# Respiratory Syncytial Virus (RSV) – Guidance for the Management of

<table>
<thead>
<tr>
<th>Post holder responsible for Procedural Document</th>
<th>Judy Potter, Lead Nurse, Infection Prevention and Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author of Guideline</td>
<td>Judy Potter, Lead Nurse, Infection Prevention and Control</td>
</tr>
<tr>
<td>Division/ Department responsible for Procedural Document</td>
<td>Specialist Services, Infection Prevention &amp; Control</td>
</tr>
<tr>
<td>Contact details</td>
<td>x2355</td>
</tr>
<tr>
<td>Date of original guideline</td>
<td>April 2008</td>
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<tr>
<td>Impact Assessment performed</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Ratifying body and date ratified</td>
<td>Infection Control Operational Group: 4th September 2014</td>
</tr>
<tr>
<td>Review date (and frequency of further reviews)</td>
<td>March 2017 (every 3 years)</td>
</tr>
<tr>
<td>Expiry date</td>
<td>September 2017</td>
</tr>
<tr>
<td>Date document becomes live</td>
<td>29th December 2014</td>
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Please specify standard/criterion numbers and tick ✓ other boxes as appropriate

<table>
<thead>
<tr>
<th>Monitoring Information</th>
<th>Strategic Directions – Key Milestones</th>
</tr>
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<tr>
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<td>Waiting</td>
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<tr>
<td>Assurance Framework</td>
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<td>Monitor/Finance/Performance</td>
<td>Efficiency and Effectiveness</td>
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<tr>
<td>CQC Regulations/Outcomes:</td>
<td>Delivery of Care Closer to Home</td>
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<tr>
<td></td>
<td>Infection Control [✓]</td>
</tr>
<tr>
<td>NHSLA Risk Management Standards for Acute Trusts</td>
<td></td>
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<tr>
<td>NHSLA CNST Maternity Clinical Risk Management Standards:</td>
<td></td>
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<tr>
<td>Other (please specify):</td>
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</table>

**Note:** This policy has been assessed for any equality, diversity or human rights implications

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**Controlled document**

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<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Reason</th>
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<tr>
<td>1.0</td>
<td>April 2008</td>
<td>Lead Nurse</td>
<td>New Guidance</td>
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<td>August 2010</td>
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<td>Lead Nurse</td>
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<tr>
<td>4.0</td>
<td>8th August 2014</td>
<td>Lead Nurse</td>
<td>Routine revision</td>
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### Associated Policies:
- Source Isolation Policy
- Standard Infection Control Procedures
- Patient Placement and Movement Policy (Infection Prevention & Control)

### In consultation with and date:
- Infection Prevention & Control Team: 8th August 2014
- Infection Control Operational Group: 4th September 2014
- Policy Expert Panel: 1st December 2014

### Review Date (Within 3 years):
March 2017

### Contact for Review:
Lead Nurse, Infection Prevention & Control

### Executive Lead Signature:
(Only applicable for Strategies & Policies)
N/A
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1. **INTRODUCTION**

1.1 For most people respiratory syncytial virus (RSV) infection causes a mild respiratory illness. Those that are at risk, for example immunocompromised patients and those with chronic heart and lung conditions, may develop a severe respiratory illness and pneumonia. RSV causes bronchiolitis in infants and is the commonest cause of hospital admissions due to acute respiratory illness in young children (*Health Protection Agency, 2010*). Premature infants and neonates are at particular risk for severe illness and respiratory complications following RSV infection.

1.2 RSV is a paramyxovirus, an enveloped RNA virus, which is unstable in the environment. Humans are the only known reservoir. It can remain infectious on surfaces or objects for about 4 to 7 hours, and survives on unwashed hands. Hand hygiene using alcohol hand rubs or, washing with soap and water, removes it effectively.

1.3 Epidemics of the virus occur annually and tend to start in November or December and last for 4 to 5 months. It is estimated that over 60% of children have been infected by age one year and 80% by age two. Immunity is short lived and relatively ineffective, therefore recurrent infections with or without symptoms are likely to occur throughout life.

