

ISOLATION POLICY

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Contents

(For quick access to a specific heading - press CTRL and click your mouse to follow the link for the below options)

1.	INTRODUCTION.....	3
2.	PURPOSE	3
3.	SCOPE	3
4.	DEFINITIONS	3
5.	RESPONSIBILITIES	4
6.	POLICY STATEMENT.....	4
7.	PROCEDURE	4
8.	MONITORING AND REVIEW	12
9.	REFERENCES.....	12
10.	ASSOCIATED POLICIES & PROCEDURES	13
11.	AUTHOR	13
12.	APPENDICES.....	13
1.	Appendix – Cleaning Chart	14
13.	EQUALITY & DIVERSITY IMPACT ASSESSMENT	17
14.	DOCUMENT CONTROL	17

1. INTRODUCTION

The correct and timely placement of infected patients (suspected or proven) into single rooms can be very effective in reducing the overall numbers of infected patients; it can also reduce the risk of colonisation in other patients within the ward. Isolation practices can also be carried out within ward areas; this is called 'cohorting'. Through such measures, it is possible to control the spread and minimise the impact of infections such as MRSA, Clostridium difficile and other Health Care Associated Infections (HCAIs).

It is the responsibility of healthcare bodies to ensure that:

'Patients presenting with an infection or who acquire an infection during treatment are identified promptly and managed according to good clinical practice, for the purposes of treatment and to reduce the risk of transmission' (Health Act 2008). They also have a duty to provide 'adequate isolation facilities for patients sufficient to prevent or minimise the spread of HCAIs'.

2. PURPOSE

The purpose of this policy and procedure is to provide concise guidance for all staff and minimise the potential risks when caring for patients with an infection.

3. SCOPE

This policy and procedure applies to all staff either employed or contracted within in-patient areas in East Coast Community Healthcare CIC (ECCH).

4. DEFINITIONS *(if relevant)*

The following definitions are intended to provide a brief explanation of the various terms used within this policy.

Term	Definition
Policy	A policy is a formal written statement detailing an enforceable set of principles or rules. Policies set the boundaries within which we operate. They also reflect the philosophy of our organisation.
Droplet	Micro-organisms transmitted through the air within droplets, mainly saliva.
Airborne	Micro-organisms carried in droplet nuclei or by dust particles (skin scales or clothing fibres).
Ingestion	Ingested into the body with food or water causing gastrointestinal infections and excreted in the faeces.
Vector	Transmission via insects or rodents.

5. RESPONSIBILITIES

- **ECCH Employees** – Are responsible for the implementation of this policy and following the requirements of the policy.
- **Chief Executive of ECCH** – Overall responsibility for the enforcement of this policy lies with the Chief Executive of ECCH
- **ECCH Board** – Are responsible for responsible for ensuring assurance that appropriate and effective policies are in place to minimise the risks of health care associated infections.

6. POLICY STATEMENT

This policy will be implemented to ensure adherence to safe practice.

7. PROCEDURE

Routes and modes of transmission

Transfer from body surface to body surface or between an infected or colonised person and susceptible host (DIRECT). Contact with contaminated objects or surfaces in the environment (INDIRECT).

Droplet
Airborne
Ingestion
Vector

When to isolate

The decision to isolate a patient should be based on the infection risk to other patients identified by the staff looking after the patient.

The factors that need to be taken into account when assessing the risk of transferring infection to other patients include;

- The site or specimen from which the infection has been isolated (eg wound swab, sputum etc).

NB leaking wounds, drains in situ, exfoliating skin problems and coughing and expectorating patients carry a higher risk of transmission to others due to the nature in which it can be spread, eg a coughing patient will cough out large numbers of micro-organisms which will become airborne, a patient with exfoliating skin problems will shed skin scales in and around the environment which will come into contact with others, similarly a patient with a leaking wound that is striking through a dressing frequently would introduce high levels of infectious exudates into the environment. Patients with infective diarrhoea and/or vomiting can also pass the infection to other patients via their own hands/skin, the hands of healthcare workers and environmental contamination

