Isolation Policy

Policy PH 12

November 2008
## Title of document
Isolation Policy

## Type of document
Policy  PH 12

## Description
This policy is intended to provide some general principles of isolation precautions, when they may be required and the rationale behind their use in-patient areas of provider services Northamptonshire teaching Primary Care Trust.

## Target audience
All staff

## Author
Infection Control Team

## Department
Infection Control

## Directorate
Provider Services

## Approved by
Infection Control Committee

## Date of approval
9 December 2008

## Version Number
1

## Next review date
October 2009. Document will be reviewed annually or earlier if necessary

## Related documents
- Essence of Care (2001)
- The Health Act 2006: Code of Practice for the prevention and control of health care associated infections
- Essential Steps to Safe Clean Care (2006)
### Superseded documents

| Infection Control Policy and Guidelines for Northamptonshire Heartlands Primary Care Trust (2003) |
| Infection Control Policy and Guidelines for Northampton Primary Care Trust (2005) |
| Infection Control Policy and Guidelines for Daventry and South Northants Primary Care Trust (2005) |

### Internal distribution

- All staff

### External distribution

- Health Protection Agency
- Northampton General Hospital
- Kettering General Hospital

### Availability

- Shared drive & Livelink
- Intranet site (primary care staff) ✓
- Internet site (general public)

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1. **Introduction**

1.1 This policy is intended to provide some general principles of isolation precautions, when they may be required and the rationale behind their use in patient areas of provider services Northamptonshire teaching Primary Care Trust. This document is also available via the intranet.

1.2 Isolation precautions should be used for patients who are either known or suspected to have an infectious disease, are carrying a multi-resistant organism or are particularly vulnerable to infection. It is important however, that staff ensure that standard infection control precautions are used for all patients regardless of their infection status. These include the use of gloves, aprons, masks and visors following a risk assessment to identify the risks of exposure to blood, body fluids and micro-organisms. The Trust’s Infection Control Policy (2007) highlights the broad and complex issues relating to infection prevention and control and is available on the intranet.

2. **Scope of the Policy**

2.1 Evidence suggests that some healthcare associated infections are preventable through adherence to good infection control procedures.

2.2 This policy applies to all staff employed within Northamptonshire teaching Primary Care Trust and staff working in a contracted capacity.

2.3 This policy confirms Northamptonshire teaching Primary Care Trust’s (NtPCT) commitment to the prevention and control of infection. This is to be achieved through the development of policies and guidelines supporting this overarching policy and the promotion of training and education in infection prevention and control procedures.

3. **Modes of Transmission**

3.1 Infection can spread by a number of methods: airborne, droplet, contact and blood-borne spread

- **Airborne transmission** occurs by dissemination of droplet nuclei or dust particles containing the infectious agent; microorganisms are therefore dispersed widely and over long distances.

- **Droplet transmission**: droplets are generated from the source person primarily during coughing, sneezing and talking and are propelled a short distance only; hence special ventilation is not required to prevent transmission.
• **Contact transmission** is the most important and frequent mode of transmission and involves either direct person-to-person contact or indirect contact via a contaminated intermediate object.

• **Blood-borne infection** via inoculation is prevented by standard precautions which should, however, be applied to all patients.

4. **Source Isolation**

4.1 Source isolation is the physical separation of one patient from another, in order to prevent spread of infection. Standard Infection Control Precautions must be observed at all times with all patients, including those in isolation.

5. **Protective isolation**

5.1 Protective isolation (reverse barrier nursing) is the physical separation to prevent the transmission of infection to an immunocompromised patient. It does not involve the special precautions of full protective isolation, which aims to protect from commensal (endogenous) infection in patients whose neutropenia is likely to be prolonged. Standard Infection Control precautions must be observed at all times with all patients including those in source or protective isolation.

6. **Cohort Nursing**

6.1 Cohort nursing patients with the same organism (or displaying similar signs and symptoms of infection) is an alternative form of nursing should single room capacity be exceeded.