2. **PURPOSE**

2.1 The purpose of this guidance is to prevent the spread of RSV in the neonatal unit and in paediatrics.

3. **DEFINITIONS**

3.1 Refer to 1.2.

4. **DUTIES AND RESPONSIBILITIES OF STAFF**

4.1 *Infection Prevention and Control Team (IPCT)* is responsible for:

- Advising that patients with suspected or confirmed RSV are isolated appropriately
- Acting as a resource for best practice for clinical staff
- Support education for the neonatal unit and paediatric staff on the management of RSV
- Monitoring compliance through patient placement auditing

4.2 *Assistant Directors of Nursing and Senior Nurses* are responsible for:

- Ensuring that there is adequate staffing and expertise to provide care for patients with suspected or confirmed RSV when required

4.3 *Ward Matrons* are responsible for:

- Ensuring that all relevant nursing staff are aware of the need to isolate patients with suspected or confirmed RSV and implement the guidance contained in this document
• Ensuring that hand hygiene, the use of Personal Protective Equipment (PPE), equipment decontamination and ongoing environmental cleaning standards are maintained to minimise the risk of cross infection
• Ensuring that single rooms or cohort areas are terminally cleaned after use by patients with suspected or confirmed RSV

4.4 **Medical Directors and Associate Medical Directors** are responsible for:
• Ensuring that relevant medical staff are aware of this guidance

4.5 **Other Medical and Nursing Staff** are responsible for:
• Maintaining standards of hand hygiene and the use of PPE for the prevention of transmission of infection

4.6 **Microbiology Department** is responsible for:
• Providing a diagnostic and clinical advice service
• Ensuring that results are communicated promptly to medical teams

4.7 **Site Management Team** is responsible for:
• Ensuring that there is capacity to isolate patients with suspected or confirmed RSV

4.8 **Housekeepers and Domestic Services** are responsible for:
• Maintaining standards of environmental cleanliness
• Providing terminal cleaning to the single room or cohort area following suspected or confirmed RSV patient usage

4.9 **All Staff**
It is the responsibility of all staff to:
• Promote good infection control practice
• Have the necessary knowledge and skill to perform the tasks they are required to do

5. **GUIDELINES FOR MANAGEMENT**

5.1 **Patients Risk Group**

5.1.1 Those most at risk of developing severe illness due to RSV are the very young, aged one year and under, and the elderly. Premature neonates or children with underlying cardiac or chronic lung disease are at particular risk.

5.2 **Identification of Infection and Diagnosis**

5.2.1 Common symptoms are similar to a cold including coughing, sneezing, nasal congestion, rhinitis and sometimes fever. Bronchiolitis is seen in infants. Children can also develop ear infections and croup.
5.2.2 Diagnosis is based on clinical symptoms. Laboratory confirmation of RSV can be achieved by obtaining a nose or throat swab using a COPAN viral swab which is tested in the lab by SmartCycler.

5.3 Prevention and Treatment

5.3.1 There are no vaccines against RSV. Children at high risk from infection may be offered passive immunity with a monoclonal antibody preparation (Palivizumab).

5.3.2 For mild disease no specific treatment is required except that of symptom management. For more severe cases nursing support, oxygen therapy and mechanical ventilation may be required. Ribavirin may be used in life-threatening infection, but evidence of effectiveness is limited.

5.4 Transmission

5.4.1 The incubation period ranges from 2 to 8 days. However, 4 to 6 days is most common. The period of communicability ranges from 2 days prior to onset of symptoms to 10 days after their resolution. However in young infants viral shedding may continue for as long as 3 to 4 weeks.

5.4.2 The virus is spread from respiratory secretions via close contact with infected individuals or contact with contaminated surfaces or fomites. Infection can occur when the virus comes into contact with the mucous membranes of the eyes, mouth, or nose, and possibly through the inhalation of droplets generated by a sneeze or cough. Aerosol transmission is uncommon (Health Protection Agency, 2010). Consequently good hand hygiene technique and environmental hygiene is paramount to prevent cross infection.

5.5 Infection Control measures

5.5.1 Children with suspected RSV illness should be isolated in a single room and the door kept closed (refer to Source Isolation Policy). Diagnostic samples should be taken to confirm infection.

5.5.2 If an adequate number of single rooms are not available, those with a laboratory confirmed diagnosis of RSV and no other illness warranting isolation can be cohorted in a single area.

5.5.3 All children attending the paediatric ward or neonatal unit (NNU) who have had contact with a symptomatic case should be isolated as a precaution. This will apply until either the end of the incubation period is reached or 10 days post resolution of subsequent symptoms.

5.5.4 Aprons and gloves must be used for patient contact and the immediate environment. Hand hygiene is essential after contact with a patient or after touching respiratory secretions or the potentially contaminated environment. This should be done irrespective of whether gloves are worn or not.

