UNIQUE IDENTIFIER NO: C-42-2013
Review Date: April 2024
Review Lead: Lead Infection, Prevention and Control Nurse

Calderdale and Huddersfield NHS Foundation Trust

Section W - Infection Prevention and Control Policy for Bed Management and Movement of Patients

Version 7

Important: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

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Document Summary Table		
Unique Identifier Number	C-42-2013	
Status	Ratified	
Version	7	
Implementation Date	October 2007	
Current/Last Review Dates	June 2009; October 2011, July 2013, September 2015, July 2017, April 2021	
Next Formal Review	November 2023	
Sponsor	Medical Director	
Author	Lead Infection, Prevention and Control Nurse	
Where available	Trust Intranet - Infection Prevention and Control Policies	
Target audience	All Staff	
Ratifying Committee		
Executive Board		19 August 2021
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Infection, Prevention and Control Committee	Consultant Microbiologist/Infection Prevention and Control Doctor	April 2021
Other Stakeholders Consulted		
Patient Flow Team		
Director of Operations		
Does this document map to other Regulator requirements?		
Regulator details	*Regulator standards/numbers etc*	

Document Version Control	
Version 7	Updated to include reference to Covid-19 management, updated CPE management and updated transfer form.
Version 6	This version reflects the new EPR system. It also refers to the CPE policy.
Version 5	A link to the Multi Resistant Organism Policy has been added and Appendix 2 of the Nursing Assessment Tool has been updated.
Version 4	The document has been reviewed and updates have been made to the Trust Equalities statement. The Infection Prevention and Control Risk Assessment has been amended to concur with the Nursing Assessment Tool. Public Health England contact details updated.
Version 3	The document has been reviewed and changes to the duties sections have been made.

Contents

1. Introduction

The Health and Social Care Act (2008), Code of Practice on the prevention and control of infections and related guidance (DH 2015) states that there should be a policy addressing admission, transfer, discharge and movements of patients between wards, departments and between health care facilities.

The risk of healthcare associated infection (HCAI) is increased by the movement of patients, very high bed occupancy and an absence of suitable isolation facilities (DoH 2008).

1.1 Key points

- The IPC risk assessment tool must be completed as soon as possible on arrival.
- Covid-19 pathways guide patient placement and step down.
- Patients transferred from **any** other hospital (national or international) should be isolated until MRSA screen negative.
- Patient bed movement must be kept to a minimum.
- Elective orthopaedic wards at CRH remain 'ring-fenced'.
- Patients with suspected or confirmed viral gastroenteritis should not be admitted to MAU.
- Infection risk MUST be shared when transferring patients between departments to enable control measures to be instigated.
- HPV cleans must not be bypassed.

2. Purpose

The spread of HCAIs is associated with high bed occupancy rates and movements of patients between wards/departments. This policy sets out the infection prevention and control principles that must be applied to bed management and movement of patients to minimise the risk of infection.

3. Definitions

HCAI is defined as 'infections that are acquired as a result of healthcare interventions' (NICE, 2011)

4. Duties (Roles and responsibilities)

The Chief Executive is responsible for ensuring that there are effective Infection Prevention and Control (IPC) arrangements in the Trust.

Managers, Matrons, Clinical Commanders, Patient flow team and Ward and Department Managers are responsible for ensuring that this policy is adhered to.

5. Infection Prevention and Control Policy

Whilst understanding the increasing number and complexity of patients within the Trust it is essential to utilise beds in a way that minimises the risk of spread of infections between patients. The key to this is recognising that some patients can be very vulnerable to specific infections. Close liaison between the Patient Flow team and the IPC team is essential to ensure the risks are minimised while making best use of the available bed base.

