

**Policy Number
IP10
Title of Policy
Isolation Policy for Infectious Diseases**

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1.0 Policy Statement (Purpose / Objectives of the policy)

The Royal Wolverhampton NHS Trust is committed to minimising the risk and preventing the spread of microorganisms among patients, staff and visitors by the use of additional infection control precautions.

This policy describes the method and responsibilities for the appropriate and successful implementation of patient isolation for medical staff, nursing, midwifery and all allied health professionals (AHP) as well as staff under temporary contract or working in contracted services within the Trust.

This Policy applies to all services directly provided by the Trust, and all clinical staff must familiarise themselves with this policy.

This policy describes the practices and procedures to be followed to minimise and control the potential of cross infection with the appropriate and safe use of isolation facilities. This policy must be used in conjunction with the following policies:

- [Standard Precautions for Infection Prevention \(IP 12\)](#)
- [Prevention, Control and Management of *Clostridioides difficile* \(IP 06\)](#)
- [Hand Hygiene \(IP 01\)](#)
- [Outbreak of Communicable Infection/ Infection Prevention/ Serious Incident \(IP 13\)](#)
- [Waste Management Policy \(HS 10\)](#)
- [Management of Health and Safety \(HS 01\)](#)
- [Prevention and Control of MRSA, VRE and other Antibiotic Resistant Organisms \(IP03\)](#)

Isolation involves the use of practices aimed at controlling:

- The spread of pathogenic organisms amongst patients, visitors and staff
- The spread of infection from patients with communicable disease
- The spread of infection from patients colonised / infected with organisms that are resistant a range of antibiotics
- To protect those patients whose susceptibility to infection is increased

Patients who present a risk of infection or are at a specific risk of acquiring an infection due to their underlying medical condition must be isolated and/or risk assessed according to this policy.

All patients must be risk assessed for their need for isolation according to the procedure outlined in [Appendix 1](#) immediately when the risk has been identified e.g. on admission, or subsequently on development of symptoms.

2.0 Definitions

2.1 **Source Isolation** - This type of isolation is used for patients with known or suspected infection or colonisation by infectious agents which require additional precautions over and above standard precautions (see [Appendix 3](#)) to minimise the risk of transmission to other patients or staff.

2.2 **Protective Isolation** - This is isolation of a patient who is immunocompromised (due to underlying disease, such as cystic fibrosis, desquamatic dermatoses or

neutropenia, or medical treatment) to minimise the patient's exposure to infectious conditions.

- 2.3 **Cohort isolation** - Segregation of patients with the same infectious agent to reduce the potential for dissemination within a ward. Cohorting patients may be advised where single room availability demand is exceeded or during outbreaks where cohorting on a ward may be required, but must be following discussion with the Infection Prevention Team (IPT) or Microbiologist on call. There must be microbiological or confirmed clinical opinion that all patients to be cohorted have the same infection.
- 2.4 **Outbreak** - Two or more cases of the same disease where there is evidence or suspicion of an epidemiological link between the cases.
- 2.5 **Hand decontamination** - The process of removing organic matter and transient micro-organisms using a trust approved recognised hand wash technique with soap and water or as an alternative using alcohol hand gel at the of point of care where hands are physically clean.
- 2.6 **Personal Protective equipment (PPE)** - Protective equipment that is worn to provide a barrier from infectious agents and bodily fluids for example a plastic apron, disposable gloves and eye protection to be available in all care settings as a minimum. Additional respiratory protection may be required in conditions where infectious agents are spread by the airborne or droplet route (see [Appendix 3](#)).

3.0 Accountabilities

The appropriate and successful implementation of isolation procedures is widely recognised as an effective means for preventing transmission of infectious agents. This policy sets out the methods to be employed in order to achieve a range of various isolation practices, procedures and methods.

Advice can be sought from the IPT on the appropriateness of isolation. The IPT is available 9am – 5pm seven days a week including Bank Holidays. In the absence of the IPT out of hours, an on-call Microbiologist can be contacted via the Trust switchboard. The IPT must be contacted as soon as possible on the next working day.

3.1 The Director of Infection Prevention and Control (DIPC), Chief and Deputy Chief Operating Officers are responsible for:

- Facilitating the opening, operation and prompt closure of temporary additional isolation facilities

3.2 The Clinician is responsible for

- Ensuring patients are placed in isolation (following discussion with the Ward Manager and IPT), either to protect the patient (protective isolation), or to prevent the spread of infection to other patients, staff or visitors (source isolation)
- Identifying patients who require isolation and informing them of the requirement for isolation precautions.
- Some diseases are notifiable by law; it is the responsibility of the clinician who diagnoses these infections to notify the relevant Public Health England

unit and/or Consultants in Communicable Disease Control (CCDC) (see [Appendix 2](#))

- Seeking advice from the IPT regarding appropriate precautions and when these precautions can be stopped
- It is essential that electronic systems and notes are appropriately flagged, where appropriate and that General Practitioners, other Health Care professionals/ services and relevant social agencies are informed of the precautions required to manage patients appropriately on discharge
- The risk assessment undertaken to isolate the patient must be clearly documented in the patients medical records.

3.3 The Infection Prevention Team (IPT) responsible for

- Maintaining this policy and revision in light of new guidance or evidence
- Advising the Chief Operating Officer and Deputy Chief Operating Officers when local surveillance data indicates escalation of cases and the need for a temporary isolation facility to be opened
- All patients who are identified or suspected to have an infectious disease or alert organism will be risk assessed for the need of isolation. This will take place between the IPT, clinical team and the capacity team
- Advising on the time when it is safe to close a temporary isolation facility
- Advising on patient movement within positive and negative pressure isolation facilities
- Advising levels of environmental decontamination required when isolation is discontinued following discharge, transfer or death of a patient in source isolation.
- Surveillance to minimise the placement of patients who require isolation in side rooms
- Advising Trust Capacity Team and operational staff in the area affected by ward/bed closures in the event of confirmed or suspected outbreaks of infection.
- Advising on the isolation of individuals with infections/infectious diseases through the publication and maintenance of Infection Prevention policies, protocols and guidelines and provision of expert advice
- Communicating the content of and any updates to this policy in a clear and concise format for dissemination within the Trust
- Auditing and communication of audit results relating to this policy
- Providing advice where mandatory isolation is not required (see [Appendix 9](#)).
- Be available to talk to patients and relatives if requested at the earliest available opportunity.
- Where appropriate to indicate infectious status on electronic data systems and Patient Administration System (PAS)
- Providing education to clinical staff on the early detection of possible infectious conditions and possible outbreaks
- Providing training on Isolation Policy

3.4 Matrons and Clinical Directors are responsible for

- Co-ordinating Root Cause Analysis (RCA) for outbreaks of infection within their clinical areas
- Disseminating information on policy updates and audit results
- Ensuring that standards and protocols outlined in this policy are enforced within their areas of responsibility.

