COVID-19 Infection Prevention and Control Isolation and barrier nursing

MAY 2020 (v5)

Residents may need to be nursed/cared for in “isolation” or “barrier nursed”. This document has been produced to help everyone understand what this means.

The Public Health England Influenza Like Illness (COVID-19) case definition for use in care homes is as follows:

Oral or tympanic temperature ≥37.8°C AND one of the following:

acute onset of at least one of the following respiratory symptoms: cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing

OR
an acute deterioration in physical or mental ability without other known cause

Monitoring

Enhanced surveillance for further cases should be initiated by way of daily monitoring of all residents by care home staff, for elevated temperatures and other respiratory symptoms. It is important to identify infected patients as early as possible in order to implement infection control procedures such as isolation to reduce the further spread of infection.

Outbreak control and communications

The following individuals may either be involved in the response to an ILI (COVID-19) outbreak in a care home or need to be informed about this:

- health protection specialist from the local HPT
- care home manager
- care home occupational health practitioner (if identified)
- GPs
- local DPH or appropriate representatives from the local authority
- communications leads
- microbiologist from the local laboratory
- representative from Infection Control in the local trust
- representative from Community Infection Control Teams (if applicable)

Residents & Staff

Isolation
If possible, symptomatic residents should be cared for in single rooms or cohorted. If this is not possible, symptomatic residents with compatible symptoms should be cared for in areas well away from residents without symptoms. All isolation areas should be marked with the 'RED HAND' for clarity.

If the design and capacity of the care home and the numbers of symptomatic residents involved are manageable, it is preferable to isolate residents into separate floors or wings of the home. Signage to control entry into isolation rooms or areas of the care homes should be in place for all staff and visitors. The movement of symptomatic residents should also be minimised.

Staff should work with either symptomatic patients only, or asymptomatic patients, **but not both**, such as to limit the risk of cross contamination of residents by staff members.

DoLS

Imposed isolation (for example, confinement to a room) may not constitute a deprivation of liberty either because it meets the criteria for life saving treatment set out above or because it does not meet the acid test. Managers should consider the MCA and appropriate guidance in deciding what is a deprivation. This type of isolation may be covered for people with an existing DoLS or other authorisation (e.g. through Court of Protection) for deprivation that was given prior to the COVID-19 emergency.

Managers should consider whether a person with a DoLS may have capacity to consent to isolation even if they lack capacity to consent to other arrangements that gave rise to the need for a DoLS in the first place.

Managers should consider the least restrictive option and avoid depriving someone of their liberty unless it is absolutely necessary. If the reasons for the isolation are solely to prevent harm to others or in relationship to public health, then Public Health Officer powers may be more appropriate than using the Mental Capacity Act.

If proposed or imposed restrictions do not reach the level of depriving someone of their liberty - see the 'acid test'- then the wider provisions of the MCA should be followed if a person lacks capacity to consent to the isolation– following the principles of the MCA best interests process as a matter of priority and ensuring any arrangements are the least restrictive option.

DHSC -The Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) During the Coronavirus (COVID-19) Pandemic

Personal protective equipment (PPE) for staff

Staff should use PPE and adhere to infection control measures.

When delivering personal care, whether the resident you are caring for has symptoms or not, you should be wearing:

- Disposable gloves,
- Disposable plastic apron and a
- Fluid resistant surgical mask

When working closely with residents, such as at meal times, medication rounds or during activity sessions, you should be wearing:

- Fluid resistant surgical mask

PPE for Barrier Nursing
For residents in isolation/Barrier nursed, with symptoms and/or a positive test result, you should be wearing:

- Disposable gloves,
- Disposable plastic apron
- Fluid resistant surgical mask
- Eye protection / visor

The PPE should be put on before entering the room and removed before leaving the room – disposable items should be put into the bin provided inside the room. Once the bin is full the bag should be placed inside another bag and left in the room for 72 hours before being disposed of with other waste.
It is important NOT to re-use gloves, masks or aprons after barrier nursing.

More stringent infection control is needed when aerosol generating procedures (such as airway suction and CPR) are carried out on cases or suspected cases. Such procedures should be performed only when necessary and in well ventilated single rooms with the door closed. Numbers of staff exposed should be minimised during the procedure and FFP3 respirators and eye protection used.