5.1 Allocation of single rooms

- Allocation of single rooms must be based on a clinical risk assessment with infection control requirements given priority over bed management/capacity issues (Healthcare Commission, 2006)

- Delays in transferring A & E patients awaiting a single room on the ward for the purpose of isolation must be kept to a minimum

- During escalation procedures, patients requiring isolation must **not** be transferred to temporary in-patient facilities (eg Day Surgery Unit)

5.2 Infection Prevention and Control Risk Assessment

The Infection Prevention and Control Risk Assessment within EPR, which also includes the Covid-19 screening tool, must be completed for all admissions.

The EPR banner bar must also be checked for a flag/alert (check before starting the assessment)

- If a flag /alert is present highlighting an infection control risk, isolation may be required

- If the patient answers yes to any questions in the risk assessment, isolation is required

- For those with flag/alert for suspected infections, or where screening may be required, eg TB or CPE, the need for isolation should be discussed with the IPC team to ensure it is still appropriate

5.3 Movement of patients between wards, departments & on discharge

- Assess the need to move the patient. If an inter-ward transfer or an investigation/procedure can be postponed until the patient is no longer requiring isolation without compromising the patient's management, then it should be

- Communication between wards and departments regarding the **infection status and isolation requirements** of a patient is essential to enable the receiving department to put suitable control measures in place. The transfer form (appendix 2) is to be used in all cases

- Once vacated, an isolation room must have a 'terminal' clean with a chlorine releasing agent i.e. Tristel as per decontamination poster

  NOTE: as per the poster, in addition to terminal cleaning, decontamination with Hydrogen Peroxide Vapour (HPV) is required for side rooms where patients with the following infections have been transferred or discharged from; - clostridium difficile, known CPE, PVL, VRE or multi-drug resistant MRSA plus any other room identified by the IPC team. The IPC team advise Domestic Services of the room locations and ward staff contact Domestic services directly to arrange as required

5.4 Prevention of Multi-drug resistant organisms (MDROs)

Refer to specific infection policies for further details

- All patients should be screened for MRSA on admission or for planned admissions this should be completed prior to admission
- Patients transferred from other hospitals (including overseas hospitals) must be isolated in a single room and screened for MRSA and CPE
- Additional risk associated with CPE are presented in the CPE risk tool at appendix 3. This identifies a broader group of patients requiring screening for CPE on admission and prioritises isolation within this broader group
- Where a known MRSA carrier is being managed in a main bay, avoid placing the patient adjacent to others with invasive devices or wounds
- Elective and emergency orthopaedic patients should be segregated on separate wards

5.5 Orthopaedic ring-fenced Ward at CRH

The elective orthopaedic 'ring fenced' ward at CRH is an area considered 'high risk'. The following measures aim to prevent MRSA being introduced to these wards, where the effect of MRSA infection can be life changing.

The ring-fenced ward maintains a strict admission criterion that gives priority admission to patients undergoing joint replacement surgery.

- Only patients with an MRSA screen negative result should be admitted to the ring-fenced ward
- Patients **must not** be admitted to the ring-fenced ward if the answer is "yes" in the MRSA section of the 'Infection Prevention and Control Risk Assessment on EPR, (Appendix 2)
- Patients from nursing homes, those with long term invasive devices and/or chronic wounds and those with a previous history of MRSA in the previous 3 years, even if the last result was negative should not be admitted to the ring-fenced ward

5.6 Prevention of Outbreaks of Viral Gastroenteritis

Viral gastroenteritis is easily spread within a hospital environment. It is essential the following actions are adhered to:

- All patients requiring admission must be verbally screened for viral gastroenteritis using the flow chart found in Appendix 1
- Patients admitted with a history of diarrhoea and vomiting or recent contact with D&V are **NOT** to be admitted on MAU or SAU, but directly into an isolation room on a ward (see Appendix 1)
- Patients with acute diarrhoea must be isolated and remain in isolation until 48 hours symptom free, unless there is a clinical need (eg transfer to ICU) and the IPCT informed