5.5.5 Visitors with RSV-infected children must be instructed not to have contact with other patients or to mix with other visitors within the hospital. Visitors must perform hand hygiene before and after seeing the patient. Visitors with symptoms of respiratory tract infection should be discouraged from visiting,
unless essential, and should be excluded from high risk areas such as the high dependency unit and the neonatal unit.

5.6 Outbreaks

5.6.1 Whilst every effort will be made to isolate suspected RSV cases on admission, there is always a possibility that a patient will develop symptoms post admission. If this happens and other patients have potentially been infected, isolation will be necessary for all contacts and the index case. The bay will be closed to admissions and the infection control team must be informed at the earliest opportunity. The occupants may then be isolated separately or nursed as a cohort.

5.7 Management of RSV on the Neonatal Unit (NNU)

5.7.1 Neonates and premature infants are especially susceptible to severe RSV infection, which can also result in long term respiratory sequelae. RSV infection discovered on the NNU therefore is especially serious and requires rigorous control.

5.7.2 In the event of an outbreak or suspected outbreak of RSV on the NNU, the unit will be closed to admissions. An urgent outbreak control meeting will be convened by the infection control team to confirm control measures including unit closure and the possible use of prophylaxis.

5.7.3 The following precautions will apply unless otherwise determined:

- Visiting to the NNU will be restricted to PARENTS ONLY.
- Parents of symptomatic children must restrict their movement around the NNU and their contact with other parents and children within and outside of the unit to reduce the risk of potential transmission.
- If a symptomatic neonate has siblings on the unit then ensure parents always see non infected baby first.
- All parents should be informed of visiting restriction and the rationale for such actions during NNU closure.

5.7.4 Single room isolation for suspected and confirmed cases

- Source isolation sign on doors.

- Gloves and apron to be worn for all ‘hands on’ care and cleaning in cubicle. Parents need only wear aprons. Hands to be decontaminated after removal of gloves and aprons before leaving the cubicle and again after vacating the cubicle. All non essential equipment and stock to be removed from cubicle.

- Inside cubicle
  - Gloves all sizes
  - Disposable aprons available in case a change is required
  - Alcohol hand gel must be available and used
  - Bins with liners for infected linen and clinical waste
  - Sharps bin
  - Thermometer
Outside cubicle
  - Disposable aprons
  - Alcohol hand gel
  - Notes, folders and charts
  - Baby monitor

Should equipment be taken into the cubicle, it must be decontaminated upon exit.

Suspected RSV cases are screened by obtaining nasal swab (COPAN viral swab). Three samples are required at weekly intervals to ensure clearance of positive. Once clearance has been established and the medical staff have determined that no infective cause for symptoms exists, isolation precautions can cease.

Cleaning of source isolation rooms must be done last, after cleaning in other areas. Where a confirmed case is considered no longer infectious, the cubicle must be terminally cleaned before it can be reused.

Explain to parents the reason for and details of isolation and where possible its anticipated duration. Parents should be given written information.

6. ARCHIVING ARRANGEMENTS
The original of this guidance will remain with the author lead nurse, infection prevention and control. An electronic copy will be maintained on the Trust Intranet (iA), P – Policies – Respiratory Syncytial Virus (RSV). Archived copies will be stored on the Trust’s “archived policies” shared drive, and will be held for 25 years.

7. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE GUIDANCE

7.1 In order to monitor compliance with this guidance the auditable standards will be monitored as follows:

<table>
<thead>
<tr>
<th>No</th>
<th>Minimum Requirements</th>
<th>Evidenced by</th>
<th>NHSLA standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Patients are appropriately placed on wards so as to minimise the risk of infection to others</td>
<td>Annual audit of patient placement</td>
<td>N/A</td>
</tr>
</tbody>
</table>

7.2 Frequency
The Infection Provision and Control team will undertake an annual audit of patient placement which includes the placement of patients with RSV to ensure that this guidance has been adhered to and a formal report will be written and presented at the Infection Prevention and Control Assurance Group.

7.3 Undertaken by
Monitoring will be undertaken by the Infection Prevention and Control Team.
7.4 **Dissemination of Results**
Results will be disseminated at the Infection Control Operational Group which is held monthly and the Infection Control and Decontamination Assurance Group which is held quarterly.

7.5 **Recommendations/ Action Plans**
Implementation of the recommendations and action plan will be monitored by the ICOG, which meets 6 weekly.

7.6 Any barriers to implementation will be risk assessed and added to the risk register.

7.7 Any changes in practice needed will be highlighted to Trust staff via the Governance Managers cascade system

8. **REFERENCES**


9. **ASSOCIATED TRUST POLICIES**

- [Source Isolation Policy](#)
- [Standard Infection Control Procedures](#)
- [Patient Placement and Movement Policy (Infection Prevention & Control)](#)
APPENDIX 1: RAPID IMPACT ASSESSMENT SCREENING FORM

| Name of procedural document | Respiratory Syncytial Virus (RSV) – Guidance for the Management of |
| Directorate and Service Area | Trustwide |
| Name, job title and contact details of person completing the assessment | Elizabeth Perry, Infection Prevention and Control Nurse Specialist |
| Date: | 22.12.2014 |

EXECUTIVE SUMMARY
This section summarises:
- the impacts identified for action
- mitigating action
- the likely severity of the impact as a result of that action ("result").

<table>
<thead>
<tr>
<th>Impact</th>
<th>Action</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>None identified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(If you need to progress to a full impact assessment, please include this as an action, above.)

1. **What is the main purpose of this policy / plan / service?**
The purpose of this guidance is to prevent the spread of RSV in the neonatal unit and in paediatrics.

2. **Who does it affect?** Please tick as appropriate.
   - Carers ☐
   - Staff ☐
   - Patients √
   - Other (please specify)
3. What impact is it likely to have on different sections of the community / workforce, considering the “protected characteristics” below?

Please insert a tick in the appropriate box ✔

<table>
<thead>
<tr>
<th>Protected Characteristics</th>
<th>Positive impact -- it could benefit</th>
<th>Negative impact -- it treats them less favourably or could do</th>
<th>Negative impact -- they could find it harder than others to benefit from it or they could be disadvantaged by it</th>
<th>Non-impact – missed opportunities to promote equality</th>
<th>Neutral -- unlikely to have a specific effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>✔</td>
</tr>
<tr>
<td>Disability</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
<td>✔</td>
</tr>
<tr>
<td>Sex including Transgender and Pregnancy / Maternity</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
<td>✔</td>
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<tr>
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<td>✔</td>
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<td>Religion / belief</td>
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<td>✔</td>
</tr>
<tr>
<td>Sexual orientation including Marriage / Civil Partnership</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>✔</td>
</tr>
</tbody>
</table>

In identifying the impact of your policy across these characteristics, please consider the following issues:

- **Fairness** - Does it treat everyone justly?
- **Respect** - Does it respect everyone as a person?
- **Equality** - Does it give everyone an equal chance to get whatever it is offering?
- **Dignity** - Does it treat everyone with dignity?
- **Autonomy** - Does it recognise everyone’s freedom to make decisions for themselves?

If you have any negative impacts, you will need to progress to a full impact assessment.
In sections 4 and 5, please copy and repeat the tables below, for each “protected characteristic” considered. Alternatively, you can use one table for more than one “protected characteristic”, if the outcomes are similar.

4. If you have identified any positive impacts (see above), what will you do to make the most of them?

<table>
<thead>
<tr>
<th>“Protected characteristic” affected:</th>
<th>Issue</th>
<th>Who did you ask to understand the issues or whose work did you look at?</th>
<th>What did you find out about?</th>
<th>What did you learn or confirm?</th>
<th>Action as a result of above</th>
<th>Action</th>
<th>By who?</th>
<th>When?</th>
</tr>
</thead>
</table>

5. If you have identified any missed opportunities (“non-impacts”), what will you do to take up any opportunities to promote equality?

<table>
<thead>
<tr>
<th>“Protected characteristic” affected:</th>
<th>Issue</th>
<th>Who did you ask to understand the issues or whose work did you look at?</th>
<th>What did you find out about?</th>
<th>What did you learn or confirm?</th>
<th>Action as a result of above</th>
<th>Action</th>
<th>By who?</th>
<th>When?</th>
</tr>
</thead>
</table>

6. If you have identified a neutral impact, show who you have consulted or asked to confirm that this is the case, in the table below:

| Tony Williams Equality & Diversity Manager |

If you need help with any aspect of this assessment, please contact:
Tony Williams   Equality and Diversity Manager
Ext: 6942       anthony.williams1@nhs.net

Please note:
This impact assessment needs to be sent, with the policy, to the Equality & Diversity Manager at the following stages: as part of consultation, prior to final ratification of the policy and when final ratification has been given.