3.5 The Capacity Management Team is responsible for

- Facilitating the prompt movement/identification of patients who present a high risk of infection to other patients/ staff.
- Data collection on isolation usage from ward teams for distribution within the daily capacity report

3.6 Senior Sisters/Senior Charge Nurses and Department Managers are responsible for:

- Prioritising isolation facilities in their area
- Ensuring staff are aware of occupational health requirements and the process to follow when staff are managing patients with reportable conditions
- Placing the patient into isolation either to protect the patient, or to prevent the spread of infection to other patients, staff or visitors.
- Acting on information provided by patients which may indicate the need for the patient to be nursed in isolation (e.g. if a patient presents with an alert card for an alert organism)
- Ensuring that all members of staff adhere to this policy and the correct use of PPE
- Ensuring staff are aware of the screening process for MRSA, CPE and COVID of patients admitted to the Trust
- Ensuring staff are aware of the requirement to monitor effects of isolation for individual patients
- Assessing and monitoring patients for potential or actual adverse psychological effects of isolation and where necessary putting in controls to mitigate these effects e.g. for non-airborne infections allowing the door to the isolation room to be open during periods of minimal activity in the room; seeking advice from IPT to facilitate further risk assessment for continued/discontinued isolation
- Communicating appropriate room decontamination requirements with hotel service teams
- Ensuring that the patient and their relatives are properly advised about isolation procedures
- Ensuring other agencies are alerted to precautions required to manage patients safely and prevent transmission following discharge or transfer
- Ensuring staff in their area complete mandatory Infection Prevention updates and receive information on policy updates
- Ensuring that patients in their area of responsibility are identified as requiring isolation or risk assessed immediately a risk of infection arises (see [Appendix 1](#))
- Ensuring that staff utilise correct PPE in all care activities (see [Appendix 3](#))

- Displaying isolation signage to ensure correct use of PPE and isolation precautions for visitors and staff accessing isolation areas (see Appendix [4&5](#))
- Ensuring all staff are aware of this policy
- Alerting the IPT about patients with alert conditions or those developing symptoms which may require isolation e.g. development of rash (see Appendix [6](#) & [8](#))
- Monitoring of isolation facilities that have positive or negative air supply and take immediate action in the event of any malfunction of the ventilation. To notify the IPT and Estates of any malfunction of the ventilation supply. **NB:** patients with a known or suspected infection must not be nursed in a positive pressure isolation room Patients who are immunocompromised but have or are suspected of having a transmissible infection must be nursed in source isolation.

3.7 The Estates and Facilities Department is responsible for

- The servicing of ventilation systems in isolation facilities with special ventilation at least once every 12 months and any subsequent repairs.

3.8 The Hotel Services Team responsible for

- Maintaining a high standard of cleaning to minimise the level of environmental contamination and reduce the potential for transmission to other patient's, visitors and staff.
- Standard precautions must be used when handling and disposing of infected waste and sharps.
- Ensuring recommended practices and levels of decontamination are in line with this policy throughout the patients stay in isolation and following discharge, transfer or death.
- Seeking advice from the IPT to guide levels of cleaning and decontamination where required.
- Using appropriate methods, products and technology to ensure environmental cleanliness in isolation facilities, and cohort areas
- Working in accordance with the Trust's Cleaning Strategy and colour coding system: see link:
- http://intranet.xrwh.nhs.uk/pdf/policies/ST_Cleaning_Strategy.pdf

3.9 All staff are responsible for:

- Maintaining a safe environment and adhering to the precautions outlined in this policy when a patient is nursed in isolation
- Maintaining a clean and clutter free environment and be aware of the cleaning framework and schedule
- Reporting breaches in following this policy which put patients/staff at risk of infection to the IPT and through the Trust's incident reporting mechanisms
- Identifying patients who may need source protective side room
- Acting on information provided by patients which may indicate the need for the patient to be nursed in isolation (e.g. if a patient presents with an alert card for an alert organism).
- Implementing standard infection prevention and control precautions for all patients and abiding by the guidance of this policy

- Reporting to Occupational Health and Wellbeing/ Line manager prior to attending work if they have an infectious illness such as diarrhoea and vomiting, flu like symptoms or a rash of unknown origin.
- Ensure that the room/ bed space is cleaned to the appropriate standard after the discharge/ transfer of patient
- Risk assess the patient if they are a risk of falls and need to be isolated, this should be completed in conjunction with the multidisciplinary team. Ensure cleaning and disinfection of reusable equipment between patients.

4.0 Policy Detail

4.1 Notification

Certain diseases, or suspicion of these diseases, are notifiable by law to the Consultant in Communicable Disease Control (CCDC) at Public Health England (Refer to [Appendix 2](#)). The clinician that considers or diagnoses the infection is responsible for the notification; the IPT must also be notified.

4.2 Viral Haemorrhagic Fever

See Trust Intranet and [Viral Haemorrhagic Fever Policy IP07](#)

In the event of a patient being suspected of having a Viral Haemorrhagic Fever in the Emergency Department or on a ward, **do not move the patient**, limit the number of staff that come into contact with the patient and then **immediately contact one of the following**:

- On-Call Consultant Microbiologist via switchboard
- Public Health England West Midlands West Tel: 03442253560
- Infection Prevention reactive mobile 07500954410
- Infection Prevention extension
- Consultant in Communicable Disease Control (CCDC)

4.3 Temporary isolation facility:

The IPT must consider recommending the opening of a temporary isolation facility when single room or cohort isolation facilities are exhausted. The re-badging of an existing ward may have to be considered. Where a hospital wide outbreak of a specific infection is confirmed or suspected (see hyperlink below). The opening of an isolation facility will only occur when a large outbreak is identified from surveillance data. A period of at least 24 hours is required prior to opening this facility and the [Outbreak of Communicable Infection/ Infection Prevention/ Serious Incident policy IP 13](#) must be followed.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation of this policy require additional revenue resources	No
3	Does the implementation of this policy require additional manpower	No

4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments	

6.0 Equality Impact Assessment

It is not anticipated that this policy will have any impact on race equality and equality or diversity.