5.7 Communication between Infection Control & Patient Flow Teams

- During office hours, close liaison between the Infection Control Team and Patient Flow is essential
- Out of office hours, an Infection Control Nurse can be contacted via the hospital switchboard
- The Patient Flow Manager (or representative) must always attend Infection Outbreak/Incident Meetings when the Outbreak/Incident impacts on bed availability
- An IPC team representative will provide regular feedback on relevant issues to the Patient Flow Team

5.8 The role of the Pre-Assessment Unit in IPC/bed management

Certain patients may have infection risks (eg MRSA carriers; risk of CJD) and this should be documented in EPR and flagged in the flag / alert section on EPR. In addition:

- All patients should be screened for MRSA during pre-assessment as per MRSA policy. In the event of positive screening results, pre-assessment staff are to ensure the ward and theatre are aware, so appropriate action can be taken
- Pre assessment are to ensure MRSA suppression treatment is prescribed and supplied in a timely manner
- The IPC team must be contacted by Pre-assessment staff regarding patients who present a risk of CJD, see CJD policy

6. Training and Implementation

All Trust managers are responsible for ensuring that staff are aware of the location of this policy, for ensuring that staff read this policy and implement it in practice.

7. Trust Equalities Statement

Calderdale and Huddersfield Foundation Trust aims to eliminate discrimination, harassment and victimisation and advance equality of opportunity through fostering good relationships, promoting inclusivity and embedding the “One Culture of Care” approach throughout the organisation. Stakeholder engagement is vital to analyse the equalities impact of this policy and ensure where there are any negative impacts, mitigation has been discussed and acted on.

8. Monitoring Compliance with this Procedural Document

This policy will be reviewed two yearly or earlier in light of new national guidance or other significant changes in circumstances.

Compliance with this policy will be monitored through audit of the Infection Prevention and Control risk Assessment sticker and the Inter-Healthcare Infection Prevention and Control Transfer Form.

9. Associated Documents/Further Reading

This policy applies to all staff involved in patient care and management including patient placement and should be used in conjunction with other relevant sections of the Infection Control Policy including:

Section B: Notifiable Diseases Policy
Section C: Standard Precautions Policy
Section D: Meningococcal Infection Policy
Section E: Major Outbreak Policy
Section J: Management of patients with Multi Resistant organisms
Section K: Isolation Policy
Section S: TB Policy
Section T: MRSA and PVL-SA policy

10. References

Department of Health (2008) Clostridium difficile infection: How to deal with the problem. © Crown copyright. London.

Department of Health (2015) The Health & Social Care Act (2008). Code of Practice on the Prevention and Control of Infections and associated guidance.

Healthcare Commission (2006) Investigation into outbreaks of *Clostridium difficile* at Stoke Mandeville Hospital, Buckinghamshire Hospital NHS Trust.