- Whether the patient has clinical evidence of an infection (i.e. has associated symptoms) or is colonised (i.e. is asymptomatic)
- The patient has unexplained symptoms of diarrhoea and/or vomiting

- The environment in which the patient is being managed (i.e. the susceptibility of other patients to the infection)
- The organism that is causing the infection

Please refer to the specific protocols and policies

- Viral Gastroenteritis
- Clostridium difficile
- Infection control management of Tuberculosis
- Transmissible Spongiform Encephalopathies
- Staphylococcus aureus and MRSA
- Multi-drug resistant organisms
- Respiratory viruses
- CPE

The Infection Prevention and Control Team is available to discuss, and assist with risk assessment

- A risk analysis approach should be carried out. For example, patients who wander or have poor hygiene are more likely to cause cross-infection.
- Isolated patients may experience more anxiety and depression. Isolation may hamper rehabilitation. To reduce these risks, preparatory information should be given wherever possible. Staff should explain the nature of the disease or organism, symptoms and treatment to the patient. Control methods and their rationale with advice for patients regarding their responsibility and their adoption of correct measures must also be clearly described.

Regular assessment and evaluation of the situation, in conjunction with the Infection Prevention and Control Team is necessary to decide if isolation of the patient remains the most appropriate form of care.

Source isolation

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) by **all** staff.

Key points

- Decision to isolate a patients must be based on a risk assessment.
- Regular assessment and evaluation of the situation must occur to ensure appropriate use of isolation facilities.
- The patient must be nursed in a single room with a wash basin and preferably an en-suite toilet.
- Ensure the isolation room door is closed at all times apart from necessary entrances and exits.
- 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.
- If isolation is for childhood diseases (i.e., infections such as measles, mumps, rubella, for which routine vaccination occurs, or chicken pox), it is preferable that only staff who

are immune to the disease attend to the patient (see specific guidelines, or if necessary, discuss with the Infection Prevention and Control Team (IPCT) and/or Occupational Health Department).

- Psychological support and reassurance must be given to the patient whilst in isolation.
- Ensure all staff are aware of the necessary precautions.
- Single/isolation rooms are deep cleaned twice a day. Prior to this the domestic staff liaise with the nurse in charge to ascertain which single rooms are being utilised for isolation purposes. These rooms are then cleaned last, after other rooms, bays and general areas on the ward.
- Visitors are not expected to wear PPE unless directed by the IPCT or they are performing personal care.

How to prepare the room

- Ensure that all unnecessary equipment and furniture are removed from the room; this will facilitate cleaning and limit the items, which may become contaminated.
- It is important that the equipment in the room is dedicated to the isolated patient.
- The room should not be overstocked, as equipment that cannot be cleaned will need to be disposed of when patient is discharged.
- All personal belongings and equipment should be washable, cleanable or disposable.
- All equipment must be cleaned daily with detergent followed by a chlorine-based agent. Contact Infection Prevention and Control Team if in doubt.
- The patient should be discouraged from keeping unnecessary belongings in the room, thereby balancing the need for psychological care of the isolated patient whilst facilitating cleaning.
- Single use gloves and aprons are wall mounted outside of all single rooms. Sanitising hand rub/gel must be available within the constraints of COSHH.
- Charts and notes must be kept **outside** the room to reduce the risk of contamination.
- The hand wash basin is stocked with appropriate hand hygiene products (soap, sanitizing gel/liquid and paper towels).
- Clinical waste bin and sharps disposal container must be in the room.

How to care for the patient

- To reduce the risk of cross infection, adhere to a visiting policy, two visitors per patient per bed. Discourage small children and elderly frail from visiting.
- **Visitors with symptoms of infection must not be allowed, unless it is considered necessary due to patient being terminally ill or for psychological reasons, in which case inform Infection Prevention and Control Team to arrange safe visiting.**
- Visitors must not sit on the patient's bed, nor eat or drink whilst in the room
- Hand decontamination **must be** undertaken by everyone prior to entering and when leaving the room.
- Bed linen must be changed daily.
- Skin should be kept clean by daily bathing or washing.
- Patient should receive education on good hygiene practices. This should include washing hands before eating and after using the lavatory.

