# Infection Control Guidance for Patients with Cystic Fibrosis

<table>
<thead>
<tr>
<th>Post holder responsible for Procedural Document</th>
<th>Infection Prevention &amp; Control Nurse Specialist</th>
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<tbody>
<tr>
<td>Authors of Guideline</td>
<td>Mel Burden Infection Prevention &amp; Control Nurse Specialist</td>
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<tr>
<td>Division/ Department responsible for Procedural Document</td>
<td>Specialist Services, Infection Prevention &amp; Control</td>
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<tr>
<td>Contact details</td>
<td>x2355</td>
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<td>Date of original guideline</td>
<td>March 2000</td>
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Please specify standard/criterion numbers and tick ✓ other boxes as appropriate

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<tr>
<th>Monitoring Information</th>
<th>Strategic Directions – Key Milestones</th>
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<td>Patient Experience</td>
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<td>Assurance Framework</td>
<td>Integrated Community Pathways</td>
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<td>Develop Acute services</td>
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<tr>
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<td>Infection Control ✓</td>
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Other (please specify): The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance

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

**Controlled document**

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Infection Control Guidance for Patients with Cystic Fibrosis

Ratified by Infection Control & Decontamination Assurance Group: 24th January 2017
Review date: October 2021

Full History

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<th>Date</th>
<th>Author (Title not name)</th>
<th>Reason</th>
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<td>Infection Prevention &amp; Control Nurse Specialist</td>
<td>New guidance</td>
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<td>Routine revision</td>
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<td>4.0</td>
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<td>Infection Prevention &amp; Control Nurse Specialist</td>
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<td>5.0</td>
<td>November 2016</td>
<td>Infection Prevention &amp; Control Nurse Specialist &amp; CF Nurse Specialist</td>
<td>Routine revision and update</td>
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Associated Trust Policies/Procedural documents:
- Uniform and Workwear Policy
- Standard Infection Control Policy & Procedures (Including Hand Hygiene)
- Decontamination Policy and Procedures
- Source Isolation Procedures
- Multi-Drug Resistant Organism Policy

Key Words
- Cystic Fibrosis
- Infection prevention & control
- Non-Tuberculous Mycobacterium *abscessus*
- Personal protective equipment
- Physiotherapy
- Psychology

In consultation with and date:
- Adult CF team: 01.11.16
- Paediatric CF team: 01.11.16
- Infection Prevention and Control team: 01.11.16
- Infection Control Decontamination and Assurance group: 24.01.17
- Policy Expert Panel (PEP): 01.02.17

Contact for Review:
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  Infection Prevention & Control Nurse Specialist
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Executive Lead Signature:
(Only applicable for Strategies & Policies)
- N/A
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1. INTRODUCTION

1.1 Regular bacteriological surveillance of sputum for patients with Cystic Fibrosis (CF) is extremely important. Respiratory infection in patients with CF can be more significant than for other individuals and is associated with deterioration of lung function. Many different bacterial organisms, viruses and fungi can infect the respiratory tract of patients with CF. For the purpose of this guidance these will be categorised in order of virulence as follows:

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>No known pathogens</td>
<td>Meticillin sensitive <em>Staphylococcus aureus</em> (MSSA)</td>
<td>Non-tuberculous <em>mycobacterium mycobacterium</em> (NTM) other than <em>abscessus</em></td>
<td>Non-Tuberculous <em>Mycobacterium abscessus</em> (NTMA)</td>
</tr>
<tr>
<td>Haemophilus influenzae</td>
<td>Pseudomonas aeruginosa</td>
<td>Burkholderia cenocepacia (Genomovar III)</td>
<td></td>
</tr>
<tr>
<td><em>Aspergillus fumigatus</em></td>
<td><em>Burkholderia cepacia</em> (Other than Genomovar III)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fungi and Yeasts e.g. <em>Exophiala</em></td>
<td>Meticillin resistant <em>Staphylococcus aureus</em> (MRSA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Stenotrophomonas maltophilia</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Achromobacter</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.2 To reduce risk of transmission between patients with CF, strict infection control practice with avoidance of patients mixing within respiratory clinics and of CF in-patients is essential.

