

Isolation Policy

Introduction

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as 'we statements', they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes (EFH) will commit to the following quality statements for:

Learning culture

We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Safe systems, pathways and transitions

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Safe environments

We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

Safe and effective staffing

We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.

Involving people to manage risks

We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

Infection prevention and control

We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.

Assessing needs

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Delivering Evidence Based Care and Treatment

We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.

How staff, teams and services work together

We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.

Monitoring and improving outcomes

We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.

Consent to care and treatment

We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Kindness, compassion and dignity

We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

Treating people as individuals

We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Responding to people's immediate needs

We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.

Person-centred care

We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.

Care provision, integration, and continuity

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Listening to and involving people

We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.

Partnerships and communities

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Learning, improvement and innovation

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Scope

For the benefit of persons using this policy EFH will use the term “Isolation” for residents as a control measure for reducing the risk of cross contamination during an infective outbreak.

This may require individual isolation or isolation of areas / whole home.

The term “Isolation” is the use of infection prevention and control precautions aimed at controlling and preventing the spread of infection. There are two types of isolation – Source Isolation (barrier nursing) where the patient is the source of infection and Protective Isolation (reverse barrier nursing) where the patient requires protection i.e. they are immunocompromised.

The resident may also be in isolation to protect them from acquiring an infection during susceptible periods, e.g. receiving immunosuppressant treatment, this could be from other residents, staff or visitors. This is known as Protective Isolation.

During times of an outbreak, e.g. COVID-19 or Norwalk outbreaks, periods of isolation may also be required. This is referred to as Outbreaks.

Staff should also refer to EFH Infection Control Policies

This policy and procedure are provided for the regulated activity of accommodation for persons who require personal care or nursing.

Equality Statement

EFH is committed to equal rights and the promotion of choice, person-centred care and the promotion of independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

Policy Statement

Staff working within the care home environment will have training, knowledge and competency to care for residents receiving either:

1. Source isolation which is when they have an infection that may be spread to other visitors or staff.
2. Protective isolation which is when the resident is vulnerable and at risk of acquiring an infection, e.g. immunosuppressed from chemotherapy, from visitors or staff.

Staff will take advice from local community infection prevention control teams regarding isolation procedures prior to instigating isolation.

A risk assessment of the individual resident’s needs will be undertaken relevant to their condition and the impact on others residing in the home and the staff involved in their care.

When undertaking the risk assessment the following should be taken into account:

- The susceptibility of others to the infection.
- How the infection is spread, e.g. air-borne, faecal-oral route.
- Any outbreak of diarrhoea and/or vomiting should be considered infectious, and the individuals isolated until they are 48 hours symptom free.
- The environment.
- Resident’s clinical condition.
- Evidence-based practice.

- Isolation of residents must take place in a single occupancy room and, where possible, with en-suite facilities.
- Any equipment used for that resident in isolation will remain for their use only for the duration of the isolation period.
- Agreed PPE should be worn, depending upon the reason for isolation, being donned prior to entering the isolation room and removed (doffed) in the isolation room.
- Strict hand hygiene will take place prior to entering the isolation room and exiting the isolation room and after PPE is removed.
- Visitors should speak to the staff in charge prior to entering an isolated resident's room to identify what precautions should be taken.
- Any staff, residents or visitors who have diarrhoea or vomiting should not visit or work for at least 48 hours after symptoms have stopped or, in the case of a confirmed infection, have resolved.
- Cleaning of the rooms will be undertaken according to advice on the particular infection encountered.
- Deep cleaning will be required when infection with suspected or confirmed C difficile, viral gastroenteritis or the transfer or death of a resident who has any of these infections.
- Respiratory Infections / COVID specific advice is changing on a regular basis and the government websites should be checked on a regular basis for updates to guidance on infection control and isolation.

The Policy

Source Isolation

Source isolation is designed to prevent the spread of pathogens from an infected resident to other residents, home staff and visitors. This has previously been known as barrier nursing. The need for isolation is determined by the way the organism or disease is transmitted.

Examples of organisms requiring source isolation:

- Covid-19
- Influenza
- Pulmonary Tuberculosis
- Chickenpox
- Methicillin Resistant Staphylococcus aureus (MRSA)
- Viral diarrhoea and vomiting

This is not a comprehensive list and advice will always be sought from your local infection control team.

Risk Assessment

- All residents identified with an infections disease or alert organisms will be risk assessed for the need of isolation.
- Risk assessment is the assessment of factors that influence the transmission of the pathogen and its impact.
- The risk assessment must be documented within Access and Clinical form 3.03

The following factors should be considered:

- Classification of the pathogen and ability to protect against or treat individual infections
- Probable route of transmission and evidence of transmission
- Susceptibility of the other residents near to the infected resident
- Whether the organism is antibiotic resistant
- Detrimental effects of isolation to the resident:
- Risk of falls
- Confusion
- Wellbeing

Communication

Communication must be cascaded to the home team across all departments to prevent accidental contamination. Suspected infectious pathogens must be communicated to Operational Support Manager.

Source isolation achieved by isolating resident in their room

What is required when isolating a resident.

- The resident will be in a single room with en-suite facilities.
- Door notices should be in place to advise anybody trying to enter to seek advice from the person in charge of the shift before entering.
- If no en-suite facilities are available, then a designated toilet or commode should be allocated to the resident for their use only.
- For males, a separate urine bottle must be used and kept in their room. When emptying is required then disposable covers or lids should be used for transportation to a sluice.
- Protective personal equipment appropriate to the infection should be used, as a minimum gloves and an apron should be used. Eye protection should be used if there is a risk of splashing bodily fluids into the eyes, nose or mouth. See latest Government COVID-19 guidance:

'Guidance COVID-19 supplement to the infection prevention and control resource for adult social care,' updated November 2023.