7.0 Maintenance

The IPT will be responsible for advising on updates, amendments and review of this policy. Any changes to this policy must be agreed by the Infection Prevention and Control Group.

8.0 Communication and Training

This policy will be communicated via the Senior Infection Prevention Nurses, Divisional Leads and Matrons for dissemination in the Divisions following the approved process. The policy will be made available on the Trust Intranet and will be communicated at Senior Nurse Operational Group and Senior Manager's Briefing.

8.1 Training

Every member of staff involved in patient care must be able to appropriately use isolation precautions when this type of management is required. Training will be supported through an infection prevention programme of education via Trust Induction and the infection prevention leads. Staff have a responsibility to undertake mandatory infection prevention induction and subsequent annual updates.

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee/ Group
Isolation facilities	IPT	IPS tools	Bi-ennial	IPCG

10.0 References - Legal, professional or national guidelines must underpin policies and be referenced here. Where appropriate cross references must be made to other policies.

All references to appendices and attachments within the body of the document must be highlighted in blue and all hyperlinks inserted.

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Part A - Document Control

Policy number: IP10 Isolation Policy for Infectious Diseases Policy version: V6.0	Policy Title: Isolation Policy for Infectious Diseases	Status: Final		Author: Infection Prevention Team Director Sponsor: Chief Nurse
Version / Amendment History	Version	Date	Author	Reason
	V1	Sept 07	IPN	Introduction
	V2	July 2011	IPN	Review
	V3	Oct 2012	IPN	Review
	V4	July 2015	Infection Prevention Team	Learning from incidents/planned review
	V5	Sept 2018	Nurse Manager IP	Review date
	V5.1	July 2020	Infection Prevention Team	COVID Pandemic
	V5.2	February 2021	Infection Prevention Team	Inclusion of Appendix 11 - ACPCS6 – Isolation of patients
	V6.0	March 2023	Infection Prevention Team	Review date and Change of Isolation Posters on Appendix 4
Intended Recipients: Trust wide				
Consultation Group / Role Titles and Date: Infection Prevention Control Group (IPCG) / Consultant Microbiologist				
Name and date of Trust level group where reviewed		Trust Policy Group – July 2023		
Name and date of final approval committee		Trust Management Committee – July 2023		
Date of Policy issue		July 2023		
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)		July 2025		
Training and Dissemination: Mandatory Training and Induction to Trust, Dissemination via Matrons and Departmental Managers to Clinical Teams				
To be read in conjunction with: IP01, IP03, IP09, IP12, IP13, IP17, IP18				
Initial Equality Impact Assessment (all policies): Completed Yes				
Full Equality Impact assessment (as required): Completed Yes If you require this document in an alternative format e.g., larger print please contact Policy Administrator 8904				
Monitoring arrangements and Committee		Infection Prevention and Control Group (IPCG)		

Document summary/key issues covered:	
The Royal Wolverhampton NHS Trust is committed to minimising the risk and preventing the spread of micro-organisms among patients, staff, and visitors by the use of additional infection control precautions. This policy outlines the methods and responsibilities for safe management of patients requiring source and protective isolation.	
Key words for intranet searching purposes	Isolation policy
High Risk Policy? Definition: <ul style="list-style-type: none"> • Contains information in the public domain that may present additional risk to the public e.g. contains detailed images of means of strangulation. • References to individually identifiable cases. • References to commercially sensitive or confidential systems. <p>If a policy is considered to be high risk it will be the responsibility of the author and director sponsor to ensure it is redacted to the requestee.</p>	No

IP10 Appendix 1: Protocol for admission/transfer of patient with an infectious condition/at special risk of infection

1. Introduction

- a. The risk of transmission of infectious conditions is reduced by minimizing or avoiding the period of time the patient with the condition spends in general admission areas (e.g. ED/AMU)
- b. Isolation rooms in the Trust must be used to accommodate such patients as early as possible in their stay
- c. By minimising the movement of these patients the number of opportunities for infection to spread is reduced and beds can be utilized more efficiently

2. Risk Assessment

- a. Patients must be risk assessed according to their presenting infection risk or risk of infection due to their source of admission, symptoms, travel history or medical condition
- b. Patients in the **high risk groups identified in risk categorisation** below must be admitted directly to isolation facilities as soon as the risk is identified
- c. Patients in the **medium risk group identified in risk categorisation** below will ideally be admitted directly to isolation rooms but may be held for a short period of time in an admission room with strict isolation precautions
- d. Conditions described below are grouped by risk for transmission of the organism/condition. It is the responsibility of the Capacity Team to assist in the identification of patients in the risk groups based on the information they have prior to/on admission and coordinate isolation (see section 3 procedure for direct admission/transfer to isolation).

3. Procedures for direct admission/transfer to isolation facilities

- a. Direct admission in an isolation facility / single room is the ultimate aim where an initial risk assessment indicates a potentially transmissible condition
- b. Where this is not possible due to underlying condition or no available single room the patient must be managed separately from other patients until risk assessment is undertaken

4. Monitoring compliance

- a. The Infection Prevention Team will conduct bi-annual audits of isolation facilities

5. Patient who may not be suitable for isolation

Patients who may not be suitable for isolation in a single room and would require a risk assessment to balance their condition against the risk of spread of infection include:

- Confused patients who present a risk to themselves if not constantly observed
- Critically ill patients who cannot be adequately observed or for whom the move to a single room is likely to further destabilize their clinical condition.
- Patients with a history of depression
- Patients with a history of claustrophobia

On occasion it is necessary to nurse patients who require source isolation in bays. Advice must be sought from the IPT / on-call Microbiologist, and the Capacity team for suitable patient placement in bay areas to reduce the risk of transmission.

Risk categorization:

High Risk	Direct admission to isolation.
Medium risk	Infection can be contained for short period with strict adherence to infection control precautions. Isolation will be required on transfer to ward area
Low risk	Infection can be contained with strict adherence to standard infection control precautions. Isolation is not required.

