# Respiratory Syncytial Virus (RSV) – Policy 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>
</tr>
<tr>
<td>Impact Assessment performed</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Ratifying body and date ratified</td>
<td>Infection Control &amp; Decontamination Assurance Group: 3rd August 2017</td>
</tr>
<tr>
<td>Review date (and frequency of further reviews)</td>
<td>March 2022 (every 4 ½ years)</td>
</tr>
<tr>
<td>Expiry date</td>
<td>September 2022</td>
</tr>
<tr>
<td>Date document becomes live</td>
<td>10 October 2017</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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<tbody>
<tr>
<td>Patient Experience</td>
<td>Maintain Operational Service Delivery</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>Integrated Community Pathways</td>
</tr>
<tr>
<td>Monitor/Finance/Performance</td>
<td>Develop Acute services</td>
</tr>
<tr>
<td>CQC Fundamental Standards - Regulation:</td>
<td>Infection Control ✓</td>
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</tbody>
</table>

Other (please specify):

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

## Controlled document

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Respiratory Syncytial Virus (RSV) – Guidance for the Management of
Ratified by: Infection Control & Decontamination Assurance Group: 3rd August 2017
Review date: March 2022

<table>
<thead>
<tr>
<th>Full History</th>
<th>Status: Final</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>1.0</td>
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Associated Trust Policies/Procedural documents:
- Source Isolation Policy & Procedures for Hospital Patients
- Standard Infection Control Procedures and Policy (Including Hand Hygiene)
- Patient Placement and Movement Policy (Infection Prevention & Control)

Key Words
- Respiratory Syncytial Virus, RSV

In consultation with and date:
Consultant Paediatricians: 25th July 2017
Paediatric Governance Group: 5th August 2017
Full membership of the Infection Control and Decontamination Assurance Group which includes representation from the executive team, divisional management teams (including community services), nursing and medical staff, therapists, facilities, operations support, estates and Public Health England’s Devon/Cornwall and Somerset Local Team: 3rd August 2017.


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

Executive Lead Signature:
- Medical Director
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Respiratory Syncytial Virus (RSV) – Guidance for the Management of
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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 it is the commonest cause of hospital admissions due to acute respiratory illness in young children. 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. It is highly communicable but humans are the only known reservoir (Green Book, 2015). The virus 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 (PHE, 2008). Immunity is short lived and relatively ineffective, therefore recurrent infections with or without symptoms are likely to occur throughout life. There is currently no vaccine for RSV.

1.4 Failure to comply with this policy could result in disciplinary action. However, it is recognised that the management of RSV and the appropriate actions to take are entirely dependent on the background levels of disease in the community and therefore the volume of patients admitted to hospital. As RSV season escalates, close liaison between the clinicians and the Infection Prevention and Control Team may result in pragmatic adjustments in practice.

2. PURPOSE

2.1 The purpose of this policy is to prevent the spread of RSV in hospital amongst patients, staff and visitors.

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 The **Chief Nurse** is 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 policy

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 clinical teams

4.7 **Site Management Team** is responsible for:

- Isolation facilities are provided promptly when the need is identified

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 nonspecific, similar to a cold and include coughing, sneezing, nasal congestion, rhinitis and sometimes fever. Bronchiolitis is seen in infants. Children can also develop ear infections and croup. Because RSV occurs in seasonal epidemics, diagnosis based on symptoms alone is likely to be accurate during periods of high incidence.

5.2.2 Diagnosis is based on clinical symptoms. Laboratory confirmation of RSV requires a nose swab using a COPAN viral swab, which is tested by a specific molecular test either in the Microbiology Laboratory or, if available, on equipment located near the patient (near patient testing).

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. Consequently good hand hygiene technique and environmental hygiene is paramount to prevent cross infection.

5.5 Infection Control measures

5.5.1 Source isolation

All cases of confirmed and suspected RSV infection should be isolated. The escalation strategy outlined below aims to optimise the use of limited isolation facilities when cases of RSV increase:

5.5.1.1 No restrictions on the availability of isolation facilities:
Children and adults with suspected RSV illness should be isolated in a single room and the door kept closed (refer to Source Isolation Policy & Procedures for Hospital Patients). Diagnostic samples should be taken to confirm infection.

5.5.1.2 Moderate restrictions on the availability of isolation facilities: Laboratory confirmed cases of RSV can be cohorted in a single area, providing there is no co-infection which requires isolation separate from the cohort.

