# Patient Placement and Movement Policy (Infection Prevention and Control)

<table>
<thead>
<tr>
<th>Post holder responsible for Procedural Document</th>
<th>Judy Potter, Lead Nurse/Director Infection Prevention and Control</th>
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<tbody>
<tr>
<td>Author of Policy</td>
<td>Judy Potter, Lead Nurse/Director Infection Prevention and Control</td>
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<tr>
<td>Directorate/Department responsible for Procedural Document</td>
<td>Specialist Services/Infection Control</td>
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<tr>
<td>Contact details</td>
<td>Extension number x 2355</td>
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<td>Date of original document</td>
<td>May 2008</td>
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<tr>
<td>Impact Assessment Performed</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Approving body and date approved:</td>
<td>Infection Control and Decontamination Assurance Group</td>
</tr>
<tr>
<td>Review date and (frequency of further reviews):</td>
<td>February 2022 (every 4.5 years)</td>
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<td>Expiry date</td>
<td>July 2022</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>
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<tr>
<td>Patient Experience</td>
<td>Maintain Operational Service Delivery</td>
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<tr>
<td>Assurance Framework</td>
<td>Integrated Community Pathways</td>
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<tr>
<td>Monitor/Finance/Performance</td>
<td>Develop Acute Services</td>
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<tr>
<td>CQC Fundamental Standard Regulation No.</td>
<td>Infection Control</td>
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<td>✓</td>
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Other (please specify):

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

## Controlled document

This document has been created following the Royal Devon and Exeter NHS Foundation Trust Development, Ratification & Management of Procedural Documents Policy. It should not be altered in any way without the express permission of the author or their representative.
### Associated Trust Policies/Procedural documents:

- Infection Prevention & Control Policy
- Standard Infection Control Procedures and Policy inc Hand Hygiene
- Source Isolation Policy and Procedures for Hospital Patients
- MRSA Policy
- *Clostridium difficile* Infection Policy
- Guidance on the Management of Seasonal Influenza
- Guidance for the Management of Suspected Cases of Severe Imported Respiratory Virus Infections including Avian Influenza and MERS Cov
- Multi-drug Resistant Organism policy
- Various guidance documents related to infectious diseases available on the Infection control pages of hub.
- Incident Reporting, Analysing, Investigating and Learning Policy

### Key Words

Patient placement

### In consultation with and date:

Full membership of the Infection Control and Decontamination Assurance Group which includes representation from the executive team, divisional management teams nursing (specifically all four Assistant Directors of Nursing) and medical staff from all divisions and key specialties, therapists, facilities, operations support (site management), estates and Public Health England’s Devon/Cornwall and Somerset Local Team: 3rd August 2017

Policy Expert Panel (PEP): 15th August 2017
Executive Lead Signature:
(Only applicable for Strategies & Policies)

Medical Director
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1. INTRODUCTION

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).

1.2 The need for restricting movement of infected patients between wards and for the rapid isolation of infected patients was emphasised in Healthcare Commission reports into outbreaks of *Clostridium difficile* (Healthcare Commission, 2006 and 2007).

1.3 Failure to comply with this policy could result in disciplinary action.

2. PURPOSE

2.1 To identify the process by which the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as 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.

2.2 To provide a framework for use when movement of patients cannot be avoided to ensure that infection risks are minimised.

2.3 To provide a framework for prioritising the use of isolation facilities which, in most cases, will be prioritised for patients with infectious conditions but must also take into consideration competing needs such as patients requiring end of life care and those with greater need for privacy and dignity/reduction of harm afforded by single room accommodation for certain groups of patients.

3. SCOPE

3.1 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 and Procedures for Hospital Patients
- MRSA Policy
- *Clostridium difficile* Infection Policy
- Outbreak Control Policy
- Viral Gastroenteritis Guidelines
- Guidance on the Management of Seasonal Influenza
- Guidance for the Management of Suspected Cases of Severe Imported Respiratory Virus Infections including Avian Influenza and MERS Cov
- Multi-drug Resistant Organism policy
4. DUTIES/RESPONSIBILITIES OF STAFF

4.1 Trust Board

4.1.1 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.

