATELY ON SUSPICION</u> Also refer VHF guidance
Whooping Cough	Airborne - respiratory secretions	Yes	DCC	DCC		Exclude non immune	5 days after antibiotics started	NOTIFIABLE DISEASE
Yellow Fever	Contact - percutaneous exposure	Yes	LSP	LSP			5 days after onset	NOTIFIABLE DISEASE

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Modes of transmission

Contact – direct (touching, kissing, biting) or indirect via equipment/fomites (includes percutaneous exposure via used sharps)
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5. Index of Specific Gastrointestinal Infections

Organism	Risk Group	Source	Person to Person Spread	Incubation Period	Period of Excretion	Specific Therapy	Single Room	Duration of Isolation	Notes
Adenovirus	Pre school children	Human	++	?	2-5 days	No	Yes	Duration of disease	
Amoebic Dysentery	Foreign Travellers	Human	+	? May be prolonged	Variable	Metronidazole	Yes	Duration of disease	NOTIFIABLE DISEASE
Astrovirus	Pre school children	Human	++	?	2-7 days	No	Yes	Duration of disease	
<i>Bacillus cereus</i>	All ages	Food esp. Chinese takeaway	-	1-6 hours	N/A	No	No	N/A	NOTIFIABLE DISEASE as food poisoning
Calicivirus	All ages	Human	++	24-48 hours	2-3 days	No	Yes	Duration of disease	
<i>Campylobacter</i>	All ages	Food Raw milk Water	+	2-7 days	Variable	Possibly Erythromycin or Ciprofloxacin	If possible	Duration of disease	NOTIFIABLE DISEASE as food poisoning
<i>Clostridium botulinum</i>	All ages	Food	-	12-36 hours	N/A	Specific Anti-toxin	No	N/A	NOTIFIABLE DISEASE as food poisoning
<i>Clostridium difficile</i>	Post antibiotic	Human. Contaminated environment	++	Variable	Variable	Oral Metronidazole	Yes	48 hours after resolution of symptoms with return to normal bowel action	Inform Infection Control Nurses Also refer C.difficile guidance

Organisms	Risk Group	Source	Person to Person Spread	Incubation Period	Period of Excretion	Specific Therapy	Single Room	Duration of Isolation	Notes
<i>Clostridium perfringens</i>	All ages	Food esp. cooked meats	-	10-18 hours	N/A	No	No	N/A	NOTIFIABLE DISEASE as food poisoning
<i>Cryptosporidium</i>	Mainly children	Human Water Animal contact	+	2-14 days	1-3 weeks	No	Yes	Duration of disease	NOTIFIABLE DISEASE as food poisoning
<i>E. Coli 0157</i>	All ages	Contact with cattle Contaminated food.	++		Variable	If severe	Yes	48 hours after resolution of symptoms	NOTIFIABLE DISEASE as food poisoning
Enteropathogenic <i>E.coli</i>	Children under 3 years	Human	++	12-72 hours	Variable	Not usually	Yes	Duration of disease	NOTIFIABLE DISEASE as food poisoning
<i>Giardia lamblia</i>	All ages	Human Water	++	1-4 weeks	Variable	Metronidazole	If possible	Duration of disease	NOTIFIABLE DISEASE as food poisoning
Norovirus	All ages	Human	+++	24-48 hours	Variable	No	Yes	Min 48 hours resolution of symptoms	NOTIFIABLE DISEASE as food poisoning Also refer viral gastroenteritis guidance
Rotavirus	Mainly pre school children	Human	++	1-4 days	2-5 days	No	Yes	Min 48 hours resolution of symptoms	

Organisms	Risk Group	Source	Person to Person Spread	Incubation Period	Period of Excretion	Specific Therapy	Single Room	Duration of Isolation	Notes
<i>Salmonella sp.</i> (non typhi)	All ages	Food Human cases	+	12-72 hours	Variable	Severe cases only	Yes	Duration of disease	NOTIFIABLE DISEASE as food poisoning
<i>Salmonella typhi</i> & <i>paratyphi</i>	All ages esp. after foreign travel	Human Food	++	1-3 weeks	Variable	Yes	Yes	Period of hospitalisation	NOTIFIABLE DISEASE
<i>Shigella sp</i>	Young children Following foreign travel	Human	++	1-7 days	Variable	If severe	Yes	Period of hospitalisation	NOTIFIABLE DISEASE as food poisoning
<i>Staph aureus</i>	All ages	Food esp. cooked meats	-	2-6 hours	N/A	No	No	N/A	NOTIFIABLE DISEASE as food poisoning
<i>Vibrio cholerae</i>	Travel abroad	Human Water Food	+	1-5 days	Variable	Yes Tetracycline	Yes	Period of hospitalisation	NOTIFIABLE DISEASE
<i>Yersinia sp</i>	Mainly children	Food	+	3-7 days	Variable	If severe	Yes	Duration of disease	NOTIFIABLE DISEASE as food poisoning

MANAGEMENT OF THE CONTACTS OF PATIENTS AT RD&E HOSPITAL WITH PROBABLE MENINGOCOCCAL DISEASE

The object of this flowchart is to *identify contacts* at risk of meningococcal infection, and to prescribe them appropriate antimicrobial prophylaxis *within 12 hours*

Patient with probable meningococcal disease in the Royal Devon and Exeter Hospital

Action by medical/nursing member of team, at the earliest opportunity

Telephone the Health Protection Unit (HPU) 01803 861833 and ask for the Doctor/Nurse on duty for Public Health. Out of normal working hours ask RD+E switchboard for the Devon & Cornwall Health Protection Unit Contact Rota 1st on.

- 1) Have the patient's details to hand
- 2) If possible have a relative / partner / friend accompanying the patient available

Action by duty HPU Doctor

HPU doctor will draw up lists of contacts, either by visiting or talking on 'phone to hospital staff or persons who have accompanied the patient to hospital. An assessment is made of which contacts need prophylaxis, this includes hospital and ambulance staff as well as family / community contacts

Copy list of staff contacts to Exeter Occupational Health Service (EXOHS)

Close/ family contacts needing prophylaxis
- present in hospital

Staff contacts needing prophylaxis
- Hospital staff
- Others e.g. ambulance

All other contacts needing prophylaxis
- **not** present in hospital

Emergency Department (ED) at RD&E informed by phone (01392 402310) or fax (01392 402313) of list of contacts needing prophylaxis.

Action by GP/DDOC
Duty GP/DDOC phoned and faxed to prescribe appropriate antibiotic

Action by ED doctor
ED doctor to prescribe and dispense from stock **ciprofloxacin** or **rifampicin** or **ceftriaxone** as appropriate to contacts. Drug stock and patient leaflets held in ED pharmacy cupboard.

Copy of prescription to go to EXOHS and HPU

Action by EXOHS
Keep records of
1) all staff contacts
2) all staff antibiotic prescriptions

Action by HPU doctor
Make a record of
1) all contacts
2) all antibiotic prescriptions