5.5.1.3 Severe restrictions on the availability of isolation facilities: Clinically diagnosed (ie without lab confirmation) cases can be cohorted during periods with high RSV activity. Caution should be exercised when there is also a high incidence of other respiratory infections, or significant co-morbidities.

- Infants/children with confirmed Influenza must not be cohorted with RSV patients
- Infants/children with a fever >38 may have bacterial infections and need to be assessed by an experienced paediatrician before cohorting
- Babies who have not completed their primary immunisations should ideally not be cohorted. This will include all those under 16 weeks
- Infants/children with high risk conditions such as cyanotic heart disease, immunosuppression, neuromuscular conditions and Cystic Fibrosis, need to be considered on a case by case basis.

5.5.2 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.

5.5.3 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.

5.5.4 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 in paediatrics or the neonatal unit and other patients have been exposed and 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. In adult patients who are RSV positive, they must be isolated and their contacts observed for symptoms. Adult patient contacts do not require isolating unless they become symptomatic.
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 prevention and control team to confirm control measures including unit closure and the possible use of prophylaxis with Palivizumab.

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 document will remain with the Lead Nurse, Infection Prevention and control. An electronic copy will be maintained on the Trust Intranet, P – Policies (Trust-wide) – R – Respiratory Syncytial Virus – Policy for the Management of. 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.

7. **PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY**

7.1 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 are appropriately placed on wards so as to minimise the risk of infection to others</td>
<td>Annual audit of patient placement</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 policy has been adhered to and a formal report will be written and presented at the Infection Control and Decontamination Assurance Group (ICDAG).

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 ICDAG which is held quarterly.

7.5 **Recommendations/ Action Plans**
Implementation of the recommendations and action plan will be monitored by the ICDAG.

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

Green Book 2015. Respiratory syncytial virus Chap 27a v 2_0 p1. Available at

Public Health England 2008. Respiratory syncytial virus (RSV): symptoms, transmission, prevention, treatment. Available at:
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>
</tr>
</thead>
<tbody>
<tr>
<td>The key changes if a revised policy/strategy</td>
<td>No significant changes</td>
</tr>
<tr>
<td>The key objectives</td>
<td>The purpose of this policy is to prevent the spread of RSV amongst patients, staff and visitors.</td>
</tr>
<tr>
<td>How new staff will be made aware of the policy and manager action</td>
<td>Senior nurse and matrons to ensure that all relevant staff are aware of this guidance and how to access it on the intranet</td>
</tr>
<tr>
<td>Specific Issues to be raised with staff</td>
<td>Nil</td>
</tr>
<tr>
<td>Training available to staff</td>
<td>Annual essential training provides the principles on which this policy is based</td>
</tr>
<tr>
<td>Any other requirements</td>
<td>Nil</td>
</tr>
<tr>
<td>Issues following Equality Impact Assessment (if any)</td>
<td>No negative impact</td>
</tr>
<tr>
<td>Location of hard / electronic copy of the document etc.</td>
<td>Trust intranet ‘Hub’</td>
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</table>
APPENDIX 2: EQUALITY IMPACT ASSESSMENT TOOL

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

Division/Directorate and service area
Trust wide

Name, job title and contact details of person completing the assessment
Carlton Kneil
Infection Prevention and Control Nurse Specialist

Date completed:
08/07/17

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 policy is to prevent the spread of RSV in the hospital environment.

2. Who does it mainly affect?
Carers ☐   Staff ☐   Patients ☒   Other (please specify)

3. Who might the policy have a ‘differential’ effect on, considering the “protected characteristics” below?

<table>
<thead>
<tr>
<th>Protected characteristic</th>
<th>Relevant</th>
<th>Not relevant</th>
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<tbody>
<tr>
<td>Age</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Disability</td>
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<td>☒</td>
</tr>
<tr>
<td>Sex - including: Transgender, and Pregnancy / Maternity</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Race</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Religion / belief</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Sexual orientation – including: Marriage / Civil Partnership</td>
<td>☐</td>
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</tbody>
</table>

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to... (e.g. those

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affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

All patient groups

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

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?**

There were no concerns that may be relevant to equality or human rights identified during the creation of this policy

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>
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<tbody>
<tr>
<td>Issue:</td>
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<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>
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