4.2 Divisions

4.2.1 Each Divisional Management Team 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 Divisional Governance Group meetings and identifying corrective measures

4.3 Infection Prevention and Control Team (ICT) including the Directors for Infection Prevention and Control

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.
- Present audit results to the Infection Control & Decontamination Assurance Group (ICDAG) and, if relevant, include them in the Infection prevention and control annual report.
4.4 Clinical staff providing patient care

Clinical staff have a responsibility to:

- Assess patients on admission for risk of infection (refer section 5 and 6), including ensuring that there are systems in place to check for infection prevention and control alerts on the Patient Administration System (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-whiteboard when appropriate so that infectious status is apparent.
- Ensure that patients with an infection prevention and control alert are not transferred to other wards unless clinically indicated. (refer section 8 and 9)
- 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 report if it is identified that patients with an infection prevention and control alert have been transferred unnecessarily and/or without communication in line with the Incident Reporting, Analysing, Investigating and Learning Policy.

4.5 Site Management Team (Wonford only)

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 9).

5. INFECTION RISK ASSESSMENT ON/PRIOR TO ADMISSION

5.1 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. It is important to document the risk assessment process and the outcome. 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.
6. DISEASE/CONDITION SPECIFIC ACTION

6.1 Diarrhoea and/or Vomiting

6.1.1 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.

6.1.2 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.

6.2. Suspected Clostridium Difficile Infection

6.2.1 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.

6.2.2 For patients in the acute hospital, 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. If for clinical reasons, the patient needs to remain on the base ward then this must be a consultant decision following discussion with the Infection Control Team. If there is a difference of opinion over the need for the patient to remain on the base ward this should be discussed with the Director for Infection Prevention and Control.

6.3. MRSA

6.3.1 Patients known to have a history of MRSA are indicated with an infection prevention and control alert on the Patient Administration System (PAS).

6.3.2 The relevant field on PAS must be checked for Infection Control (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.

6.3.3 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.

6.3.4 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
6.3.5 Patients with a history of MRSA are managed, in terms of placement, according to the MRSA Policy unless another patient has a greater (infection prevention and control) need for a single room. (Refer Section 7.)

7. PRIORITISING PATIENTS FOR SINGLE ROOM ACCOMMODATION

7.1 When the number of patients with infectious conditions exceeds the single rooms available priority for the single rooms goes to the following (this is not an exhaustive list):

<table>
<thead>
<tr>
<th>Condition</th>
<th>Where to isolate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected viral haemorrhagic fever</td>
<td>Torridge isolation room whilst arranging transfer to a high security infectious disease unit</td>
</tr>
<tr>
<td>Suspected or confirmed multidrug resistant tuberculosis</td>
<td>Torridge isolation room No 1 or 2</td>
</tr>
<tr>
<td>Suspected or confirmed infectious pulmonary tuberculosis</td>
<td>Torridge isolation room 1, 2, 3, 4 or 5 but otherwise a single room on any ward, (except Yeo and Yarty)</td>
</tr>
<tr>
<td>Suspected or confirmed chickenpox or measles</td>
<td>Torridge isolation room 1, 2, 3, 4, 5 or if a child, isolate on Bramble</td>
</tr>
<tr>
<td>Pyrexia of unknown origin (PUO) from abroad (where viral haemorrhagic fever is not a concern)</td>
<td>A single room on any ward</td>
</tr>
<tr>
<td>Suspected or confirmed mumps, rubella or whooping cough</td>
<td>Single room on any ward</td>
</tr>
<tr>
<td>Multi drug resistant organisms e.g. CPE, multidrug resistant acinetobacter</td>
<td>Torridge isolation room</td>
</tr>
<tr>
<td>Suspected viral gastroenteritis</td>
<td>Single room on any ward or Torridge isolation room following discussion with Infection Prevention and Control Team</td>
</tr>
<tr>
<td>Suspected <em>Clostridium difficile</em> infection</td>
<td>Single room on any ward</td>
</tr>
<tr>
<td>Confirmed <em>Clostridium difficile</em> infection</td>
<td>Single room or cohort bay on Torridge unless clinically contraindicated or the patient is a child, in which case isolate on Bramble, or the patient is in a community hospital.</td>
</tr>
<tr>
<td>Avian influenza</td>
<td>Torridge isolation room No 1 or 2 and ICU No 11 or 12</td>
</tr>
<tr>
<td>MERS Cov</td>
<td>Torridge isolation room No 1 or 2 and ICU No 11 or 12</td>
</tr>
<tr>
<td>Seasonal influenza</td>
<td>Single room on any ward</td>
</tr>
</tbody>
</table>
7.2 To make additional accommodation available, the following action should be taken:

- Remove non-infectious patients from single rooms, wherever segregation of gender allows
- Check whether infection prevention and control alerts are current and that patients with alerts still require a single room
- In particular, 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 perineal carriage

7.2.1 If MRSA positive 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. Patients known to have MRSA or with a history of MRSA carriage (without evidence of three consecutive negative full screens) must never be managed in a bay on orthopaedic wards.

8. MOVEMENT OF PATIENTS BETWEEN WARDS AND DEPARTMENTS

8.1 Unfortunately, ‘outlying’ patients, from one specialty ward into a different specialty ward to create bed capacity for new admissions, is a familiar feature of our healthcare system.

8.2 Patients in some wards, i.e. elderly care and most other medical wards, are more likely to have an existing infection and more likely to be infected or colonized with antibiotic resistant organisms such as MRSA or Extended Spectrum Beta Lactamase (ESBL)-producing organisms. Movement from these areas increases the risk of unwittingly spreading infection across the Trust, therefore as a guiding principle, the movement of patients from one specialty or ward into a different specialty or ward to create capacity, rather than for sound clinical reasons, should be minimized.

8.3 When outlying cannot be avoided, patients known to have infectious conditions, who should be indicated with an Infection Control (IC) alert on PAS or the e-whiteboard must not be selected for ‘outlying’ unless the transfer is for the clinical benefit of that patient (refer Section 9).

8.4 There are particular specialties where acquisition of infection is more likely to be associated with devastating clinical or reputational consequences and therefore additional caution must be applied to these areas (refer section 8.5 and 8.6).
8.5  **Elective Orthopaedics Unit**

8.5.1 If an orthopaedic patient with any prosthesis, implant or metalwork acquires any infection there is significant risk of haematogenous spread from that site to the prosthetic device which may result in permanent disability.

8.5.2 Healthcare associated infection in any body site e.g. urinary tract, wound, respiratory tract, can be minimised if beds are ring fenced for elective orthopaedic patients (Biant et al 2004; Kelly et al, 2012).

8.5.3 Local evidence shows that outbreaks of norovirus infection on the orthopaedic wards are predominantly associated with the outlying of medical or trauma patients. Outbreaks have resulted in ward closure, delayed discharges and, occasionally, life threatening illness in patients who have undergone major surgery. There is also an impact on achieving referral to treatment targets.

8.5.4 Refer Appendix 1 for bed management guidelines for Orthopaedics and Trauma wards which aim to protect this vulnerable group of patients which includes elective spinal patients.

8.6  **Neonatal Unit and the Centre for Women’s Health**

8.6.1 Microorganisms that cause mild or no infection in a healthy adult or child can be life threatening to vulnerable neonates. Outbreaks of infection in neonatal units are not only clinically challenging but may also result in loss of reputation. Single cases of hospital acquired MRSA infection often make headlines in local or national media.