Risk	Condition/organism (Known or highly likely)
High	Varicella Zoster (Chickenpox)
	Immunocompromised patients (neutrophil count <1)
	Infectious diarrhea
	<i>Clostridioides difficile</i> associated diarrhoea
	Pyrexia of unknown origin with recent (last 2 weeks) travel abroad
	PVL associated MRSA/MSSA
	Influenza
	Salmonella
	Blood borne virus with active bleeding
	MRSA - sputum positive with cough
	MRSA - with exfoliating skin condition
	Invasive Group A <i>Streptococcal</i> infection (necrotising fasciitis)
	Open pulmonary tuberculosis
	Acute Hepatitis A
	Measles
	German Measles
	Mumps
	Whooping Cough
	Diarrhoea and vomiting i.e. Norovirus
	Carbapenemase Producing Enterobacteriaceae (CPE) confirmed positive (at any time in the patient's history)
Medium	Carbapenemase Producing Enterobacteriaceae (CPE) 'high risk' admissions - Healthcare abroad in the last 12 months Direct transfers from other UK hospitals
	COVID-19 confirmed positive or suspected
	MRSA colonization/infection
	Transfer/admission requiring screening (including transfers from abroad)
	ESBL colonization/infection
	VRE colonization/infection
	Shingles (Zoster)
Meningitis/Meningococcal septicemia	
Respiratory Infection	

	Carbapenemase Producing Enterobacteriaceae (CPE) 'high risk' admissions - Healthcare in the UK in the last 12 months – excluding RWT - Foreign travel to a high risk country – Italy, Greece, Turkey and the Indian sub-continent
Low	Campylobacter
	Head lice
	Scabies
	Malaria
	Legionellosis

IP10 Appendix 2: Notifiable diseases

Registered medical practitioners (RMPs) have a statutory duty to notify the 'proper officer' at their local council or local health protection team (HPT) of suspected cases of certain infectious diseases. The clinician who suspects or diagnoses a notifiable disease is responsible for notification. Persistent carriers of typhoid bacilli and Salmonellae must also be reported. For optimal infection control the IPT must also be notified.

Please use the hyperlink below to see the list of notifiable diseases

<https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report#list-of-notifiable-diseases>

All URGENT cases should be reported by PHONE, within 24 hours. ROUTINE cases should be notified in writing within 3 days. Please use the hyperlink below for further guidance on this.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/820133/PHE_Notifiable_diseases_poster_HPT.pdf

Please use the hyperlink below to access the registered medical practitioner notification form.

<https://www.gov.uk/government/publications/notifiable-diseases-form-for-registered-medical-practitioners>

Contact details for the local HPT:

West Midlands Health Protection Team
UK Health Security Agency
23 Stephenson Street
Birmingham
B2 4BH
Telephone: 0344 225 3560 (option 2)

Out of hours advice (health professionals only): 01384679031

Email bat@ukhsa.gov.uk for non-clinical enquiries

Email phe.wmnoids@nhs.net for clinical notifications

Notification must also be made to the IPT (the IPT must also be informed of any diseases/pathogens not listed here which present a risk of hospital acquired infection e.g. MRSA, Group A *streptococcus* in a wound etc).

IP10 Appendix 3: Standard Precautions

Standard precautions must be applied for the care of all patients irrespective of their diagnosis.

Note: Under certain conditions, such as the COVID-19 Pandemic, standard precautions may vary according to national guidance.

Skin care	Cuts and abrasions in any area of exposed skin must be covered with a dressing, which is waterproof and semi-permeable
Hand Hygiene	All healthcare workers must frequently and appropriately wash their hands before, during and after patient care, this must not be neglected even if an aseptic non-touch technique is used or if gloves are worn Hand washing must be also carried out after the removal of protective clothing, between patient contacts, after contact with blood and body fluids, before invasive procedures and manipulation of medical devices
Gloves	Non-powdered (non-sterile) nitrile gloves must be worn whenever contact with blood or body fluids is anticipated Nitrile gloves must be worn for terminal cleaning of the environment Sterile gloves must be worn for invasive procedures
Aprons	Aprons must be worn whenever splashing with blood or body fluids is anticipated, or when contamination of clothing is likely from a patient, or their immediate environment
Eye protection	Visors, goggles or safety spectacles must be worn for all procedures where splashes of blood or body fluids into the face and / or eyes may be anticipated
Masks	Fluid resistant surgical masks (type IIR) with a water-shield membrane must be worn for all procedures where splashes of blood or body fluids may be anticipated
Sharps	All sharps must be discarded immediately after use in accordance with the Trust Safe Disposal and Handling of Sharps Policy

STOP. PAUSE. THINK

PLEASE SPEAK TO A TRAINED NURSE
BEFORE ENTERING THIS ROOM



PRECAUTIONS:



ENVIRONMENTAL CLEANING:



VISITORS: Please wash your hands before entering and before leaving the room. Staff can advise if any protective clothing is needed.

*Gloves are only required if there is potential exposure to blood, body fluids or chemicals. **FFP3 mask. Refer to personal protective equipment policy for correct choice of mask or contact Infection Prevention.

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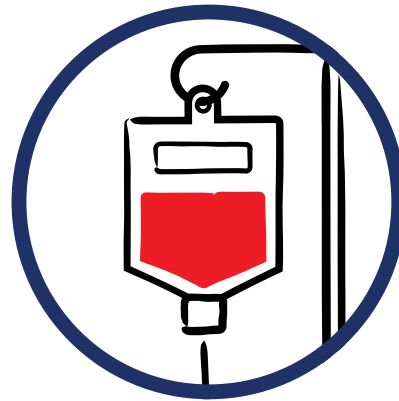


CLEAN HANDS SAVE LIVES



1
BEFORE
PATIENT
CONTACT

2
BEFORE A
CLEAN/ASEPTIC
PROCEDURE



3
AFTER
BODY FLUID
EXPOSURE RISK

4
AFTER
PATIENT
CONTACT



5
AFTER CONTACT
WITH PATIENT
SURROUNDINGS



SOAP & WATER: Any time



GEL: Any time except if patient has diarrhoea or hands visually soiled



IP10 Appendix 5:

Table 1: Essential elements of transmission-based isolation precautions

Standard precautions are shown in the shaded areas - these apply for all patients

- Duration of isolation precautions for any individual patient depends on the diagnosis (see A - Z tables).
- Household and close social contacts that have had prior exposure to the infectious disease during its period of infectivity generally do not need to wear PPE while visiting the patient