Hand Hygiene

- Always wash hands thoroughly with soap and water or use approved hand sanitizer before entering the room or immediately after entering the room. Hand sanitizer is an alternative to handwashing on visibly clean skin or a supplement to hand washing to achieve a higher level of disinfection, please refer to ECCH Hand Hygiene Policy.
- Strict and thorough hand washing is mandatory before and after any direct contact with the patient or his/her immediate environment e.g., bed making, moving the patient, cleaning etc. Also following removal of gloves.
- Remember when dealing with blood and/or body fluids, gloves must be worn, and hands must be decontaminated following the removal of the gloves.
- Encourage the patient to cleanse their hands before eating and after using the lavatory.

Protective clothing (PPE)

- Single use gloves must be worn for direct patient contact, contact with body fluids, potentially infectious material or when touching items in the environment which may be contaminated. Gloves must be changed between procedures on the same patient.
- Single use plastic apron for close patient contact (e.g., bed bathing, examining patient, moving patient), when in close contact with potentially infected material (e.g., bed making), and any other situation when contamination of clothing may occur. Aprons must be changed between procedures on the same patient.
- To discard PPE, remove apron, then gloves and discard promptly into clinical waste bag. Wash and dry hands thoroughly after removal of protective clothing and before leaving the isolation room. Use the sanitizer hand rub/gel outside the room.
- There is little evidence that the routine use of masks contributes to preventing cross infection, except in certain circumstances. For suspected and/or confirmed TB refer to TB policy. If in doubt, discuss with the Infection Prevention and Control Team.
- Protection of eyes, nose and mouth may be necessary if blood/body fluid sprays are likely, please refer to ECCH Standard Infection Control Precautions Policy. Masks are available in all clinical areas if required.
- Visitors are not required to wear PPE unless directed by the IPCT or they are performing personal care.

Disposal of body fluids, waste, linen and sharps

- Dispose of all excreta promptly, discarding it directly into the bedpan washer/macerator or the patient's own lavatory.
- Use protective cover for bedpans/urinals/vomit bowls when transporting to the sluice room.
- Protective clothing used within the isolation room may be worn to the sluice room but discarded immediately into orange clinical waste bag after disposal of excreta.
- Commodes must be thoroughly cleaned after every use with detergent followed by a chlorine-based agent.
- Deal with any blood/body fluid spillage immediately, wearing appropriate protective clothing and disinfecting the spillage with detergent followed by a chlorine-based agent.
- Place waste contaminated with blood/body fluids directly into the clinical waste bag in the isolation room. As soon as these bags are 2/3 full, they 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.

- All linen within the isolation room must be placed into water soluble alginate red bags. This includes unused linen when the room is no longer required for isolation purposes. The alginate bags must then be placed into the white laundry bags, which should be secured and taken to collection area.
- Needles, syringes, sharps must be disposed of into sharps containers at the point of use.
- 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.

Dressings

- All wounds should be dressed in the isolation room using Aseptic Non-Touch Technique (ANTT)

In the case of death

- Please refer to the ECCH 'Care of the Cadaver' policy

Terminal Cleaning

- The nurse in charge must inform the domestic supervisor of the need for terminal cleaning.

Investigations/visits to other departments

- Ideally, investigations should be performed in the isolation room.
- If visits to other departments/wards are unavoidable, please contact the Infection Prevention and Control Team and the receiving department to ensure that adequate precautions are taken. In principle the patient from the isolation room should be last on the list to minimise contact with other patients. The same precautions taken on the ward should be carried out in the department. The patient must not spend any time in the waiting area.

Transfers to other wards/health care institutions

- These should only take place if the patient can be suitably isolated or a written risk assessment is preformed indicating suitability, please discuss with the Infection Prevention and Control Team.
- The receiving facility must be informed, and a single room arranged.
- The Infection Prevention and Control Team will inform the relevant Infection Control Nurse about the transfer to other institutions.
- The patient's health should take priority over the infection problem and will require medical clarification, e.g. if the patient is required to be transferred to an ICU or CCU.

What about visitors/parents/carers?