Uniform
Staff should not wear uniform to and from work.
If uniform is to be taken home to wash, this should be in a pillowcase and should be washed along with the uniform. If using a disposable plastic bag, the bag should be disposed of once the uniform has been removed.

Hygiene

During outbreaks, messages about respiratory hygiene and cough etiquette ('Catch it, Bin it, Kill it') and hand hygiene should be reinforced among residents, staff and visitors. Hand washing after any cough, sneeze or tissue use is critical in limiting the risk of contamination,

and symptomatic residents should be provided with tissues and hygienic methods to dispose of those.

Hand hygiene is a key infection control precaution to reduce transmission between staff and patients. Staff should wash their hands as a minimum before touching the patient, before any clean/aseptic procedure, after exposure to body fluids, after touching the patient and after touching the patient's environment, as per World Health Organization 'Five Moments in Hand Hygiene'.

Cleaning and waste disposal

Resident's clothes, linen and soft furnishings should be washed on a regular basis and all rooms kept clean. More frequent cleaning of surfaces, such as lockers, tables, chairs, televisions and floors is indicated, especially those located within one metre of a symptomatic patient. Hoists, lifting aids, baths and showers should also be thoroughly cleaned between patients.

HOURLY - Cleaning of handrails and reception areas.
TWICE DAILY - Frequently touched surfaces such as medical equipment, door/toilet handles, lo locker tops, bedside tables, call bells and bed rails.
DAILY - Residents isolation room, cohort areas and clinical rooms.

DEEP CLEAN - Following a resolution of symptom's a full deep clean of the room/area should be undertaken, including the removal and laundering of curtains.

Uniforms and other work clothing should be laundered at work if there are facilities for this. If laundered at home the general advice on washing work clothes would apply. **Uniforms should never be worn between home and the place of work or vice versa.**

Clinical waste should be disposed of according to standard infection-control principles.

Description of uncomplicated influenza, complicated influenza (COVID-19) and risk factors for complicated influenza

- Uncomplicated influenza: Influenza presenting with fever, coryza, generalised symptoms (headache, malaise, myalgia, arthralgia) and sometimes gastrointestinal symptoms, but without any features of complicated influenza

- Complicated influenza Influenza requiring hospital admission and/or with symptoms and signs of lower respiratory tract infection (hypoxaemia, dyspnoea, lung infiltrate), central nervous system involvement and/or a significant exacerbation of an underlying medical condition

- Risk groups for complicated influenza:

    - Neurological, hepatic, renal, pulmonary and chronic cardiac disease

- Diabetes mellitus
- Severe immunosuppression
- Age over 65 years
- Pregnancy (including up to 2 weeks post-partum)
- Children under 6 months of age
- Morbid obesity (BMI ≥40)

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Information for Families and Residents

Residents may need to be nursed in "isolation" or "barrier nursed". This document has been produced to help everyone understand what this means and to answer any questions.

Why do we need to Isolate/barrier nurse?

- To reduce the risk of spreading COVID-19 or antibiotic resistant germs to other residents and staff.
- To protect residents from infection if they have a weak immune system due to disease or taking certain drugs.

What is isolation/barrier nursing?

- **Isolation nursing** is carried out by placing the resident in a single room or side room.
- **Barrier nursing** – this occurs when a resident(s) is kept in isolation and extra precautions are implemented to prevent spread of the germ.

Protective Clothing

- Staff will wear protective clothing for example gloves, apron and mask (if required) in order to reduce the risk of passing the infection / germ to other residents.
- The type of clothing that staff wear will depend upon what type of care they are carrying out and how the infection is spread.
- If the infection is likely to be spread by breathing in the germs that are causing the infection then staff will wear masks.

Isolation rooms can be identified by a red hand sign which will be placed on the door.

Can I leave my bed area or room?

- Residents in isolation should not wander around the communal areas as this may pass on the germ to other residents. They should remain in their own rooms.
- Residents will be asked to keep the door to the isolation room closed. For any concerns please discuss this with the nursing/care staff.

We understand that isolation and barrier nursing can be a very worrying time for all involved. We want to reassure you that we will maintain a person-centred approach to you / your loved one, understanding yours/their individual needs, and will communicate regularly. If you have any further questions, please contact the Home Manager directly.

ISOLATION AREA

CORNWALLIS
CARE SERVICES

BARRIER NURSING