	<i>Airborne</i>	<i>Droplet</i>	<i>Contact</i>
Room	<ul style="list-style-type: none"> • Side room under negative pressure • Door must be kept closed 	<ul style="list-style-type: none"> • Standard side room • Door may remain open 	<ul style="list-style-type: none"> • Standard side room • Dedicated use of non-critical care items to a single patient
Disposable mask	<ul style="list-style-type: none"> • FFP 3 mask for all those entering room. Staff must have been successfully fit tested for the type of FFP3 mask they are using. • Remove mask outside of the room • Patient must wear surgical facemask mask for transport outside of side room 	<ul style="list-style-type: none"> • Surgical mask for those administering hands-on care or examining Service User • Patient must wear surgical mask for transport outside of side room • HCW remove mask before leaving the room 	<ul style="list-style-type: none"> • Not routinely required
	Required for procedures / activities likely to generate splashes / sprays of blood, body fluids, secretions, excretions		
Visor/ eye protection & fluid resistant surgical mask (type IIR)	Required for procedures/activities likely to generate splashes / sprays of blood, body fluids, secretions, excretions		
Disposable apron	<ul style="list-style-type: none"> • Not routinely required, but see section 2 • If used must be removed before leaving the room 	<ul style="list-style-type: none"> • Not routinely required, but see section 2 • If used must be removed before leaving the room 	<ul style="list-style-type: none"> • When entering room, particularly if: contact is anticipated with patient, surfaces or items in the room or the

			<p>patient has diarrhoea, ileostomy or colostomy, or uncontained wound drainage</p> <ul style="list-style-type: none"> • Remove apron before leaving the room
	<p>Required for procedures / activities likely to generate splashes / sprays of blood, body fluids, secretions, excretions</p>		
Disposable non-sterile gloves	<ul style="list-style-type: none"> • Not routinely required, but see section 2 	<ul style="list-style-type: none"> • Not routinely required, but see section 2 	<ul style="list-style-type: none"> • When entering room • Remove gloves before leaving the room
	<p>Required when touching blood, body fluids, secretions, excretions, contaminated items, mucous membranes, non-intact skin. Remove promptly after use before touching non-contaminated items, and before next patient</p>		
Hand washing & hand disinfection	<ul style="list-style-type: none"> • If hands are not visibly contaminated, use alcohol hand rub / gel after leaving room, before attending to next patient 	<ul style="list-style-type: none"> • If hands are not visibly contaminated, use alcohol hand rub / gel after leaving room, before attending to next patient 	<ul style="list-style-type: none"> • Use liquid soap for hand washing after removing gloves, before leaving the room • Use alcohol hand rub / gel after leaving the room, before attending to next patient
	<p>Hand washing with liquid soap required after touching blood, body fluids, secretions, excretions, contaminated items, and immediately after glove removal. Hand disinfection with alcohol hand rub / gel is then required before attending to next patient</p>		

IP10 Appendix 6: Table 2: A - Z of common infections requiring transmission-based isolation precautions
(ND = Notifiable Disease)

Disease or infectious agent	Type of isolation	Duration of isolation	Notes
<i>Acinetobacter</i> – multi-drug resistant (MDR)	Contact	Until no longer colonised	Increasingly a problem in ventilated and burns patient
Acquired Immunodeficiency Syndrome (AIDS)			AIDS does not require isolation in itself, although end-stage disease may require <i>protective</i> isolation. However, certain AIDS- and HIV-related infections, such as TB (where the risk of MDR strains is high), do require appropriate isolation precautions.
Adenovirus – infants and young children	Contact and Droplet	Until resolution of symptoms (usually 3-5 days)	Most commonly causes pneumonitis, pharyngitis and conjunctivitis. Less commonly causes hemorrhagic cystitis, diarrhea and meningoencephalitis.
Bronchiolitis – infants and young children	Contact	Until resolution of symptoms (usually 3-7 days)	Most commonly caused by Respiratory Syncytial Virus (RSV) and Parainfluenza viruses.
<i>Campylobacter</i> ND	See Diarrhea and/or Vomiting		
Cellulitis and other soft tissue infections			Isolation required if caused by Group A <i>Streptococcus</i> or a MDR organism, such as MRSA. See relevant sections
Chickenpox	See Varicella		

<i>Clostridium difficile</i> -associated diarrhea (CDAD)	Contact	Until 48 hours after first formed stool	Patient with detectable <i>C. difficile</i> toxin in the stool, who are asymptomatic, do not require isolation or treatment. Negative stool samples not required.
Conjunctivitis – Adenovirus	Contact	Until resolution of symptoms	Highly infectious. Use individual patient eye drops. No isolation required for bacterial conjunctivitis unless caused by an "alert" organism, e.g. MRSA
COVID-19 ND	Contact and Droplet	Until 10 days have elapsed since the patient's first positive SARS-CoV-2 test.*	Airborne precautions must be implemented when undertaking AGPs. *Refer to national guidance, hyperlink below this table.
Diarrhea and/or Vomiting	Contact	Until 48 hours after first formed stool and/or cessation of vomiting	Most commonly caused by Rotavirus, Small Round-Structured Virus (SRSV), <i>Campylobacter</i> , and <i>Salmonella</i> . Negative stool cultures not required.
Dysentery – bacillary ND	Contact	Until 48 hours after first formed stool	Caused by <i>Shigella</i> species. Negative stool cultures not required before cessation of precautions.
<i>E. coli</i> O157 ND	Contact	Until 48 hours after first formed stool	Negative stool cultures not required before cessation of isolation precautions.
Enteric fever ND	See Typhoid fever		
Enterovirus (Coxsackie and Echovirus) – infants & young children	Contact	Until resolution of fever	Most commonly cause maculopapular or petechial rashes, and meningitis encephalitis.
Erysipelas	See Group A Streptococcus		

Food poisoning & Gastroenteritis ND	See Diarrhea &/or Vomiting		
German measles ND	See Rubella		
Group A Streptococcus	Contact and Droplet	Until skin and/or throat cultures negative, or lesions heal	Most commonly causes soft tissue infections, such as cellulitis and erysipelas, and pharyngitis
<i>Hemophilus influenzae</i> serogroup B (HiB)	Droplet	Until 48 hours after start of appropriate antibiotics	A cause of bacterial meningitis and epiglottitis. Rare now because of childhood vaccination program
Hepatitis A ND	Contact	Until 7 days after onset of jaundice	
Herpes simplex – infants & children	Contact	Until lesions are dry	Adults with disseminated (widespread) infection must also be placed under contact precautions
Herpes zoster	See Zoster		
Human Immunodeficiency Virus (HIV)	See AIDS		
Impetigo	Contact	Until skin cultures negative, or lesions heal	Most commonly cause by <i>Staphylococcus aureus</i> and Group A <i>Streptococcus</i>
Influenza	Droplet	Until symptoms have resolved (usually 5-7 days)	

Lice	Contact	Until patient washed and clean clothing put on	Warm bath removes lice from patient. Clothes must be washed separate from others at 60°C. No specific treatment required
Measles (Rubeola) ND	Airborne	Until 4 days after onset of rash	Isolation may need to be extended for complicated cases, e.g. pneumonitis
Meningitis ND	Droplet	Dependent on causative organism	Isolation required if caused by Meningococcus or HiB. Isolate Service User until culture results available.
Meningococcal meningitis and septicemia ND	Droplet	Until 48 hours after start of appropriate antibiotics	
Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)	Contact	Until 3 consecutive weekly screens are negative	See specific policy also IP03.
Multi-resistant Gram-negative bacilli, e.g. <i>Klebsiella</i> , <i>Pseudomonas</i>	Contact	Until no longer colonised	
Mumps ND	Droplet	Until 7 days after onset of symptoms	
Ophthalmia neonatorum ND	Contact	Until 48 hours after start of appropriate antibiotics	Usually caused by <i>Neisseria gonorrhoeae</i> or <i>Chlamydia trachomatis</i>
Paratyphoid fever ND	See Typhoid fever		
Pediculosis	See Scabies		

Pertussis (Whooping cough) ND	Droplet	Until 3 days after start of appropriate antibiotics	
Pharyngitis			Isolation required if caused by Group A Streptococcus or Adenovirus in infants and young children. See relevant sections
Pseudomembranous colitis	See <i>Clostridium-difficile</i> associated diarrhea.		
Respiratory Syncytial Virus (RSV)	See Bronchiolitis		
Rotavirus	See Diarrhea and/or Vomiting.		
Rubella ND	Droplet	Until 5 days after onset of rash	
<i>Salmonella</i> gastroenteritis ND	See Diarrhea and/or Vomiting.		
Scarlet fever ND	Droplet	Until resolution of symptoms (and after at least 48 hours of appropriate antibiotics)	Caused by Group A <i>Streptococcus</i>
Scabies	Contact	Until treatment administered	Crusted scabies (severe infestation previously entitled -Norwegian scabies) may require repeated treatments
<i>Shigella</i> ND	See Dysentery - bacillary		
Shingles	See Zoster		
Small Round-Structured Virus (SRSV)	See Diarrhea and/or Vomiting		

Syphilis – mucocutaneous (secondary)	Contact	Until 48 hours after start of appropriate antibiotics	
Tuberculosis (TB) ND	Airborne	Until 2 weeks after start of appropriate antibiotics, providing resolution of fever	See specific policy also. Suspected or confirmed MDR-TB will require isolation for longer periods
Typhoid fever (<i>Salmonella typhi</i> & <i>paratyphi</i>) ND	Contact	Until resolution of fever	
Vancomycin-resistant <i>Enterococcus</i> (VRE)	Contact	Until no longer colonised	
Varicella (Chickenpox)	Airborne and Contact	Until lesions are dry	Non-immune healthcare workers must not attend to persons affected with Varicella. Caution in pregnancy where non immune or status unknown. Immunization available via Occupational Health and Well Being Service
Whooping cough ND	See Pertussis		
Zoster (Shingles)	Contact	Until lesions are dry	

IP10 Appendix 7:

A-Z of rare infections requiring transmission-based isolation precautions
(ND = Notifiable Disease)

Disease of infectious agent	Type of isolation required	Notes
Anthrax ND (<i>Bacillus anthracis</i>)	Contact	<ul style="list-style-type: none"> • No person-to-person transmission of pulmonary disease has been documented, but contact with skin lesions can result in cutaneous disease at sites of broken skin • Lesions become culture-negative within 48 hours of appropriate antibiotic therapy • Patient must be transferred to regional Infectious Diseases unit • Linen must be treated as highly infectious clinical waste, it must not be sent to the laundry
Cholera ND (<i>Vibrio cholerae</i>)	Contact	<ul style="list-style-type: none"> • Direct person-to-person spread relatively rare • Isolate until resolution of symptoms • Patient must be transferred to regional Infectious Diseases unit
Diphtheria ND (<i>Corynebacterium diphtheriae</i>)	Droplet - respiratory Contact - cutaneous	<ul style="list-style-type: none"> • Isolate until antibiotic treatment is completed • Person-to-person spread more efficient with cutaneous disease than respiratory • Patient must be transferred to regional Infectious Diseases unit • Occupational Health must be contacted to review staff immunization status
MERS -CoV ND (Middle East Respiratory Syndrome)	Droplet –respiratory	<ul style="list-style-type: none"> • Isolate where history indicates acute influenza type illness –History of fever plus cough, with radiological evidence of pneumonia, contact with camels or consumption of products in 14/7 preceding illness in an affected country. • https://www.gov.uk/government/collections/middle-east-respiratory-syndrome-coronavirus-mers-cov-clinical-management-and-guidance

Nipah Virus ND	Direct contact with infected source	Direct contact with infected source, unwell travelers from India/Bangladesh https://www.gov.uk/guidance/nipah-virus-epidemiology-outbreaks-and-guidance PHE advises same measures as for MERS –CoV https://www.gov.uk/government/collections/middle-east-respiratory-syndrome-coronavirus-mers-cov-clinical-management-and-guidance
Plague ND (<i>Yersinia pestis</i>)	Droplet pneumonic Contact-cutaneous	Direct person to person transmission is rare. Isolate until 48hours after resolution of fever. Patient must be transferred to regional Infectious Diseases unit. Linen must be treated as highly infectious clinical waste; it must not be sent to the laundry.
Poliomyelitis – acute ND	Contact & Droplet	<ul style="list-style-type: none"> • Virus is present in respiratory secretions during the first week of illness • Virus may be shed in the stool for up to six weeks after the onset of illness • Patient must be transferred to regional Infectious Diseases unit • Occupational Health must be contacted to review staff immunization status
Rabies ND	Contact	<ul style="list-style-type: none"> • Person-to-person transmission has not been documented except for six cases acquired through corneal grafts. However, the risk of transmission via a break in the skin or via intact mucous membranes does exist • Patient must be transferred to regional Infectious Diseases unit
Viral Hemorrhagic Fevers ND – Ebola, Lassa, Marburg	Category 4	<ul style="list-style-type: none"> • Highly infectious • Urgent transfer to regional Infectious Diseases unit is mandatory • Linen must be treated as highly infectious clinical waste, it must not be sent to the laundry

IP10 Appendix 8:

Table 4: Summary table of indications for transmission-based isolation precautions

(* = > 1 mode of transmission)

Under certain conditions, such as a Pandemic, national guidance must also be referred to as it may be subject to change.

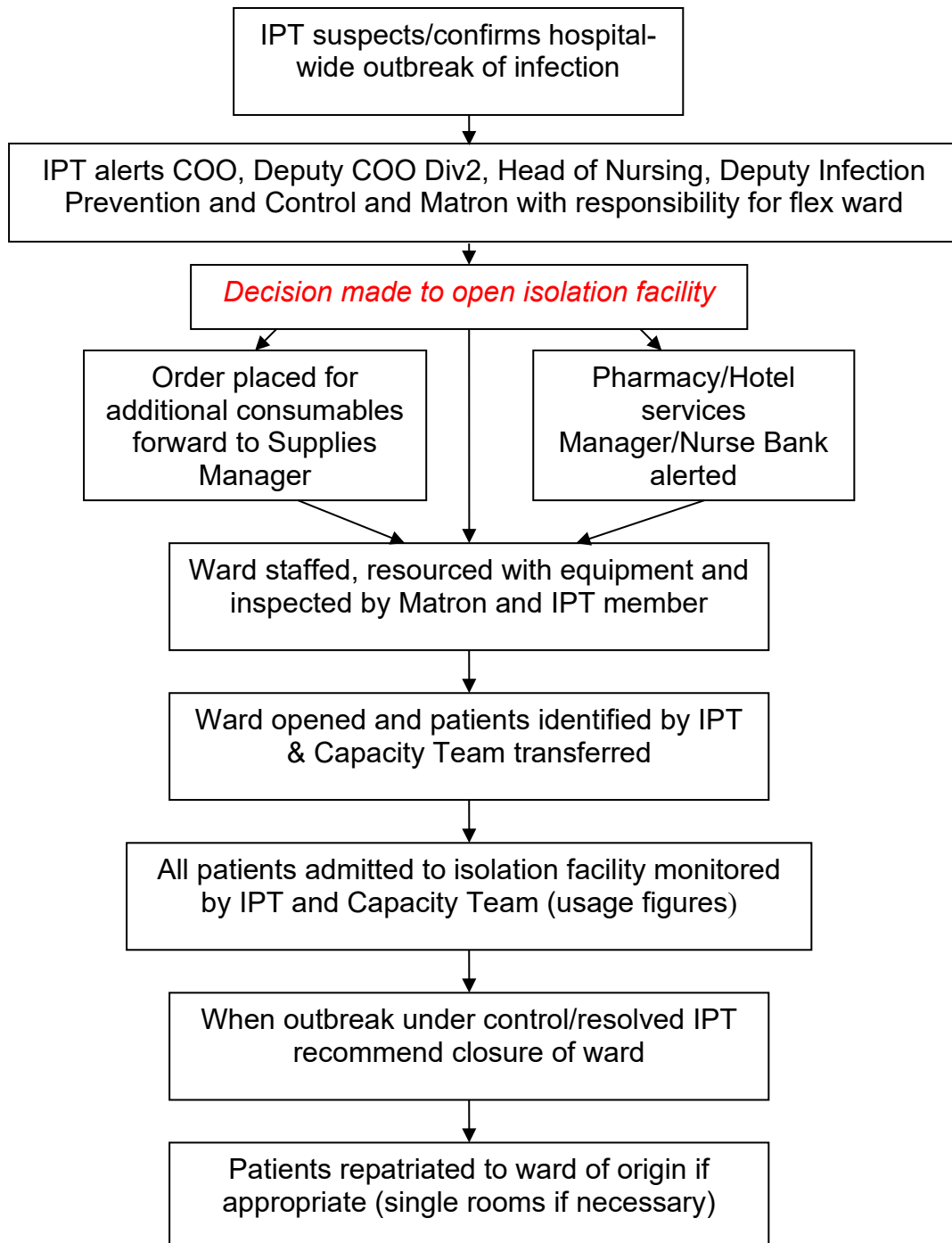
	<i>Airborne</i>	<i>Droplet</i>	<i>Contact</i>
Scenarios requiring empirical implementation of precautions	<ul style="list-style-type: none"> • Vesicular rash* • Maculopapular rash with coryza & fever • Cough, fever, upper lobe pulmonary infiltrate where TB is thought likely • Cough, fever, any pulmonary infiltrate in an HIV-infected Service User (or patient at risk for HIV infection) 	<ul style="list-style-type: none"> • Meningitis • Petechial or purpuric rash with fever • Paroxysmal or severe persistent cough where pertussis is thought likely • Returning traveler with fever of as yet unknown cause 	<ul style="list-style-type: none"> • Acute diarrhea &/or vomiting of likely infectious cause. • Diarrhea in adult with history of recent antibiotic use • Vesicular rash* • Respiratory infections in infants and young children • History of infection or colonization with multi-drug resistant (MDR) organisms • Returning traveler with fever of as yet unknown cause
Known or suspected diseases or pathogens	<ul style="list-style-type: none"> • COVID-19 when undertaking Aerosol Generating Procedures (AGP) • Measles • Open pulmonary TB • Varicella* (Chicken pox) • Zoster* (Shingles) <ul style="list-style-type: none"> - disseminated - immunocompromised Service User 	<ul style="list-style-type: none"> • Adenovirus* (infants & young children) • COVID-19* • Diphtheria (respiratory tract) • Group A streptococcal infection (pharyngitis/tonsillitis & scarlet fever) • <i>Haemophilus influenzae</i> serogroup B (meningitis & epiglottitis) • Influenza • Meningococcal meningitis and septicemia 	<ul style="list-style-type: none"> • <i>Acinetobacter</i> (multi-drug resistant) • Adenovirus* (infants & children) • Anthrax (cutaneous) • Bacillary dysentery (<i>Shigella</i> species) • Bronchiolitis (infants & young children) • <i>Campylobacter</i> enteritis • Cholera • <i>Clostridium difficile</i>-associated diarrhea • COVID-19* • Diphtheria (cutaneous) • <i>Escherichia coli</i> O157:H7 colitis • Enterovirus infections (infants & young children)