NICE (2011) Healthcare-associated infections: prevention and control

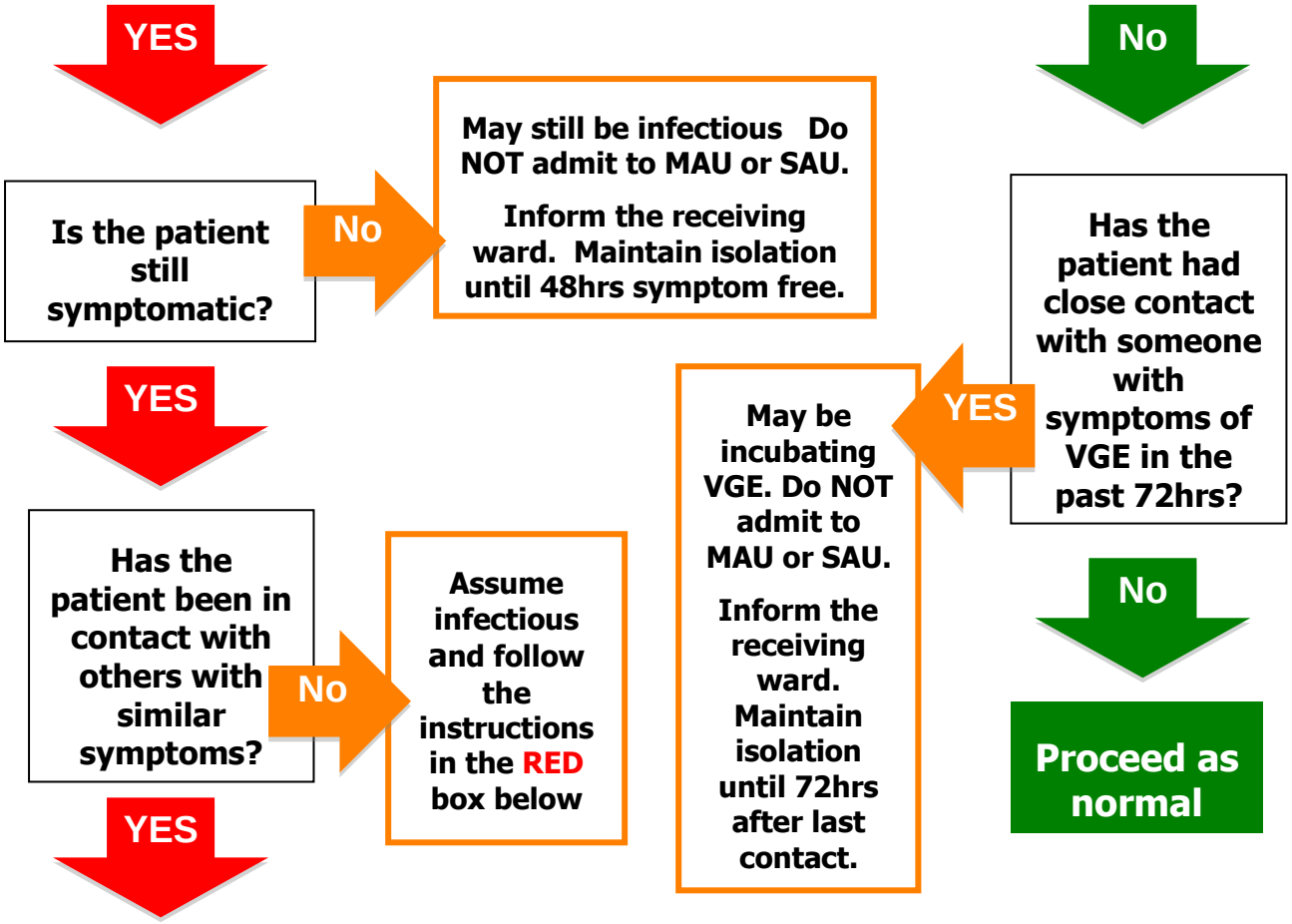
APPENDIX 1

Viral Gastroenteritis (VGE) screening tool
Risk Assessment for admission to Hospital

Use this tool to assess anyone being admitted to hospital to minimise the risk of cross-infection and service disruption. Document response in the IPC assessment tool in EPR and actions to take in general documentation.

ASK THE PATIENT/CARER ON ASSESSMENT IN A&E OR GP PRIOR TO ADMISSION TO MAU OR SAU.

Is there a history of one or more of the following VGE symptoms: Diarrhoea, vomiting & abdominal cramps now or in the last 48hrs?



Probable VGE.

Do NOT admit to MAU or SAU

Inform the receiving ward and implement:

- ✓ **Isolation – ideally ensuite, following contact precautions**
- ✓ **Stool Specimen**
- ✓ **Stool/fluid balance Chart**
- ✓ **Notify the IPCT**

APPENDIX 2

Transfer Form

Patient Transfer Form	(Patient ID Label) Name: DOB: NHS Number: Hospital Number:	Ward:

This form has been completed with information provided by the transferring nurse

From (ward):	Name Transferring Nurse:
To (ward):	Name Receiving Nurse:
Date: Time:	Signature of Receiving Nurse:

Situation

Admitted with/ Diagnosis:	Background:	
Plan of Care:		
For resuscitation?	Yes/No	
Relative/ Carer contacted re: transfer?	Yes/No	Name:

Assessment

NEWS Score	
Does the patient have a pressure ulcer?	Yes/No Details:
Is the patient a falls risk?	Yes/No Details:
Does the patient require 1-1 care?	