- Explain the reason for isolation, maintaining confidentiality at all times, (if available give information leaflet on specific infection)
- Advise on hand hygiene and/or other precautions. Visitors must not have contact with other patients on the ward.
- **Visitors need only wear protective clothing if they are going to have close contact with the patient, eg helping with patient's physical care, or are otherwise advised.**
- Discuss with the Infection Prevention and Control Team or see specific disease policy to ascertain if visitors should be excluded from visiting due to particular susceptibility.

When can isolation precautions be stopped?

- When the patient is no longer at risk of spreading infection to others.
- Frequent assessment and evaluation of the patient's situation is therefore important.
- If in doubt, discuss with the Infection Prevention and Control Team.
- Make sure the vacated room is thoroughly cleaned.

Protective isolation

Protective isolation is the physical separation of a patient at high risk from common organisms carried by others. The aim is to prevent the transmission of infection to an immunocompromised patient.

The term immunocompromised applies to patients whose immune mechanisms are deficient. This may be due to immunologic disorders, infection, congenital immune deficiency syndrome, disease or immunosuppressive therapy.

Key points

- Protective isolation is necessary for patients with a severely compromised immune system.
- The patient must be nursed in a single room with a hand wash basin, and preferably en-suite facilities
- If commodes are used, they must be cleaned thoroughly with detergent followed by a chlorine based agent after each use.
- Ensure the isolation room **door is closed at all times**, apart from the necessary entrances and exits.
- 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 cross infection
- Staff who are nursing patients with infections in standard isolation should avoid nursing patients in protective isolation during the same span of a duty in order to reduce the risk of cross infection.
- Staff with infections should not be working in the environment and report to Occupational Health.
- Regular assessment and evaluation of the situation, in conjunction with the medical staff and/or the Infection Prevention and Control Team is necessary to decide if isolation of the patient remains the most appropriate form of care.
- Psychological support and reassurance must be given to the patient whilst in isolation

- Ensure all staff are aware of the necessary precautions.
- Ensure thorough daily cleaning of the room
- Protective isolation rooms should be cleaned first, before other rooms, bays and general areas on the ward.

How to prepare the room

- Ensure the room is meticulously cleaned before the patient is admitted
- Ensure that all unnecessary items of equipment and furniture are removed from the room in order to facilitate ongoing cleaning. Upholstered furniture/furnishings must not be used in isolation rooms.
- The patient should be discouraged from keeping unnecessary belongings in the room, balancing the need for psychological care of the isolated patient whilst facilitating cleaning.
- The room must not be overstocked, as equipment etc. that cannot be cleaned will need to be disposed of when the room has been vacated.
- The equipment in the room must be dedicated to the isolated patient.
- Charts and notes must be kept **outside** the room to reduce the risk of contamination.
- All personal belongings and equipment should be washable, cleanable or disposable.
- All equipment must be cleaned daily with detergent and a chlorine-based agent. Contact Infection Prevention and Control Team if in doubt.
- Single use gloves and aprons are wall mounted outside of all single rooms; hand sanitizer must be available within the constraints of COSHH.
- The hand wash basin must be stocked with appropriate hand hygiene products (soap, sanitizer gel/liquid, paper towels).
- Clinical waste bin and sharps disposal container must be in the room.

How to care for the patient

- To reduce the risk of cross infection, adhere to visiting policy, two visitors per patient per bed. Discourage small children and elderly frail from visiting.
- Visitors with symptoms of infection must not be allowed, unless it is considered necessary due to patient being terminally ill or for psychological reasons, in which case inform Infection Prevention and Control Team to arrange safe visiting.
- Visitors must be advised not to sit on the patient's bed, nor eat or drink whilst in the room
- Hand decontamination must be undertaken by everyone prior to entering and when leaving the room.
- Bed linen must be changed daily.
- Skin should be kept clean by daily bathing or washing.
- Patients should receive education on good hygiene practices. This should include washing hands before eating and after using the lavatory.

Hand Hygiene

- Always wash hands thoroughly with soap and water or use alcohol-based hand rubs before entering the room or immediately after entering the room. Sanitizer hand rubs are an alternative to handwashing on visibly clean skin or a supplement to hand washing to achieve a higher level of disinfection, see ECCH Hand Hygiene policy.