8.6.2 Unlike some other units in the south west, MRSA and other antibiotic resistant organisms are not endemic in the Neonatal Unit (NNU) in this Trust and all reasonable measures must be taken to maintain this situation. This includes being extremely vigilant in connected specialties such as maternity and gynaecology.

8.6.2 Babies requiring admission to hospital from the community must not be admitted to the NNU but should be managed on Bramble ward as they may have infections, or been exposed to infections in the community, that will not yet have been encountered by neonates on the NNU. If there is no alternative but to admit to NNU from the community, the baby must be isolated in a single room.

9.  **MOVEMENT OF INFECTIOUS PATIENTS BETWEEN WARDS / DEPARTMENTS**

9.1 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, management or discharge in any way*, then this should be given due consideration.

9.2 Communication between wards and departments regarding the “infection status” of a patient is essential and enables the receiving ward/department to put local procedures in place.

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

9.4 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.
9.5 Once vacated, an isolation room (or bed space, if not in a single room) must be terminally cleaned before reoccupation.

10. INTER-HEALTHCARE TRANSFER

10.1 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.

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

11.1 Close liaison is essential.

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

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

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

12. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the author Lead Nurse, Infection Prevention and Control. An electronic copy will be maintained on the Trust Intranet, P – Policies (Trust-wide) – P – Patient Placement. Archived electronic 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 retained for 10 years.

13. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

13.1 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

13.2 The Infection Control and Decontamination Assurance Group will be responsible for ensuring that the findings/recommendations of the audit are acted upon.

13.3 In order to monitor compliance with this policy, 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 with infectious conditions are placed appropriately</td>
<td>Annual audit report as identified above</td>
</tr>
</tbody>
</table>
2. When infectious patients cannot be placed in single room accommodation, a clinical assessment has been made and plan implemented to minimise risk to others

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<tbody>
<tr>
<td>2.</td>
<td>When infectious patients cannot be placed in single room accommodation, a clinical assessment has been made and plan implemented to minimise risk to others</td>
</tr>
<tr>
<td>3.</td>
<td>Information of infection status will be communicated prior to intra hospital transfer</td>
</tr>
</tbody>
</table>

13.4 Frequency
In each financial year, the Infection Control Team will audit as identified above to ensure that this policy has been adhered to and a formal report will be written and presented at the Infection Control and Decontamination Assurance Group (ICDAG).

13.5 Undertaken by
Audit and Surveillance Nurse

13.6 Dissemination of Results
At the ICDAG which is held quarterly.

13.7 Recommendations/ Action Plans
Implementation of the recommendations and action plan will be monitored by the relevant Divisional Governance Group and reported through to the Infection Control and Decontamination Assurance Group.

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

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

14. REFERENCES


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.


The Surgeon 10 (2), 75-79.
APPENDIX 1: BED MANAGEMENT IN TRAUMA AND ELECTIVE ORTHOPAEDICS

Elective

- Tavy and Dyball Wards make up the Elective Orthopaedic Unit

- No patients should be outlied onto the elective unit. Orthopaedic patients returning from a planned stay on the Intensive Care Unit (ICU) are not considered outliers. Whenever possible, when repatriated they will be nursed in a single room, however lack of a single room will not hinder their repatriation to Dyball or Tavy.

- If an outlier is placed in a bay on an elective orthopaedic ward, that ward is treated as unsuitable for admission of further elective patients until it has been clear of outliers for 48 hours.*

- Post-operative beds on the elective unit should be identified as soon as practically possible for patients going to theatre. If it is unlikely that a bed will be available on the elective unit, but an alternative is available on another ward, then the case should be discussed with the named consultant and a risk assessment made whether or not to take the patient to theatre. The default position, unless CLINICAL urgency dictates, should be NOT to outlie elective patients.

- Semi-elective trauma patients who are not high risk for infection and who can be screened appropriately pre-operatively can be admitted to the Orthopaedic Admissions Unit on the day of surgery.

- Elective patients with known Infection Control (IC) alerts should be nursed in a single room and discussed with the infection control team before admission.