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Current Infection Control issues and Risk Assessment to be completed by receiving ward

If you answer YES to any one of the questions below please ISOLATE in a side room. If unable to isolate please risk assess on an individual basis.		
YES	NO	Does the patient have a previous history of MRSA/VRE/ESBL or another multi-resistant organism?
YES	NO	Has the patient been admitted from another NHS Trust or an overseas hospital?
Which hospital?		
YES	NO	Is this patient currently isolating **or** need isolating due to confirmed or suspected infectious disease? EG. TB, gastroenteritis, chickenpox
YES	NO	Does the patient have diarrhea and/or vomiting or have they been in contact with someone with D&V in the last 3 days – if YES please follow the diarrhea and vomiting (D&V) algorithm and isolate as appropriate.
YES	NO	Is the patient clinically extremely vulnerable to Covid-19?
YES	NO	Is the patient currently required to isolate due to Covid 19 contact or quarantine following travel?
Date isolation complete		
YES	NO	Has the patient tested positive for Covid-19 in the last 14 days?
Date of positive result		
CIRCLE the Covid19 pathway the patient is currently following - **high , medium** or **low** risk		

CPE risk prioritisation for isolation matrix

It is best practice for any patient who has a risk factor for colonisation with CPE to be isolated, screened and managed in line with the CPE policy. However, where risk prioritisation is required (due to competing priorities such as side room availability) the matrix below is intended as a guide to patient placement/isolation. This is a prioritisation tool, and while the high and medium risk groups of patients are recommended to be isolated in side rooms, it is recognised this is not always possible. Please liaise with IPCT for assistance.

	Patient Characteristics						
Care Environment	Known CPE case in last 3 years	Direct Transfer from Hospital Abroad	Contact of Confirmed Case in last 12 months	Admission to hospital in the last 12 months (UK or abroad)	Multiple treatments in last 12 months eg: Dialysis/ Chemotherapy	Broad spectrum antibiotics	No Risk Factors
Admission to high risk/augmented area.							
Admission to general ward.							
Day case/ambulatory care	**	**	**	**	**		
Outpatient areas	**	**					

High Risk	Isolate immediately in a single room with en-suite facilities (or dedicated commode) and maintain isolation until screening results available
Medium risk	Isolate in side room with en-suite facilities (or dedicated commode) if possible (see increased transmission risks below) until screening results available. If not possible to isolate, then nurse with strict emphasis on maintaining compliance with contact precautions and optimal environmental cleaning following discussion with Infection Prevention Team (IPT) ******For outpatients and day cases – provide appointment timed for end of clinic or list; consider caring for day case in side room dependent on risk of secondary transmission and degree of contact with body fluids e.g. endoscopic procedures. Maintain compliance with standard precautions and optimal environmental cleaning. In an outpatient setting, contact precautions should be instigated based on a risk assessment and in discussion with IPCT
Low Risk	No action, other than be alert to change in risk-level in light of any further information relating to patient status. Maintain compliance with standard infection control precautions and optimal environmental cleaning.

The following factors increase the risk of CPE transmission and should be considered when prioritising side rooms:

• Diarrhoea, incontinence (urine or faeces), discharging wounds, medical devices in situ, ventilatory support requirements, high risk of wandering and poor hygiene.

Augmented care/high risk settings: include critical care, renal units and patients who are severely immunosuppressed because of disease or treatment, eg Haematology/oncology/transplant patients and similar immunosuppressed patients during high risk periods in therapy.