- Strict and thorough hand washing is mandatory before and after any direct contact with the patient or his/her immediate environment e.g., bed making, moving the patient, cleaning etc. and following removal of gloves.
- Hands must be decontaminated with soap and water when dealing with blood and/or body fluids.
- Encourage the patient to cleanse their hands before eating and after using the lavatory.

Protective clothing (PPE)

- Single use gloves must be for direct patient contact, contact with body fluids, potentially infectious material or when touching items in the environment which may be contaminated. Gloves must be changed between procedures on the same patient.
- Single use plastic aprons must be used for close patient contact (e.g., bed bathing, examining patient, moving patient), when in close contact with potentially infected material (e.g., bed making), and any other situation when contamination of clothing may occur. Aprons must be changed between procedures on the same patient.
- To discard PPE remove apron, then gloves and discard promptly into clinical waste bag. Wash and dry hands thoroughly after removal of protective clothing and before leaving the isolation room. Use the sanitizer hand rub/gel outside the room.
- There is little evidence that the routine use of masks contributes to preventing cross infection, except in certain circumstances. For suspected and/or confirmed TB refer to TB policy. If in doubt, discuss with the Infection Prevention and Control Team.
- Protection of eyes, nose and mouth may be necessary if blood/body fluid sprays are likely, refer to ECCH Standard Infection Control Precautions Policy. Masks are available in all clinical areas if required.

Disposal of body fluids, waste, linen and sharps

- Dispose of all excreta promptly, discarding it directly into the bedpan washer/macerator or the patient's own lavatory.
- Use protective cover for bedpans/urinals/vomit bowls when transporting to the sluice room.
- Protective clothing used within the isolation room may be worn to the sluice room but discarded immediately into a clinical waste bag after disposal of excreta.
- Commodes must be thoroughly cleaned after every use with detergent and a chlorine-based agent.
- Deal with any blood/body fluid spillage immediately, wearing appropriate protective clothing and disinfecting the spillage with detergent and a chlorine-based agent.
- Place waste contaminated with blood/body fluids directly into the clinical waste bag in the isolation room. As soon as these bags are 2/3 full these 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.
- Needles, syringes, sharps must be disposed of into sharps containers at the point of use.
- 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
- Other items of protective clothing, eg masks, overshoes, hats, are unnecessary for routine protective isolation.

Dressings

- All wounds should be dressed in the isolation room using Aseptic Non-Touch Technique (ANTT).

In the case of death

- Follow the ECCH policy for Care of the Cadaver.

Terminal Cleaning

- The nurse in charge must inform the domestic supervisor of the need for terminal cleaning.

Investigations/visits to other departments

- Ideally, investigations should be performed in the isolation room. Visits to other departments should only take place with medical permission.
- If it is deemed essential that the patient attend another department then he/she should not be placed in a communal waiting area and should never be placed in the same room, or adjacent to, people (staff or patient) with a known infection.

8. MONITORING AND REVIEW

This document will be reviewed by the Infection Prevention & Control Team in 2024, or sooner if changes in legislation occur or new best practice evidence becomes available.

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10. ASSOCIATED POLICIES & PROCEDURES

- Viral Gastroenteritis
- Clostridium difficile
- Infection control management of Tuberculosis
- Transmissible Spongiform Encephalopathies
- Staphylococcus aureus and MRSA
- Multi-drug resistant organisms
- Respiratory viruses
- CPE