2. PURPOSE

2.1 To set out clear guidance regarding the infection control management of patients with CF in the hospital environment.

3. DEFINITIONS

3.1 **Cystic Fibrosis** – An inherited genetic disorder involving the lungs, liver, pancreas and intestine. This disorder results in the abnormal transportation of chloride and sodium across an epithelium creating thick viscous secretions.
4. **DUTIES AND RESPONSIBILITIES OF STAFF**

4.1 **Infection Prevention and Control Team (IPCT)**

4.1.1 Are responsible for:
- Advising that patients with CF are isolated appropriately
- Acting as a resource for best practice for clinical staff
- Monitoring compliance through patient placement auditing

4.2 **CF Team**

4.2.1 Are responsible for:
- The clinical care and management of patients with CF
- Providing expertise to provide patient care
- Implementation and adherence to local and national CF guidelines

4.3 **Assistant Directors of Nursing and Senior Nurses**

4.3.1 Are responsible for:
- Ensuring that there is adequate staffing and expertise to provide care for patients with CF when required.

4.4 **Ward Matrons**

4.4.1 Are responsible for:
- Ensuring that all relevant nursing staff are aware of the need to isolate patients with CF and implement the guidance contained in this document.
- Ensuring that hand hygiene, the use of Personal Protective Equipment (PPE), equipment decontamination and on-going environmental cleaning standards are maintained to minimise the risk of cross infection.
- Ensuring that single rooms are terminally cleaned prior to and after use by a patient with CF

4.5 **Assistant Medical Directors and Clinical Directors**

4.5.1 Are responsible for:
- Ensuring that relevant medical staff are aware of this guidance

4.6 **Other Medical and Nursing Staff**

4.6.1 Are responsible for:
- Maintaining standards of hand hygiene and the use of PPE for the prevention of transmission of infection

4.7 **Microbiology Department**

4.7.1 Are responsible for:
- Providing a diagnostic and clinical advice service.
- Ensuring that results are communicated promptly to medical teams.
4.8 Site Management Team

4.8.1 The site management team is responsible for:
   • Ensuring that there is capacity to isolate patients with CF.

4.9 Housekeepers and Domestic Services

4.9.1 House keepers and domestic service assistants are responsible for:
   • Maintaining standards of environmental cleanliness
   • Providing terminal cleaning to the single room prior to and after use by a patient with CF.

4.10 All Staff

4.10.1 It is the responsibility of all staff to:
   • Promote good infection prevention and control practice.
   • Have the necessary knowledge and skill to perform the tasks they are required to do.

5. MANAGEMENT OF CF OUTPATIENT CLINICS (EXCLUDING CATEGORY D)

5.1 Patients must not sit in the waiting area, but be shown straight into a consulting room. Patients should be advised not to wait in other communal areas such as the pharmacy waiting area, in order to reduce risk of contact with other patients with CF.

5.2 For all clinics, strict adherence to hand hygiene guidelines is a requirement. Clinical staff must be bare below the elbows.

5.3 While the risk of transmission of CF pathogens in clinics cannot be quantified, the health benefits of CF clinics clearly outweigh the risks of acquisition of CF pathogens, therefore strict non mixing of all patients with CF is required.

5.4 Patients can be weighed in the outpatient weighing room.

5.5 All staff involved in the consultation will visit patients in the same clinic room, rather than the patient moving from room to room.

5.6 Patients in categories A B and C (as detailed in section 1.1) should be seen in order of pathogen virulence.

5.7 If this room is required for another patient with CF, it must remain empty for at least 30 minutes before the environment and equipment are cleaned using chlorclean/chlorox wipes.

5.8 Medical equipment used must be cleaned before entry and on removal with detergent wipes.

5.9 Domestic supervisors must be informed of any outpatient rooms requiring a terminal clean.

5.10 Spirometers must be used with a bacterial filter.
5.11 Nebuliser compressors must be cleaned after each patient use. If visible dust is present on the vents please contact clinical measurements to arrange cleaning. For further information please see Appendix 4 of the Decontamination Policy.

5.12 Patients and visitors should be encouraged to decontaminate their hands when they enter the clinic room and upon leaving.

6. MANAGEMENT OF CF INPATIENTS (EXCLUDING CATEGORY D)

6.1 All CF patients should be managed in en-suite single rooms with the door closed. If en-suite facilities are unavailable, communal bath/shower rooms can be used providing they are clean, and not shared with another patient with CF.

6.2 Patients with CF should not socialise with other patients on the ward or with other CF patients.

6.3 Patients with CF can go to non-clinical areas, such as the shop and the Oasis restaurant but should avoid sitting with other patients.

6.4 Rooms occupied by patients with CF must be cleaned with chlorclean/chlorox wipes before their admission, daily during admission and after discharge.

6.5 Once vacated the room must remain empty for at least 30 minutes before the environment and equipment are cleaned using chlorclean/chlorox wipes.

6.6 Medical equipment used in CF rooms must be cleaned before entry and on removal with detergent wipes.

6.7 Spirometry and collection of respiratory samples should be performed in the patient’s own room.

6.8 Once vacated, the room must remain empty for one hour before the environment and equipment is cleaned with chlorclean.

7. PERSONAL PROTECTIVE EQUIPMENT (EXCLUDING CATEGORY D)

7.1 Gloves and aprons must be worn for direct patient contact, sputum production, aerosol generation, respiratory function tests e.g. spirometry and cleaning

8. NON-TUBERCULOUS MYCOBACTERIUM ABSCESSUS (NTMA)

8.1 Non-Tuberculuous *Mycobacterium abscessus* (NTMA) is a rapidly growing mycobacterium that is a common water contaminant. *M. abscessus* can cause chronic lung disease, post-traumatic wound infections, and persistent culture-negative skin infections mostly in patients with suppressed immune systems.
8.2 Identification of patients

8.2.1 Patients should be defined as having *M. abscessus* if they:
- have had **more than one** positive isolate from sputum or **one positive** bronchioalveolar lavage (BAL) in the past fifteen months
- are currently undergoing treatment for *M. abscessus*
- have completed treatment for *M. abscessus* in the past twelve months

8.3 Screening

8.3.1 All CF patients should be routinely screened at annual review for Non-Tuberculous *Mycobacterium*.

8.3.2 The incidence and prevalence of *M. abscessus* in the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as “the Trust”) should be known. If cross infection with *M. abscessus* is suspected, more frequent screening should occur and isolates must be sent for typing.

8.4 Clearance

8.4.1 Patients who have had positive isolates for *M. abscessus* can only be considered clear when:
- Twelve months have elapsed since the first sputum isolate negative and there have been a minimum of four quarterly sputum or BAL negatives. These must be obtained whilst the patient is not on treatment for *M. abscessus*

9. MANAGEMENT OF CF OUTPATIENTS (IN CATEGORY D)

9.1 For all clinics, strict adherence to hand hygiene guidelines is a requirement. Clinical staff must be bare below the elbows. Gloves and long sleeved aprons/gowns must be worn for direct patient contact, sputum production, aerosol generation, respiratory function tests e.g. spirometry and cleaning

9.2 Scheduled CF patients in category D must be seen in a separate outpatient clinic to other CF patients.

9.3 Patients in category D attending unscheduled/ad-hoc clinics should be seen at the end of the day in an appropriate clinic room where possible and if clinically appropriate.

9.4 Once vacated the room must remain empty for one hour before the environment and equipment are cleaned using chlorclean/chlorox wipes.

9.5 Patients will have their own allocated stethoscope and spirometer head, labelled and stored in an airtight container.