- Face masks are not routinely required and are only usually worn when splashing of bodily fluids to the face or mouth is a risk, this may vary with local infection control community advice.
- Waste bins should be foot pedal operated with a lid for both linen and waste, specifically for infected waste, i.e. orange (this may vary with local waste contractors).
- The room should be kept as clutter free as possible, anything not required should be decontaminated and removed.
- When using medical equipment this should be disposable, where possible. Re-usable equipment should be kept for the single use of the resident until no longer required, then decontaminated upon removal according to local policy and manufacturers' guidelines before being used again on another resident.

Procedure to Maintain Isolation

The resident's door should remain closed where possible. If for the safety of the resident their door needs to remain open for extended periods, then this should be risk assessed and mitigation documented in the resident's records. Windows should be opened on a regular basis, if possible, to disperse airborne infectious particles.

Prior to entering the room recommended PPE must be worn for any physical contact with the resident, even if it is simple assisting them out of the bed.

Where PPE must be changed between tasks, e.g. following an aseptic technique or changing of a wound dressing, then this should take place inside the room. On completion of tasks, and prior to leaving the room, all PPE must be removed placed in the infectious waste bin.

Hand hygiene, which in this case means washing the hands with warm soapy water or by using hand rub, (N.B hand rub alone must not be used if dealing with Norovirus or Clostridioides difficile (C difficile)) should be undertaken after removing the PPE before leaving the room and then again immediately after leaving the room.

Visitors and Staff

Any visitor and staff with a history of diarrhoea or vomiting are required not visit for at least 48 hours after symptoms have resolved.

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Where a resident is in isolation, local infection prevention advice should be sought from Public Health England Health Protection Teams before any visitors, especially children, are allowed to visit a resident. See 'Contacts: UKHSA health protection teams.'

Advice will be sought on whether visitors are required to wear PPE on a case-by-case basis relevant to the individual resident's needs and condition.

If they are visiting a resident with *C difficile* and may be in close contact with the resident or in their environment, then they should wear gloves and an apron.

They should remove PPE prior to leaving the room, disposing of the PPE in the designated waste bin inside the room and perform hand hygiene using soap and water before leaving the room and again after leaving the room.

Visiting is encouraged and cannot be restricted, however staff should offer alternative communication channels if visiting is identified as an increased risk or at the request of the resident, friends and family.

Cleaning

Routine daily cleaning should take place to ensure standards of cleanliness remain, this is especially important to prevent the spread of infection.

When cleaning a resident's room with *C difficile* or viral gastroenteritis then this should be undertaken twice daily.

PPE should be worn by staff undertaking the cleaning and the national colour coding scheme for cleaning materials in care homes (Infection Prevention Control) and 'Guidance Infection prevention and control: resource for adult social care.'

Staff should refer to the EFH Manual for Housekeeping.

Deep Cleaning

Staff should refer to the EFH Manual for Housekeeping.

This may be required when a more thorough enhanced cleaning is required which compliments the routine daily cleaning that takes place in the care home. It involves the thorough cleaning of all surfaces, floors, soft furnishings and re-usable equipment. This will be necessary following:

Suspected/confirmed *C difficile* and the resident's isolation period is over.

Viral gastroenteritis outbreaks that have been declared as 'over.'

Discharge, transfer, or death of an infected resident.

COVID-19 Statement

Currently there are no COVID-19 rules or restrictions in the UK, though this could change if there is another major outbreak.

It is the responsibility of the Registered Manager and organisation to monitor the English Government guidelines for any changes to the guidance and law. See 'Adult social care: guidance.'

In addition, there is guidance in place from NHS England, the UK Government and Health and Safety Executive on how care settings should minimise risk to both care workers and residents.

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This advice should be incorporated into the risk management and health and safety policies, procedures, and systems of work where appropriate.

Please see:

- COVID-19 restrictions replaced by public health advice, HSE
- Infection prevention and control in adult social care: acute respiratory infection

Specific additional ACS Guidance (used in conjunction with 'Infection prevention and control in adult social care: acute respiratory infection'):

<https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings>

<https://www.infectionpreventioncontrol.co.uk/content/uploads/2021/05/CH-10-Isolation-July-2020-Version-2.01.pdf>

Protective Isolation

Protective isolation is intended to prevent a more susceptible resident acquiring infection. This ideally should be delivered in a specialist unit in the local acute trust.

In a residential setting this can only be performed by advice to staff, relatives friends avoiding the resident with any known infections including colds or flu like symptoms or cold sores.

The room should be kept as clean as practicably possible.

Hand hygiene and PPE should be used for all persons entering the room.

Local advice should be sought from Infection Control Team to determine exact practice and protocols to be followed, according to individuals care plan.

Training

Care staff are provided with training regarding Infection Control Procedures at all suitable stages of their employment from induction onwards.

Seeking Feedback about

EFH will seek feedback from people, families, staff, involved professionals and volunteers about their experiences of Infection Control where it is appropriate to do so. We will seek feedback in person during conversations and via surveys and meetings. We will respond to feedback and tell people about changes and improvements we make as a result of their feedback.

References

<https://www.cqc.org.uk/guidance-providers/residential-adult-social-care/infection-prevention-control-care-homes>

Review date	Next Review Date
May 2024	May 2027