11. AUTHOR

Infection Prevention & Control Team – September 2022

12. APPENDICES

1. Appendix 1 – Infections Chart

Appendix 1

Condition	Incubation period	Period of infectivity	Method of spread	Isolation code	Patient to:
Amoebic Dysentery	A few days to several months	As long as cysts are present in faeces	Faecal / Oral	SOURCE	Single room with own lavatory
Anthrax Cutaneous	1 – 7 days	Until lesions are free of organisms	Contact	SOURCE	Single room
Pulmonary	1 – 7 days	Not known to be transmitted from man to man	Inhalation		
Aspergillosis	A few days to a few weeks	Not transmitted from man to man	Inhalation	N/A	N/A
Brucellosis	5 – 21 days	Not transmitted from man to man	Ingestion and contact	N/A	N/A
Burns (extensive uninfected/infected)	N/A	N/A	N/A	PROTECTIVE	Single room
Chicken-pox (Varicella)	11-21 days	1 – 5 days before symptoms start until all lesions have completely dried and scabs have separated	Droplet and discharge from vesicles	SOURCE	Single room
Cholera	A few hours to a few days	Until stools are negative	Faecal / Oral	SOURCE	Single room with own lavatory
Creutzfeldt Jakob Syndrome	See policy			N/A	
Gastroenteritis and / or Diarrhoea Campylobacter	1 – 1- days 6 – 48 hours	Until 48 hours after symptom free	Faecal / Oral	SOURCE	Single room
Clostridium Difficile	Refer to policy				
Diarrhoea (continued) Cryptosporidium	Unknown	Until symptom free	Faecal/Oral	SOURCE	Single room with own lavatory
E.Coli 0157	2 – 4 days	As long as organism persists	“	“	
Rotavirus	1 – 3 days	Until 48 hours after symptom free	“	“	
Salmonella	6 – 48 hours	As long as organism persists	“	“	
Shigella	1 – 6 days	As long as organism persists	“	“	
Small round virus	1 -2 days	Until 48 hours after symptom free	“	“	
Typhoid/Paratyphoid	7 – 21 days				

Condition	Incubation period	Period of infectivity	Method of spread	Isolation code	Patient to:
		As long as organism persists			
Diphtheria	2 – 6 days	Whilst present in nose and throat	Droplet	SOURCE	Isolation Unit
Diphtheria Eye, wound, vaginal	“	Whilst present in discharge	Discharge	SOURCE	Isolation Unit
Gardiasis	6 – 22 days	Whilst cysts are present in faeces	Faecal/Oral	SOURCE	Single room
German Measles (Rubella)	14-21 days	1 week before to 1 week after appearance of rash	Droplet	N/A (Check on any non-immune pregnant contacts)	Single room
Hepatitis Type A		7 days after onset of jaundice		SOURCE	
Type B	10 – 40 days)	Faecal	SOURCE	Single room with own lavatory
Type C	1 – 6 months)	Blood and sexual contact	SOURCE	
Non A, B or C	1 – 6 months)variable – may be years)		SOURCE	
HIV/AIDS	Unknown	Unknown	Blood and sexual contact	PROTECTIVE	Single room with own lavatory
Herpes Simplex (Type I & II)	Unknown	6 days after appearance of vesicles	Contact	SOURCE – (For severe or disseminated cases)	Single room
Herpes Zoster (Shingles)	N/A	Until all lesions are completely dry and scabs separate	Inhalation	SOURCE	Single room
Immuno-suppressed Patients	N/A	N/A	N/A	PROTECTIVE	Single room with own lavatory
Impetigo	4-10 days	Until lesions are cleared	Contact	SOURCE	Single room
Legionnaires Disease	Not known	None	Inhalation	None	N/A
Leptospirosis (Weil's Disease)	6 – 15 days	Not person to person spread	Contact with urine of infected animals	N/A	Single room
Mumps	12 – 25 days	2 days before to 4 days after onset of swelling	Droplet and contact	SOURCE	Single room
Measles (inc. Encephalitis)	7 – 14 days	2 days before – 7 days after rash appears	Droplet	SOURCE	Single room
Meningitis Meningococcal	Usually 1 – 3 days	Until 24 hours after starting appropriate treatment	Droplet	SOURCE	Single room for 24 hrs after starting appropriate treatment