		<ul style="list-style-type: none"> • Mumps • Pertussis (Whooping Cough) • Plague (pneumonic form) • Poliomyelitis (acute)* • Rubella (German Measles) 	<ul style="list-style-type: none"> • Group A streptococcal infection (soft tissue) • Hepatitis A • Herpes simplex virus (infants & young children, and disseminated) • Impetigo • MRSA • Poliomyelitis (acute)* • Rabies • Respiratory Syncytial Virus (infants & young children, and immunocompromised) • Rotavirus • <i>Salmonella</i> enteritis • Scabies • Small round-structure virus (SRSV) • Typhoid fever • Vancomycin-resistant enterococci (VRE) • Varicella* • Zoster* (disseminated or immunocompromised Service User)
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IP10 Appendix 9: Table 5: List of infections where side room isolation is not mandatory (ND = Notifiable Disease)

<p>Actinomycosis Amoebic abscess and dysentery (<i>Entamoeba histolytica</i>)ND Aspergillosis Atypical pneumonia Brucellosis Candidiasis Common Cold (Rhinoviruses, Coronaviruses, Parainfluenza viruses) Cryptococcosis (<i>Cryptococcus neoformans</i>) <i>Cryptosporidium</i> diarrhoea Cutaneous larva migrans Cytomegalovirus (CMV) Dengue fever EncephalitisND Epstein-Barr virus (EBV) Gas gangrene (<i>Clostridium perfringens</i>) Giardiasis (<i>Giardia lamblia</i>) Glandular Fever (Infectious mononucleosis) Gonorrhoea Hepatitis B Virus Hepatitis C Virus Histoplasmosis (<i>Histoplasma capsulatum</i>) Hookworm (<i>Ancylostoma duodenale</i>, <i>Necator americanus</i>) Legionnaires' Disease LeprosyND LeptospirosisND</p>	<p>ListeriosisND Lyme Disease (<i>Borrelia burgdorferi</i>) MalariaND <i>Mycoplasma</i> pneumonia Nocardiosis <i>Pneumocystis carinii</i> pneumonia Relapsing feverND (once de-loused) Rheumatic fever Rickettsial spotted fevers Ringworm Roundworm (<i>Ascaris lumbricoides</i>) Schistosomiasis Streptococcus pneumoniae (unless highly penicillin-resistant) Strongyloidiasis (<i>Strongyloides stercoralis</i>) Tapeworm (<i>Taenia solium</i>, <i>Taenia saginata</i>) TetanusND Threadworm (<i>Enterobius vermicularis</i>) Tinea (ringworm, athlete's foot, and other dermatophytoses) Toxocariasis Toxoplasmosis TyphusND (once de-loused) Whip worm (<i>Trichuris trichuria</i>) Weil's disease (icteric leptospirosis)ND Yellow feverND</p>
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IP10 Appendix 10: Protocol for the Opening of the Temporary Isolation Facility



Reference Number and Guideline name ACPCS6 – Isolation of patients	Version 1	Local Policy Reference ACPCS6	Status Draft	Author Tram Bui
Version/Amendment History	Version	Date	Author	Reason
	1	10/11/2020	Tram Bui	New SOP required
Intended Recipients: All RWT PCN staff				
Consultation Group / Role Titles and Date: Effective Service Group - TBC PCN Board – 8 th December 2020				
Name and Date of Group where reviewed:				
Name and date of final approval committee:				
Date of Policy issue				
Review Date and Frequency [standard review frequency is 3 yearly unless otherwise indicated]			December 2023	
Training and Dissemination: To be shared to all staff via the Business and Performance meetings				
To be read in conjunction with: <ul style="list-style-type: none"> • IP10 Isolation Policy for Infectious Diseases • CP59 Physical Restraint Policy • OP28 Policy for the Management of Prisoner Attendance • OP26 Security Policy • ACPCS14 Removing patients from the practice list • Health and Safety at Work Act 1974 • NICE Guidelines Violent and aggressive behaviours in people with mental health problems 				
Initial Equality Impact Assessment [all policies]:			NA	
Full Equality Impact assessment [as required]:			NA	
<u>If you require this document in an alternative format e.g., larger print please contact Central Governance Department on Ext 5114.</u>				
Contact for Review			Laura Harper, Service Delivery Manager	
Implementation plan / arrangements [Name implementation lead]			Kate Jenks, Directorate Manager	
Monitoring arrangements and Committee			Effective Service Group PCN Board	

Document summary / key issues covered:

- Management plan in event of outbreak
- Other situations which require a patient to be isolated
- Roles and responsibilities

VALIDITY STATEMENT

This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendments.

1. Objectives

- Identify the process in the event that a patient needs to be isolated

2. Scope

- Situations which require a patient to be isolated in practice

3. Situations to be aware of

There will be times when it is appropriate to isolate some patients and the practice should, where possible, provide a room or private area where that patient can wait.

There are many scenarios where it may be appropriate to isolate a patient. Under these circumstances, a sensitive and individual approach to each circumstance should be adopted. These scenarios can look like:

- Patients are upset when they arrive at the surgery and ask for some privacy as they cannot face a public waiting area. In this case you may ask them if they would like to wait somewhere quiet.
- A patient may request a private area to breastfeed.
- Patient is displaying violent or threatening behaviour.
- Patients with conditions such as chickenpox should be routinely isolated, especially from any pregnant patients.
- Patients with medical conditions such as cancer who are using immunosuppressants should be isolated from patients with infections.
- A patient allergic to dogs may need to be isolated if a person with a guide dog is present.

4. Process

4.1. Identify suitable room/space for patient to sit/wait in, ensure that the space does not have access to any sensitive data, no private conversations can be heard or where patients can wander off unexpected. The location should also be away from staff areas and medical areas where drugs and equipment may be stored and easily accessible.

4.1.1. This space should be communicated to all staff so they are aware of what space to use

4.2. If a patient is displaying violent or threatening behaviour, in an attempt to calm the situation down, it may be help to offer the isolated space

4.2.1. If the situation escalates, call for support from a colleague or the police if necessary.

4.2.2. Dependent on the circumstances, the SOP for removing a patient from practice lists may need to be followed (ACPCS14)

4.2.3. Report the incident via Datix

4.2.4. Inform the Service Delivery Manager/Directorate Manager

4.3. Inform the expecting clinician where the patient is located via EMIS message so they are aware of where to find the patient when it is time for their consultation.

4.4. If a patient presents with a highly infectious disease (more detail in IP10 Isolation Policy for Infectious Diseases),

4.4.1. The patient must be isolated in an empty room as soon as possible

4.4.2. For notifiable diseases follow [IP10 Appendix 2](#)

4.4.3. Advice must be sought from the IPT / on-call Microbiologist

4.4.4. All clinicians must also follow the precautions set out in [IP10 Appendix 3](#)