9.6 Domestic supervisors must be informed of any outpatient rooms requiring a terminal clean.

9.7 Spirometers and nebuliser compressors are single patient use.

9.8 Patients and visitors should be encouraged to clean their hands when they enter the clinic room and upon leaving
10. MANAGEMENT OF CF INPATIENTS (IN CATEGORY D)

10.1 Adult patients in category D must be admitted to an en-suite single room on a different ward to the respiratory ward (Culm East, West or respiratory HDU). If two or more patients in category D require admission they must be accommodated in single rooms on separate wards i.e. no more than one patient with NTMA or *Burkholderia cenocepacia* on a ward at the same time.

10.2 Rooms occupied by patients with CF must be cleaned with chlorclean/chlorox wipes before their admission and daily during admission.

10.2 Once vacated, the room must remain empty for one hour before the environment and equipment is decontaminated with chlorclean.

10.3 In exceptional circumstances CF patients in category D may require treatment such as non-invasive ventilation. In these instances please liaise with the CF/respiratory, IPC and site management teams. These patients will usually be accommodated in a single room on the Intensive Care Unit (ICU) if capacity permits.

10.4 Spirometry and collection of respiratory samples should be performed in the patient’s own room.

11. PERSONAL PROTECTIVE EQUIPMENT (CATEGORY D)

11.1 Gloves and long sleeved aprons/gowns must be worn by the CF and respiratory team who have direct contact with the patient.

11.2 On call and weekend physiotherapists who will be required to perform chest physiotherapy must wear gloves and long sleeved aprons/gowns as in 11.1. This is in case they are then required to perform chest physio elsewhere within the Trust.

11.3 All staff (other than those mentioned in 11.1 and 11.2) should wear gloves and an apron as per standard precautions.

12. MULTI-DRUG RESISTANT ORGANISMS (MDROS)

12.1 The significance of MDROs will depend on the organism and the level of antimicrobial resistance.

12.2 Treatment options may be limited and will be determined by sensitivity testing results. Any treatment, including surgical prophylaxis, should be discussed with a Medical Microbiologist.

12.3 The level of source isolation precautions required will be dependent on the organism and the level of resistance. The IPCT and/or Medical Microbiologist must be contacted for advice. A CF patient with an MDRO will be electronically ‘flagged’ on the Trust Patient Administration System (PAS) system by the IPCT with IC 8.

12.3 Visitors are not required to wear protective clothing unless involved in the patient’s personnel care, when an apron should be worn. Visitors should wash their hands immediately prior to leaving the isolation room (if the patient is isolated) and should not visit other patients.
12.4 The level of terminal cleaning required when a CF patient with an MDRO is discharged is dependent on the organism and the level of resistance. The IPCT must be contacted for advice.

12.5 For further information please refer to the Multi-Drug Resistant Organism Policy.

13. MANAGEMENT OF PEDIATRIC CF OUTPATIENTS

13.1 Pediatric outpatient clinics should be managed in the same way as the adult clinics with regards to strict non-mixing and cleaning of rooms once vacated.

13.2 Pediatric patients in category D should be seen on a separate day to those in category A, B and C.

13.3 Toys should not be passed around and must be cleaned with detergent wipes after use. Soft toys are not appropriate.

14. MANAGEMENT OF PEDIATRIC CF INPATIENTS

14.1 Pediatric patients in category D must be cared for in separate areas of Bramble ward with separate nursing teams i.e. one patient on Bramble Green and another on Bramble Yellow.

14.2 Spirometry and collection of respiratory samples should be performed in the patient’s own room.

14.3 Gloves and aprons must be worn by all staff as per standard precautions. Hand hygiene as per Trust policy.

15. SCHOOL AND PLAYROOM

15.1 Children with CF can attend the school, but must not attend the same schoolroom as another child with CF.

15.2 A risk assessment will need to be made to ensure that that the CF patient is not put at risk from other children with infections. In addition the other children must not be put at risk from a CF patient who is carrying a resistant organism.