Condition	Incubation period	Period of infectivity	Method of spread	Isolation code	Patient to:
Other bacterial meningitis	Variable	Variable	Droplet	SOURCE	Single room
Viral	Variable	Variable	Faecal	SOURCE	Single room with own lavatory
MRSA refer to policy				SOURCE	Single room
Pertussis (whooping cough)	7 – 10 days	4 weeks from onset or 7 days from start of antibiotic treatment	Droplet	SOURCE (Masks should be worn unless history of previous infection or immunisation)	Single room
Poliomyelitis	3 – 21 days	7 days before onset until stools negative	Droplet and faecal	SOURCE (Masks required)	Single room
Pyrexia of unknown origin (with history of foreign travel)	consider possible	Viral Haemorrhagic Fever		SOURCE – Strict	Single room with own toilet
Rabies	4 – 6 weeks	3 – 5 days before onset of clinical signs and during course of disease	Bites, inoculation contact, inhalation	SOURCE – Strict	May need special isolation unit
Respiratory Syncytial Virus	4 days	Until pathogen cleared	Droplet	N/A but cohort nursing of infected patients	N/A
Scabies	Few days or weeks	Until treated	Skin to skin contact	N/A	N/A
Streptococcus Group A	1 – 4 days	Until antibiotic treatment is successfully completed	Droplet	SOURCE	Single room
Tuberculosis refer to policy					
Miliary TB/Meningitis	Variable	Until two weeks after starting treatment and clinical improvement	Droplet	SOURCE	Single room
Draining Lesion/urinary infection	Variable	Until two weeks after starting treatment and clinical improvement	Droplet	SOURCE	Single room
Closed Glandular	Variable	Until two weeks after starting treatment And clinical improvement	Contact	SOURCE	Single room
Multi Drug Resistant Tuberculosis	N/A	N/A	N/A	N/A	N/A
	Variable	May be prolonged	Droplet	Discuss with ICD/TB Specialist Nursing Team Requires specialist isolation unit	See detailed policy for Multi-resistant Tuberculosis

Condition	Incubation period	Period of infectivity	Method of spread	Isolation code	Patient to:
Typhoid/Paratyphoid	(SEE	DIARRHOEA)			
VRE-Vancomycin resistant Enterococci refer to policy	N/A	While organism present. Faecal carriage may be prolonged	Environmental and personal contact	SOURCE	Single room
Viral Haemorrhagic Fever	Unknown	Unknown	Body fluids/Blood	SOURCE seek urgent advice from ICD	Will need a special isolation unit

13. EQUALITY & DIVERSITY IMPACT ASSESSMENT

In reviewing this policy, the HR Policy Group considered, as a minimum, the following questions:

- Are the aims of this policy clear?
- Are responsibilities clearly identified?
- Has the policy been reviewed to ascertain any potential discrimination?
- Are there any specific groups impacted upon?
- Is this impact positive or negative?
- Could any impact constitute unlawful discrimination?
- Are communication proposals adequate?
- Does training need to be given? If so is this planned?

Adverse impact has been considered for age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation.

Blank version of the full Equality & Diversity Impact assessment can be found here:

http://eccho/Home/FormsGuidance.aspx?udt_575_param_index=E&udt_575_param_page=2

14. DOCUMENT CONTROL

Version Date	Version No.	Author/ Reviewer	Comments
March 2011	2	IPCT	Updated references
February 2013	3	IPCT	
December 2014	4	IPCT	
November 2016	5	IPCT	CPE added
September 2018	6	IPCT	
September 2020	7	IPCT	
September 2022	8	IPCT	

DOCUMENT CONTROL SHEET

Name of Document:	Isolation Policy
Version:	8
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Date Of This Version:	September 2022
Produced By (Designation):	Infection Prevention & Control Team
Reviewed By:	Infection Prevention & Control Team
Synopsis And Outcomes Of Consultation Undertaken:	Changes relating to relevant committees/groups involved in ratification processes.
Synopsis And Outcomes Of Equality and Diversity Impact Assessment:	No specific issues. National EIA gives details on measures to reduce HCAI's
Ratified By (Committee):-	IPACC
Date Ratified:	September 2022
Distribute To:	Intranet, Policy Group
Date Due For Review:	September 2024
Enquiries To:	infectionprevention@ecchcic.nhs.uk
Approved by Appropriate Group/Committee Approved by Policy Group Presented to IGC for information	<input type="checkbox"/> Date: <input type="checkbox"/> Date: <input type="checkbox"/> Date: