Mid Essex Hospital Services NHS
NHS Trust

Transfer of patients within MEHT	**Clinical Guideline**

Developed in response to:	• Best Practice • Infection Prevention and Control

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1. Purpose

The purpose of this policy is to ensure the appropriate, timely and safe transfer of patients from one ward/department/hospital to another with appropriate communication minimizing infection risks to patient staff and visitors

Best practice is for a patient with an infectious disease or condition not to be transferred between wards. However patients in need of specialist care may be transferred with advice sought from the infection control team.

2. Transfer of patients to specialist isolation facilities

2.1 Patients with infectious diseases requiring strict isolation should be transferred to an infectious diseases unit or hospital with an appropriate facility for example; negative pressure room. Patients with certain infectious diseases listed in this category must be cared for in a High Security Isolation Unit. If admission of a patient with such an infection has occurred, transfer must be arranged immediately whilst maintaining **STRICT ISOLATION** precautions.

2.2 To enable Essex Ambulance Service to ensure the correct emergency service procedures are followed during the transfer of a patient to a high security isolation unit full information should be given when transport is booked regarding the suspected disease and the infection control precautions required. There are three isolation facilities available to us locally, bed availability and transfer should be organised by contacting the Duty Doctor for the respective Infectious Diseases Unit on:

- Northwick Park Hospital - 0208 864 3232
- Addenbrookes Hospital - #6142
- Royal Free Hospital - #6143

2.3 Out of hours

In first instance contact service co-ordinator for advice. They will refer on to on call microbiologist if appropriate. On Call microbiologist is contactable via switchboard .

2.4 Monday – Friday 9am – 5pm

Contact Infection Control Team
Telephone 01245 516398/6579 or bleep Infection Control Nurse # 6500 0700 or #6500 0680

3. Procedure for patients admitted to MEHT

- MRSA status must be recorded and accepting ward informed if patient is on the MRSA pathway. Ring fenced wards are not to take patients who are or who have a history of being MRSA positive

- The named nurse is responsible for informing bed office / receiving ward of any infection control issues

- The named nurse will ensure that the patient and his/her next of kin has been informed of the transfer, where reasonably possible, once a decision has been made and document clearly why if this communication has not taken place

- A telephone handover must be carried out to facilitate quality and continuous care needs to be met. To agree a time for transfer with the nurse in charge of the receiving area and to arrange porters / necessary equipment as required

- Ensure that all documentation is updated for example with the latest treatments given and is complete together with the patient's notes. This will include nursing records, prescription card, Par chart, invasive device management chart, medication and any other observation documents, for example MRSA Care pathway

- Patient's property will be checked and recorded in the property book, placed in a property bag and transported to the receiving area with the patient. Property should then be accepted and re-checked by the receiving nurse

4. Transporting patients to other departments from all areas

The department should be notified in advance so that arrangements may be made to prevent possible spread of infection i.e. Patients with infections spread by the airborne route, including MRSA, can be seen at the end of a list/session. Ward staff should advise of any necessary precautions

4.1 It is preferable that patients are moved as little as possible but should they require rehabilitation or specialist care, this will have priority and the move(s) may take place

4.2 Before transferring a patient with MRSA:

- inform ICN
- bathe and wash hair with Aquasept
- put on clean clothing
- transfer to a bed with clean linen

5. Transport of Patients with MRSA

5.1 This process should be carefully supervised by a member of staff with knowledge and understanding of the process who is aware and has read this policy.

5.2 Whenever possible cover all lesions with an impermeable dressing/s

5.3 Staff transferring a patient to trolley or wheelchair should wear disposable apron and gloves. These should then be disposed of as clinical waste and hands must be

decontaminated.

5.4 Gloves and apron should only be worn by transporting staff giving care (e.g. suctioning) during transport.

5.5 Following transport, the mode of transport (trolley, chair etc) should be cleaned with detergent and water using disposable cloth and dry. Or use a detergent wipe.

5.6 Correct hand hygiene before and after transport of the patient is essential.

6. Patients with MRSA Visits to Out-Patients and Specialist Departments

When this is necessary for patient care either for investigation or treatment the department should be notified in advance. MRSA infection or colonisation should not be a barrier to good clinical care.

The following precautions will apply:

- Careful attention to hand hygiene, particularly the use of alcoholic hand rub before and after every patient contact
- Attending to the patient at the end of the session (when possible and with prior warning to the patient)
- Ensuring that the patient spends as short a time as possible in the department and has minimum contact with other patients
- Minimise the number of staff and equipment used for the patient
- Surfaces with which the patient has direct contact should be cleaned with detergent and water using disposable cloth and dried, or use detergent wipe, or follow the manufacturers guidelines
- Linen in contact with the patient should be treated as fouled/ infected linen

7. Patients with MRSA - Transfers to Other Hospitals

7.1 MRSA infection or colonisation should not be a barrier to good clinical care. Consequently, inter hospital transfers for good clinical reasons should not be prevented.

7.2 It is good practice to inform the clinical and the infection control teams at the receiving hospital of the patient's MRSA status.

7.3 Inform the infection control team of impending transfer in advance, so that this process can be implemented.

8. Disharge of Patients with MRSA

8.1 MRSA patients should be discharged from the hospital or moved to a lower risk environment within the hospital as soon as possible when their clinical condition allows.

8.2 MRSA status, details of decontamination protocol employed and antibiotic treatment should be part of the normal communication of information between clinical teams / other health care workers involved in the discharge / reception of the patient.

8.3 MRSA carriage should not be a barrier to the transfer of patients to a nursing, residential or convalescent home – medical and nursing staff should be informed in advance.

9. Ambulance Transport – Patients with MRSA

Ambulance services have their own protocols for the safe transport of MRSA patients. Please inform transport when booking, to allow for adequate time so these control measures can be put in place.

10. Clostridium *Difficile*

Symptomatic patients should not leave the ward unless unavoidable. If an investigation is necessary ASK: -

- Can it be postponed until the patient is asymptomatic?
- Can it be performed on the ward?

If unable to do either of these: -

- Liaise with the Infection Control Team
- Inform staff in the receiving department who will then take the relevant precautions e.g. - putting patient last on list
- Time spent in the department is kept to a minimum. Area/equipment is thoroughly cleaned after use following infection control guidelines

11. Clostridium *Difficile* - Transfer to Intermediate care wards

For St. Peters patients should be on treatment or completed treatment and asymptomatic for 48hrs

For William Julian Courtauld patients to have finished treatment and asymptomatic for 72 hours.

12 Norovirus

12.1 Discharge/transfers

- Patients should not be discharged to nursing/residential homes or other intermediate care areas during the course of the outbreak.

- Patients who wish to be discharged to their own homes who have not been symptomatic should be made aware of the potential risks to them.

- Where transfer of patients is required for urgent clinical needs the receiving hospital ward or department should be informed of the outbreak

- Where either patient or relative seeks urgent discharges please seek infection control advice.

- If a ward is closed due to Norovirus or suspected Norovirus patients who are present on the ward but not displaying symptoms should be treated as positive as they may be incubating the virus.

- Transportation arrangements should include clear communication to all departments and personnel involved.

12.2 Bed Pressure

Admission into a closed area should be undertaken only following direct instruction from the Director of Operations, Deputy Director of Operations or On Call Manager

13. Admission to B26

- Patients with active acute infections will not be admitted to B26

- No emergency admissions are allowed onto B26. Patients may only be admitted to B26 electively from home or from B23/24 (after infection and MRSA assessment). Admissions directly from casualty, outpatients, other hospital wards, ITU or other hospitals are not permitted.

- All admissions to B26 must be assessed as clear of infection & MRSA before admission. Both the history and swab results of the assessment must be available to make this assessment

- Non-orthopaedic patients may not be admitted to B26

- Patients assessed as clear of MRSA risk on admission (by history and swab results) and who have had a recent negative swab result (within seven days of date of suggested transfer) may be moved from B23/24 if pressure on beds requires this.

- These patients must have clear, dry wounds and be at least four days after injury or operation.

14. Admission to B23/B24 wards

- Patients with active acute infections will not be admitted to B23/24 unless they are admitted under an orthopaedic consultant for treatment of an orthopaedic condition.

- Patients admitted to B23/24 under other consultant teams (because of hospital bed shortages) should not have active acute infections or diagnoses that suggest an infective cause

- Patients transferred from another hospital, another ward, or from ITU will be assessed as at risk of infection because of their history. They will be nursed in side rooms until the results of MRSA swabs taken on transfer are available. These transfers may not occur if all side rooms are full. Information given by other hospitals about the results of MRSA checking may be useful as a guide but a full set of MRSA swabs must be taken on admission: such patients must be treated as being at risk.

15. Monitoring Policy

The effectiveness of the policy is monitored through the annual trust wide documentation audit coordinated through the Clinical Audit Department. The Infection Control Committee reviews the Infection Control policies and Divisions are required to develop localised action plans which are monitored through their Directorate Governance Improvement Plans.
A Trust wide Clinical Documentation summary report is presented annually to the Information Governance Committee for review to enable monitoring at a wider level across the organisation- good standards of clinical documentation help reduce the potential for clinical risk incidents occurring.

Appendix 1

Prioritising sideroom

This document should be used in conjunction with outbreak and isolation policy.