15.3 Children with CF can attend the playroom, but only one CF child is allowed in the playroom at any one time.

15.4 Patients with CF must not mix with oncology patients. When schooling/play is required it will be at the discretion of the school/play staff decided on a case by case review and educational need.

15.5 CF patients in category D must be schooled in their own room. Any equipment taken into the single room must be cleaned after use with chlorclean/chlorox wipes.

15.6 If the child is coughing/expectorating copious secretions there may be significant contamination of the environment. Consideration should then be given to providing schooling in the child’s room. They should not attend the play room.
15.7 Children and young people with CF can access the room after an oncology patient whether that patient was neutropenic or not.

15.8 Children with CF who are taught in their own room must be given single patient use or cleanable consumables e.g. pens and pencils.

16. PHYSIOTHERAPY FOR CF PATIENTS (EXCLUDING CATEGORY D)

16.1 A risk assessment should be made as to the level of contact required and risk of sputum contamination. Gloves and an apron must be worn. If necessary long sleeved apron/gown and gloves should be worn.

16.2 Patients with CF can use the exercise gym. The room must remain empty for at least 30 minutes before the equipment used is cleaned with detergent wipes.

17. PHYSIOTHERAPY FOR CF PATIENTS (IN CATEGORY D)

17.1 For close physical contact and/or generation of cough/sputum production, theatre blues should be worn. These are delivered directly to the physiotherapy department store and CF office to maintain a constant supply.

17.2 Following treatment, discard used theatre blues into a linen skip and wash hands and arms thoroughly. Shower if contamination of the skin has occurred.

17.3 Patients in category D should use the exercise gym towards the end of the day. The room must remain empty for one hour before the environment and equipment is cleaned with chlorclean/chlorox wipes.

18. PSYCHOLOGY APPOINTMENTS FOR CF PATIENTS

18.1 Strict adherence to hand hygiene guidelines is a requirement

18.2 Patients must not sit in the waiting area, but be shown straight into their allocated room.

18.3 Only vinyl floored clinic rooms should be allocated for these patients i.e. no carpet

18.4 There should be no soft furnishings in the room such as fabric covered sofas and chairs

18.5 Infection control status may not always be known by the psychologist, therefore, if the room is required by another patient with CF the room must remain empty for one hour before the environment and equipment is cleaned with chlorclean/chlorox wipes.

18.6 If the room is not required by another patient with CF that day, the room can be accessed by other patients (who do not have CF) prior to cleaning.
19. ARCHIVING ARRANGEMENTS
The original of this guidance will remain with the author the infection prevention & control nurse specialists. An electronic copy will be maintained on the Trust Intranet (Hub), (A-Z) – P – Policies – Cystic Fibrosis, and – Infection Control – Policies and Guidelines. Archived copies will be stored on the Trust’s “archived policies” shared drive, and will be held indefinitely. A paper copy (where one exists) will be held for 10 years.

20. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE GUIDANCE
20.1 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>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Patients are appropriately placed on wards so as to minimise the risk to themselves and others.</td>
<td>Annual audit of patients placement</td>
</tr>
</tbody>
</table>

20.2 Frequency
The Infection Prevention and Control team will undertake an annual audit of patient placement which includes the appropriate placement of patients with CF.

20.3 Undertaken by
Monitoring will be undertaken by the Infection Prevention and Control Team.

20.4 Dissemination of Results
Audit results will be disseminated at the Infection Control and Decontamination Assurance group (ICDAG) which is held quarterly.

20.5 Recommendations/ Action Plans
Implementation of the recommendations and action plan will be monitored by ICDAG which meets quarterly.