* In the event of a critical lack of bed capacity across the Trust, the capacity escalation plan will be implemented. In this situation, the balance of risk will need to be considered by the on-call management team in consultation with the Director of Infection Prevention and Control, and if necessary a plan made to outlie patients with the lowest risk of infection into the elective unit. Refer Trust Capacity Escalation Plan for criteria of low infection risk outliers.

Rehabilitation

- A bay or bays can be designated as an orthopaedic/trauma ‘rehabilitation’ bay within the Elective Unit as need arises. This is a significant compromise to the principle of having a protected unit for elective orthopaedic patients and must be managed carefully. Therefore, there are strict criteria for entry to these bays. Only appropriate Trauma and Orthopaedic (T&O) patients should be placed in the rehab bay/s. The criteria for entry as follows:

  a. The rehab bay is primarily for neck of femur fracture patients and elective orthopaedic patients requiring additional rehab.
  b. Patients must be at least 72 hours post-op with dry wounds and drains must have been removed.
  c. Patients with IC alerts (e.g. MRSA, ESBL/AmpC /VRE/CPE) or other infectious conditions should not be nursed in the rehab bay.
  d. Only patients with known and negative MRSA status should be nursed in the rehab bay. Trauma patients must have had their admission screen results through and must not have subsequently been nursed in the same bay as any patient who is known to be colonised with resistant bacteria (eg MRSA, ESBL/AmpC /VRE/CPE).
Trauma

- Durbin is the Orthopaedic Trauma Unit.

- Outlying of trauma patients to other wards in the hospital should be avoided.

- If the Trauma Unit is full and beds are required, suitable post-operative patients who do not require ongoing trauma care and are due to be discharged within the following 24 hours should be identified by the nurse in charge of the Trauma Unit and a decision made whether it is safe to outlie that patient. If there is any doubt, the case can be discussed with the named or on-call consultant.

- Semi-elective trauma patients who are not high risk for infection and who can be screened appropriately in fracture clinic can be admitted to the Orthopaedic Admissions Unit on the day of surgery and nursed on the elective orthopaedic wards post-operatively. Semi elective trauma patients who have their operation in main theatres should not be admitted to the elective unit post-operatively. Patients operated on in PEOC theatres and recovery can be placed in the trauma rehabilitation bay on the elective unit.
**APPENDIX 2: EQUALITY IMPACT ASSESSMENT TOOL**

<table>
<thead>
<tr>
<th>Name of document</th>
<th>Patient Placement and Movement Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division/Directorate and service area</td>
<td>Specialist Services / Infection Control</td>
</tr>
<tr>
<td>Name, job title and contact details of person completing the assessment</td>
<td>Judy Potter Lead Nurse/ Director Infection Prevention and Control</td>
</tr>
<tr>
<td>Date completed:</td>
<td>21/07/2017</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?**
   - To identify 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.
   - To provide a framework for use when movement of patients cannot be avoided to ensure that infection risks are minimised
   - To provide a framework for prioritising the use of isolation facilities

2. **Who does it mainly affect? (Please insert an “x” as appropriate:)**
   - Carers □
   - Staff □
   - Patients ☒
   - Other (please specify) ☒ Contractors

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)**
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.)?

Please specify any groups you think may be affected in any significant way:

- **Age** - neonates and maternity - Newborn more vulnerable to infection than babies who are admitted from the community therefore special measures required to protect babies in the neonatal unit.

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

Feel free to expand on any human rights considerations in question 6 below.

**A quick guide to human rights:**
- **Fairness** – how have you made sure it treat everyone justly?
- **Respect** – how have you made sure it respects everyone as a person?
- **Equality** – how does it give everyone an equal chance to get whatever it is offering?
- **Dignity** – have you made sure it treats everyone with dignity?
- **Autonomy** – Does it enable people to make decisions for themselves?

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?

Please give a brief summary- identifying:
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>None</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>