Isolation of patients in hospital is sometimes necessary to prevent transmission of bacteria from an infected patient to others.
Source Isolation
Any patients requiring source isolation in a sideroom as prioritized below - RED
Any patients requiring isolation as protective source isolation in a sideroom- AMBER

Any patients requiring source isolation - GREEN

Each patient should have an individual risk assessment preformed by relevance clinical staff in order of priority

PRIORITY	DISEASE or infecting agent	MODE OF SPREAD from patient to patient in hospital	CATEGORY OF ISOLATION	DURATION OF ISOLATION	COMMENTS
1	***TUBERCULOSIS*** Pulmonary (Open)	Airborne via respiratory droplet	Source RED 	Two weeks treatment	Exclude non immune staff **ALSO REFER CHAPTER H INFECTION CONTROL POLICY**
1	**MENINGITIS** Bacterial Meningococcal	Airborne via oral and nasal secretion or direct contact with the secretions	Source RED 	Until patient has completed oral Meningococcal propyhalxis	**REFER ALSO CHAPTER F INFECTION CONTROL POLICY** Very close contact required for transmission

PRIORITY	DISEASE or infecting agent	MODE OF SPREAD from patient to patient in hospital	CATEGORY OF ISOLATION	DURATION OF ISOLATION	COMMENTS
2	**CHICKENPOX and SHINGLES**	Airborne. via respiratory droplets Direct contact Indirect contact (bedding, other fomites)	Source RED	Until all lesions are at scabbing stage.	Exclude non-immune staff. Door must be kept closed. Visitors who have not had chickenpox must be warned of the risks
2 Norwegian **3 Ordinary**	**SCABIES** Crusted Norwegian scabies	Direct contact with skin and bed Bed clothing As above plus skin scales	Source RED	Norwegian for duration of treatment	Family and other close contacts should also be treated. Long sleeved gowns .
2	**SALMONELLA**	Indirect contact (Faecal oral) Indirect contact (via hands)	Source RED	Whilst diarrhoea present.	It is not necessary for patients to remain in hospital until stools are negative. Door may be kept open. Own toilet preferred.
2	**TYPHOID AND PARATHRHOID**	Typhoid and Paratyphoid are transmitted via transmission of food and water contaminated by faeces and urine of infected persons.	Source RED	Whilst diarrhoea present.	It is not necessary for patients to remain in hospital until stools are negative. Door may be kept open. Own toilet preferred.
2	**MUMPS**	Airborne via respiratory droplets. Direct and indirect contact (saliva)	Source RED	Individual patient assessment For minimum of 5 days after swelling occurs	Exclude non immune staff Warn visitors who are not immune of the risks
2	**MRSA IN SPUTUM**	Direct contact Indirect contact (unwashed hands,) Airborne	Source RED	On clinical / risk assessment	**REFER TO CHAPTER G INFECTON CONTROL POLICY**

PRIORITY	DISEASE or infecting agent	MODE OF SPREAD from patient to patient in hospital	CATEGORY OF ISOLATION	DURATION OF ISOLATION	COMMENTS
Depending on outbreak situation	**SUSPECTED NOROVIRUS** with evidence of vomiting and diarrhoea	Air borne, Indirect contact (Faecal oral) Environmental contamination	Source RED 	Once symptoms have ceased for 48 hours	Sideroom with own toilet preferred Door must be kept closed
2	**ANTIBIOTIC ASSOCIATED DIARRHOEA** (Clostridium difficile)	Indirect contact (Faecal oral) Environmental contamination with Clostridial spores	Source RED 	Once diarrhoea has ceased for 48 hours Negative culture not required	Sideroom with own toilet preferred Door must be kept closed
Dependent on neutrophil levels	**Immunosuppressed patients**	***It is not always necessary to isolate these patients. This is dependant on the Individual risk assessment of patient and ward environment.***			
2	**ESBL**	Possible person to person or Indirect contact with enviroment or secretions.	Source RED 	Length of hospitilisation	
3	**MRSA -** Infections	Direct contact Indirect contact	Source GREEN 	On clinical / risk assessment	**REFER TO CHAPTER G INFECTION CONTROL POLICY**
4	**MRSA –** Colonisation / Old MRSA or high risk	Direct contact Indirect contact	Source GREEN 	On clinical / risk assessment	**REFER TO CHAPTER G INFECTION CONTROL POLICY**
Not neccessary	***TUBERCULOSIS*** Pulmonary (Closed)	No spread	None		**ALSO REFER CHAPTER H INFECTION CONTROL POLICY**

This list only includes the most common infections encountered in hospital for further guidance please refer to infection control policy (Infection Policy)