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

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

21. REFERENCES/BIBLIOGRAPHY


## APPENDIX 1: COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

<table>
<thead>
<tr>
<th>Staff groups that need to have knowledge of the strategy/policy</th>
<th>All clinical staff</th>
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</thead>
<tbody>
<tr>
<td><strong>The key changes if a revised policy/strategy</strong></td>
<td>Updated to clarify and categorise bacterial organisms, viruses and fungi that can infect the respiratory tract of patients with CF. Includes new sections on psychology appointments and the use of Bramble school/playroom.</td>
</tr>
<tr>
<td><strong>The key objectives</strong></td>
<td>The purpose of this guideline is to provide the information required to determine appropriate isolation and personal protective equipment required for patients with CF.</td>
</tr>
<tr>
<td><strong>How new staff will be made aware of the policy and manager action</strong></td>
<td>Induction and CF/IPC teams.</td>
</tr>
<tr>
<td><strong>Specific Issues to be raised with staff</strong></td>
<td>Nil</td>
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<tr>
<td><strong>Training available to staff</strong></td>
<td>Induction, infection control and respiratory study day updates.</td>
</tr>
<tr>
<td><strong>Any other requirements</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Issues following Equality Impact Assessment (if any)</strong></td>
<td>No negative impacts.</td>
</tr>
<tr>
<td><strong>Location of hard / electronic copy of the document etc.</strong></td>
<td>Infection Control Team Office and Site Management Office. Trust intranet</td>
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APPENDIX 2: EQUALITY IMPACT ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>Name of document</th>
<th>Infection Control Guidance for Patients with Cystic Fibrosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division/Directorate and service area</td>
<td>Trust-wide; Specialist Services, Infection Control</td>
</tr>
<tr>
<td>Name, job title and contact details of person completing the assessment</td>
<td>Mel Burden Advanced Nurse Specialist for Infection Prevention and Control</td>
</tr>
<tr>
<td>Date completed:</td>
<td>04/12/2016</td>
</tr>
</tbody>
</table>

The purpose of this tool is to:
- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. **What is the main purpose of this document?**

   The purpose of this guideline is to provide the information required to determine appropriate isolation and personal protective equipment required for patients with CF.

2. **Who does it mainly affect?** *(Please insert an “x” as appropriate:)*

   Carers ☐  Staff  X  Patients X  Other (please specify)

3. **Who might the policy have a ‘differential’ effect on, considering the “protected characteristics” below?** *(By differential we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)*

   Please insert an “x” in the appropriate box (x)

<table>
<thead>
<tr>
<th>Protected characteristic</th>
<th>Relevant</th>
<th>Not relevant</th>
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<td>X</td>
</tr>
<tr>
<td>Disability</td>
<td>☐</td>
<td>X</td>
</tr>
<tr>
<td>Sex - including: Transgender, and Pregnancy / Maternity</td>
<td>☐</td>
<td>X</td>
</tr>
<tr>
<td>Race</td>
<td>☐</td>
<td>X</td>
</tr>
<tr>
<td>Religion / belief</td>
<td>☐</td>
<td>X</td>
</tr>
</tbody>
</table>
4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

N/A

5. Do you think the document meets our human rights obligations?

Yes

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

The content of this guideline is not new but has been revised to clarify and categorise bacterial organisms, viruses and fungi that can infect the respiratory tract of patients with CF. It also includes new sections on psychology appointments and the use of Bramble school/playroom.

Previous discussions with the Equality and Diversity Manager did not identify any issues relating to equality, diversity and inclusion commitments. The policy has been circulated to all members of the Infection Control and CF teams which includes Specialist Nurses, Consultant Physicians, Physiotherapists, Dieticians, Psychologists and Medical Microbiologists for consultation and has been considered by the Infection Control Decontamination and Assurance Group which includes widespread representation from clinical, managerial and support staff.

7. If you have noted any ‘missed opportunities’, or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

<table>
<thead>
<tr>
<th>“Protected characteristic”</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue:</td>
<td></td>
</tr>
<tr>
<td>How is this going to be monitored/ addressed in the future:</td>
<td></td>
</tr>
<tr>
<td>Group that will be responsible for ensuring this carried out:</td>
<td></td>
</tr>
</tbody>
</table>