6.2 The decision to implement cohort nursing must be based on a risk assessment carried out in conjunction with the Infection Control Team and documented. The need to cohort the patients must be reviewed daily with a view to moving patients into single rooms as soon as possible and discontinuing the cohort area. The Infection Control Team will advise on additional resources required for effective cohort isolation care.

6.3 Cohort patients should be cared for by designated staff.

6.4 For effective isolation, bays should have doors that can be closed to provide physical separation from other patients.

6.5 In some areas it may be necessary to cohort patients into specific areas of the unit/ward, ensuring that these areas can be physically separated from the rest of the ward.

6.6 On ceasing the cohort isolation the area must be thoroughly cleaned before opening to patients.
7. **Isolation Procedure Key points**

7.1 Decision to isolate a patient should be based on a risk assessment, carried out in conjunction with the Infection Control Team.

7.2 Regular assessment and evaluation of the situation must occur to ensure appropriate use of isolation facilities.

7.3 The patient must be nursed in a single room with a wash basin and preferably an en-suite toilet. If an en-suite toilet is not available, a commode for sole use of the isolated patient should be kept in the isolation room for the duration of the patient's stay.

7.4 Ensure the isolation room door is closed at all times.

7.5 Limit the number of staff entering the isolation room. Reducing the number of staff who come into contact with the patient will further reduce the risk of spreading the infection.

7.6 Psychological support and reassurance must be given to the patient whilst in isolation.

7.7 Ensure a source isolation notice is displayed on the door.

7.8 Ensure all staff are aware of the necessary precautions.

8. **Risk Assessment**

8.1 A risk analysis approach should be carried out. Risk assessment is the assessment of the factors that influence the transmission of a pathogen and its impact. It enables staff to prioritize the use of isolation facilities and must be done in conjunction with the Infection Control Team.

8.2 When undertaking a risk assessment with the Infection Control Team the following factors will be considered:

- The classification of the pathogen and the ability to protect against or treat individual infections.
- The probable route of transmission and evidence of transmission.
- Susceptibility of the other patients near to the infected patient in the same bay i.e. do the other patients have open wounds or an invasive device.
- Whether the organism is antibiotic resistant.
• Possible detrimental effects of isolation to the patient i.e. risk of falls, confusion or depression weighed against severity of the risk of transmission to other patients.
• Isolated patients may experience more anxiety and depression. Isolation may hamper rehabilitation. To reduce these risks, preparatory information should be given wherever possible:
• Explanation of the nature of disease or organism, symptoms and treatment.
• Control methods and their rationale with advice for patients regarding the responsibility and their adoption of correct measures.
• Regular assessment and evaluation of the situation, in conjunction with the Infection Control Team is necessary to decide if isolation of the patient remains the most appropriate form of care.

8.3 The NnPCT Community Infection Prevention Tool must be used to identify patients at risk of infection, to identify further actions required

9. How to prepare the room

9.1 Make sure that all unnecessary equipment and furniture are removed from the room; this will facilitate cleaning and limit the items, which may become contaminated.

9.2 It is important that the equipment in the room is dedicated to the isolated patient.

9.3 Do not overstock the room, as equipment that cannot be cleaned will need to be disposed of.

9.4 All personal belongings and equipment should be washable, cleanable or disposable.

9.5 Discourage the patient from keeping unnecessary belongings in the room, but remember the need for psychological care of the patient whilst he/she is in isolation.

9.6 Place isolation sign on the door (see appendix 1). The sign is designed to inform anyone intending to enter the room of the situation, but not label the patient as being infectious. All isolation rooms, bays and bed spaces must be identified by an Isolation door sign.

9.7 Set up a trolley/table/shelf outside the room with single use gloves and aprons.
9.8 Ensure that alcohol hand rub/gel is available (except where the patient/s has diarrhea or vomiting when only soap and water must be used) within the constraints of COSHH.

9.9 Keep charts and patient notes **OUTSIDE** the room to reduce the risk of contamination.

9.10 Make sure the hand washbasin is stocked with appropriate hand hygiene product (discuss with the Infection Control Team if necessary) and paper towels.

9.11 Place clinical waste bag, sharps bin, water-soluble alginate bag for infected linen in the room.

10. **How to care for the patient**

10.1 Standard precautions must be used at all times (please refer to NtPCT Standard Precaution Policy)

11. **Hand hygiene**

10.1 Strict and thorough hand washing with soap and running water is essential prior to entry to the isolation room and after any direct contact with the patient or his/her immediate environment e.g. bed making, moving the patient, cleaning etc. Hands must be washed with soap and running water after removing gloves.

10.2 Alcohol based hand rubs are an alternative to hand washing on visibly clean skin or a supplement to hand washing to achieve a higher level of disinfection. (please refer to NtPCT Hand Hygiene Policy) **DO NOT use alcohol gel if managing a patient with Clostridium difficile, diarrhoea or vomiting as it is not effective for these cases.**

10.3 Encourage the patient to cleanse their hands before eating and after going to the toilet.

12. **Protective clothing**

12.1 Wear single use gloves for direct patient contact, contact with body fluids, potentially infectious material or when touching items in the environment which may be contaminated.

12.2 Wear single use plastic apron for close patient contact (e.g. bed bathing, moving patient), when in close contact with potentially infected material (e.g. bed making), and any other situation when contamination of clothing may occur.
12.3 Remove apron, then gloves and discard promptly into yellow clinical waste bag.

12.4 Wash and dry hands thoroughly after having removed protective clothing and before leaving the isolation room. Use the alcohol hand rub/gel outside the room.

12.5 Except in certain circumstances there is little evidence that the use of masks contributes to preventing cross infection. If in doubt, discuss with the Infection Control Team.

12.6 Protection of eyes, nose and mouth may be necessary if blood/body fluid sprays or splashes are possible. The following options are available: safety spectacles, goggles, masks and visors. Visors usually offer the best protection.

12.7 Dispose of all excreta promptly, preferably by discarding it directly into the bedpan washer/macerator or the patient’s own toilet. Use protective cover for bedpans/urinals/vomit bowls when transporting to the sluice room.

12.8 Protective clothing used within the isolation room may be worn to the sluice room, but discarded immediately into clinical waste bag after disposal of excreta.

12.9 Ensure thorough and frequent cleaning of the commode/toilet using Chlorine solution of 1000ppm.

12.10 Deal with any blood/body fluid spillage immediately, wearing appropriate protective clothing and disinfecting the spillage with 10,000 ppm chlorine releasing solution.

12.11 Place waste contaminated with blood/body fluids directly into the yellow clinical waste bag in the isolation room. As soon as these bags are 2/3 full the bags must be tied in a swan neck and a tag attached indicating place of origin. The bags must be removed from the room to the waste storage area and a new clinical waste bag placed in the isolation room.

12.12 All linen within the isolation room must be placed into water soluble alginate bags. This includes unused linen when the room is no longer required for isolation purposes.

12.13 Double bagging of clinical waste and linen is unnecessary, as studies have shown that the outer surface of the bags does not become significantly contaminated.

13. Crockery/cutlery
13.1 All crockery/cutlery must be decontaminated in a dishwasher with a final rinse temperature of 80°C.

13.2 Washing by hand is inadequate without a final rinse for one minute at 80°C.

13.3 There is no requirement for disposable crockery and cutlery to be used.

13.4 The highest standard of food hygiene must be followed.

14. Dressings

14.1 All wounds should be dressed in the isolation room using aseptic technique (see aseptic technique policy).

15. Cleaning

15.1 The Infection Control Team will advise on the frequency of cleaning the isolation rooms and solutions to be used.

15.2 The nurse in charge must inform the locality supervisor of the need for isolation cleaning.

15.3 The vacated bed, mattress and bed area on the ward must be thoroughly cleaned before it can be reoccupied.

15.4 Make sure that separate cleaning equipment is being used to clean the isolation rooms. This equipment must be kept clean and dry within the room. The mop head must be removed and sent to the laundry after each use.

15.5 Isolation rooms, cohort areas should be cleaned last, after other rooms, bays and general areas on the ward

15.6 Single use gloves and aprons must be worn when cleaning the isolation rooms and hands washed before leaving the room.

15.7 Special attention must be given to all horizontal surfaces and frequently touched surfaces, such as door handles/door push plates, nurse call system, toilet areas and sink taps.

15.8 Fresh flowers are not permissible in isolation rooms.

15.9 Following discharge or transfer of the patient from the isolation room, the room must be thoroughly cleaned. Curtains and walls need only be washed if visibly soiled.
16. **Investigations/visits to other departments**

16.1 Transport of patients to other departments should be avoided or kept to a minimum. Ideally, investigations should be performed in the isolation room. If visits to other departments/wards are unavoidable, please contact the Infection Control Team.

16.2 The receiving department should also be contacted to ensure that adequate precautions are taken.

16.3 In principle the patient from the isolation room should be last on the list to minimize contact with other patients. The same precautions taken on the ward should be carried out in the department.

16.4 Transfers to other wards/health care institutions. These should only take place if unavoidable, please discuss with the Infection Control Team. The receiving ward must be informed and a single room arranged.

16.5 The patient’s health should take priority over the infection problem; e.g. if the patient is required to be transferred to an acute unit. Please complete the form in appendix 2 when transferring patients between hospitals.

17. **In the case of death**

17.1 In order to protect the mortuary staff; follow the NIPCT Care of the Cadaver Policy document pending. Contact Infection Control Team for advice.

18. **What about visitors/parents/carers?**

18.1 Visitors must report to the nurse in charge prior to visiting the patient. Explain the reason for isolation, maintaining confidentiality at all times, (if available, give information leaflet on specific infection) Advice should be given on hand hygiene and/or other precautions. Encourage visitors not to have contact with other patients on the ward.

18.3 Visitors need only wear protective clothing if they are going to have close contact with the patient, e.g. helping with patients physical care, or if otherwise advised.

18.4 Discuss with the Infection Control Team, or see specific disease policy to ascertain if visitors should be excluded from visiting due to particular susceptibility.

19. **When can isolation precautions be stopped?**

19.1 When the patient is no longer at risk of spreading infection to others.
19.2 Frequent assessment and evaluation of the patient’s situation is therefore important.

19.3 Some specific disease policies give criteria on when isolation precautions can be stopped. If in doubt, discuss with the Infection Control Team.

19.4 Make sure the vacated room is thoroughly cleaned. Use the same solutions and equipment that have been used for isolation cleaning. All equipment and belongings must be cleaned before being brought out of the room or used again. Any unused disposable items, which may be contaminated and cannot be cleaned, must be disposed of.

20. Training

20.1 Any infection control education and training, provided by NtPCT’s Infection Control Nurses will reinforce the importance of effective isolation practice in preventing the spread of infection while supporting good practice with research. Training needs for staff are regularly identified through the Primary Care Trusts training needs analysis. Infection Control Training is mandatory for all staff who have direct hands on contact with patients. Attendance at mandatory training is monitored through the Training Department.

20.2 Infection control is also a component of the organisations corporate induction and mandatory training programmes. Every member of staff has a responsibility to attend training and to maintain their knowledge and skills in infection control.

20.3 Staff that require further training or information should contact the Infection Control Team at Nene House, Isebrook Hospital (Telephone no. 01536 494001 answer phone).

21. Audit and Monitoring

21.1 A fundamental principle of infection prevention and control is the creation and maintenance of environments and processes that ensure safety for patients, visitors and staff. A systematic approach to this has been developed through a comprehensive programme of audit. These audits are undertaken either as a questionnaire or as an observational audit, by the Infection Control Team to the relevant clinical areas for completion by the team at a local level or the Infection Control Team visit the clinical areas and undertake an observational audit.

21.2 The PCT’s isolation facilities and practices are audited on a rolling programme based on the Infection Prevention Society’s audit tool. This audit can be used to:

- Identify areas for improvement
• Determine whether or not staff are adhering to the policy.
• Help determine if staff require further education or training in the area covered by the policy.
• Help determine if a lack of resources is an obstacle to the correct implementation of the policy.
• Help determine if the policy contains recommendations, which need to be modified.

21.3 All audit reports and subsequent activity and outcomes are reported to the Infection Control Committee of the PCT and are used to demonstrate compliance to the Health Act 2006, Standards for Better Health (2 and NHSLA requirements.

22. References and further reading

Appendix 1

SOURCE ISOLATION

Before contact with the patient or items in the room you MUST:

1. Wear Gloves

2. Wear APRON

Remove PROTECTIVE CLOTHING and wash hands before leaving the room

All visitors and staff please wash your hands before leaving the room.
## Appendix 2

### Inter Health Care Infection Control Transfer Form

<table>
<thead>
<tr>
<th>Patient/Client details: (insert label if available)</th>
<th>Consultant:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current patient/client location:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NHS Number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Transferring facility – hospital, ward, care home, other:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Telephone No:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Receiving facility – hospital, ward, care home, district nurse:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contact No:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Is the ICT/Ambulance service aware of transfer?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Yes/No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is this patient/client an infection risk?</th>
</tr>
</thead>
</table>

*Please tick the most appropriate box and give confirmed or suspected organism.*

<table>
<thead>
<tr>
<th>□ Confirmed risk</th>
<th>Organism</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Confirmed risk</td>
<td>Organism</td>
</tr>
<tr>
<td>□ Suspected risk</td>
<td>Organism</td>
</tr>
<tr>
<td>□ No known risk</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If the patient/client has diarrhoeal illness, please indicate bowel history for last week: (based on Bristol Stool Chart)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Specimen</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Relevant specimen results and treatment information, including antimicrobial therapy</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Treatment information</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Other Information:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is the patient/client aware of their diagnosis/risk of infection?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Yes/No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Does the patient/client require isolation?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Yes/No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of staff member completing form</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Print name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Telephone No:</th>
<th>Date:</th>
</tr>
</thead>
</table>

For further advice please contact your Infection Control Team
<table>
<thead>
<tr>
<th>MRSA RISKS</th>
<th>Pts</th>
<th>C.DIFFICILE RISKS</th>
<th>Pts</th>
<th>AGE</th>
<th>Pts</th>
<th>SKIN/WOUND RISKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA Colonised</td>
<td>1</td>
<td>Does the patient have diarrhoea?</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>Skin Infection</td>
</tr>
<tr>
<td>MRSA Infection</td>
<td>2</td>
<td>Is the diarrhoea thought to be of infectious nature?</td>
<td>2</td>
<td></td>
<td>1</td>
<td>Wound Infection</td>
</tr>
<tr>
<td>Own home &amp; respite care?</td>
<td>1</td>
<td>Any catheters/lines eg: peg feeds, IV's?</td>
<td>5</td>
<td>Under 65</td>
<td>2</td>
<td>Exudate from lacerations, boils and carbuncles</td>
</tr>
<tr>
<td>Care Home?</td>
<td>1</td>
<td>Has patient been prescribed antibiotics in the past 8 weeks?</td>
<td>5</td>
<td>Over 65</td>
<td>3</td>
<td>Peripheral line infections</td>
</tr>
<tr>
<td>Any broken skin areas?</td>
<td>2</td>
<td>Is patient taking Proton Pump Inhibitors?</td>
<td>5</td>
<td></td>
<td>3</td>
<td>Venous or pressure ulcer wounds</td>
</tr>
<tr>
<td>Any catheters/lines ie:</td>
<td>5</td>
<td>Previous C. difficile infection?</td>
<td>6</td>
<td></td>
<td>1</td>
<td>Other slow to heal wounds</td>
</tr>
<tr>
<td>peg feeds, IV's?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of frequent or</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>transfer into Hospital</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Previous infections/MRSA</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital aboard</td>
<td>1</td>
<td>Please state when</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SPECIAL RISKS

<table>
<thead>
<tr>
<th>URINARY TRACT RISKS</th>
<th>Pts</th>
<th>OTHER INFECTION RISKS</th>
<th>Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected/confirmed urinary tract infection (UTI)?</td>
<td>3</td>
<td>Fever/confusion of unknown origin?</td>
<td>2</td>
</tr>
<tr>
<td>Recurrent UTI with the risks for multi-resistant ESBL (and antibiotic history)?</td>
<td>6</td>
<td>History of foreign travel?</td>
<td>1</td>
</tr>
<tr>
<td>Urinary catheter in situ or inserted in past 6 weeks?</td>
<td>5</td>
<td>If living in a care home are they in a shared room?</td>
<td>3</td>
</tr>
</tbody>
</table>

On completion of the assessment consider:
What immediate actions will need to be taken? i.e: protective clothing such as gloves and apron, hand hygiene and environmental cleaning. N.B. ALCOHOL GEL MUST NOT BE USED IN CASES OF DIARRHOEAL INFECTION.
Does the patient need to isolated? EQUIPMENT SHOULD NOT BE SHARED BETWEEN PATIENTS UNLESS IT IS CLEANED BETWEEN PATIENT USE.

Total points =

< 10 not at risk
10 + Medium risk
15 + High risk
Always practice good hand hygiene. Use soap and water for hand washing when:

- hands are visibly soiled
- The patient is experiencing vomiting and/or diarrhoea
- When in contact with any body fluids
- After wearing gloves and apron

Handwashing Technique

1. Palm to Palm
2. Backs of hands
3. Between fingers
4. Finger tips
5. Thumbs and wrists
6. Nails

Remember! The six step handwashing technique
## Policy Impact Assessment – Screening Tool

**Name of Directorate:** Public Health  
**Date of Assessment:** November 2008  
**Policy being assessed:** Isolation Policy  
**Assessment Carried out by:** Jenny Boyce

<table>
<thead>
<tr>
<th>23. Policy Title</th>
<th>Who is affected</th>
<th>Statutory requirements</th>
<th>Full Assessment Needed</th>
<th>Priority</th>
</tr>
</thead>
</table>
| As Above         | Staff  
Patients  
Visitors  
Contractors  
Volunteers  
Health Act (2008)  
NHSLA (2007)     | Yes                        | High            |
Policy Impact Assessment – Full Assessment Tool

Name of Directorate: Provider Services  
Date of Assessment: November 2008

Policy being assessed: Isolation Policy  
Assessment Carried out by: Jenny Boyce

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What consultation process will be undertaken?</td>
<td>Infection Control Committee, Governance Committee, SHA, Electronically, Infection Control Team records</td>
</tr>
<tr>
<td>2. Where will records of this consultation be kept?</td>
<td></td>
</tr>
<tr>
<td>1. What existing monitoring arrangements are in place?</td>
<td>Certain aspects of the policy are audited annually.</td>
</tr>
<tr>
<td>2. Are these sufficient?</td>
<td>Yes as a rolling programme. If particular issues arise we will audit these.</td>
</tr>
<tr>
<td>3. Are any additional arrangements required</td>
<td></td>
</tr>
<tr>
<td>1. How will the results of the assessment be published?</td>
<td>Via Infection Control Committee</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>See section 1.1 1.2, 3.1 and section 6.0</td>
<td>Statutory requirements. Policies reviewed annually or sooner if national guidance changes.</td>
</tr>
</tbody>
</table>