

INFECTION PREVENTION AND CONTROL CONSIDERATIONS FOR PATIENT PLACEMENT

INFORMATION FOR NSW HOSPITALS

Risks associated with infectious diseases present challenges for patient placement in hospitals. This information sheet provides general advice to staff in NSW local health districts and specialty health networks on how to prioritise resources and make patient placement decisions when an infection risk is present.

To ensure the safe and timely placement of a patient with a known or suspected transmissible infection (including multi-resistant organism colonisation), patient placement decisions should be made in conjunction with the patient flow team and local infection prevention and control (IPC) service wherever possible. After hours management of patients should be determined by local procedures. The decision needs to consider the prioritisation of isolation, single rooms or dedicated areas for other important uses beyond the management of infectious diseases, such as providing end-of-life care or ensuring appropriate patient security and safety. Guidance on the factors to consider when making patient placement decisions is included in Table 1.

Table 2 provides a suggested priority list on how to place patients where there are competing priorities for isolation or isolation rooms. This list should be reviewed with the local IPC service or infectious diseases (ID) service and, where necessary, adapted according to local needs. More detailed guidance can be found at:

- [NHS Ayrshire & Arran: Isolation Prioritisation Scoring System](#)
- [NHS Greater Glasgow & Clyde: Infection Prevention & Control Priority for Isolation Protocol](#)
- [Centers for Disease Control and Prevention: 2007 Guideline for Isolation Precautions Preventing Transmission of Infectious Agents in Healthcare Settings.](#)

If multiple cases of the same priority level are present, consult the IPC service and/or the ID service where possible, as guidance may be provided based on seasonal outbreaks.

Patient placement in a single or isolation room

The benefits of single-bed rooms for patient isolation, in terms of minimising transmission of infection, are described in the NHMRC [Australian Guidelines for the Prevention and Control of Infection in Healthcare \(2010\)](#) [1].

Putting a patient in isolation may increase the risk of stress, depression and anxiety [2,3]. Where there is concern about a patient posing a significant transmission risk to others and ideally requiring care in isolation, treating clinicians should consult with the IPC service and/or an ID physician prior to isolating or not isolating the patient. Where isolation is required, the treating clinician should clearly explain the reason for isolation to the patient and their carers to minimise feelings of stress, depression and anxiety. Extended periods of isolation require regular assessment by teams involved in patient care. The reason for isolation must be documented in the patient's healthcare records and reviewed by the IPC service.

Patient placement in a cohort or mixed inpatient area

Where single rooms are not available in a high risk clinical area, cohorting of patients with the same confirmed infectious agent may need to occur. If this is the only safe option available, nursing staff should be dedicated to the infected/colonised cohort. If this is not possible, consult your local IPC service and refer to Table 2 as a guide. Refer to the *Same Gender Accommodation Policy Directive (PD2015_018)* if placement in mixed gender accommodation is being considered.

In lower risk areas, such as rehabilitation units or outpatient day treatment settings, a risk analysis should be undertaken to establish the level of risk of transmission of infection and the benefit to patient treatment of remaining in a mixed inpatient area.

Based on local infection prevention and control needs, a public health organisation may consider using a designated area and equipment to accommodate an infected/colonised cohort in a mixed ward. Identification of a designated area may assist healthcare workers in maintaining strict standard precautions (and transmission-based precautions, as required) when caring for infected/colonised and non-infected patients who are in close proximity.

Table 1. Risk assessment guide outlining infection prevention and control considerations for patient placement

| RISK FACTORS TO CONSIDER | Source and modes of disease transmission | Clinical predictors of disease transmission | Clinical impact of transmission | Room availability |
|--------------------------|--|---|--|---|
| QUESTIONS TO ASK | <ul style="list-style-type: none"> • Is the disease known to spread from a single source? • Is the disease known to spread person to person? • Is the transmission route known? • Is the disease known to spread via multiple transmission routes? • Has the patient recently travelled overseas and/or received medical care overseas? | <ul style="list-style-type: none"> • Does the colonised/infected patient present with any clinical factors that would increase the likelihood of transmission? | <ul style="list-style-type: none"> • If transmitted, will disease cause significant clinical impact to a high risk patient? | <ul style="list-style-type: none"> • Are single/isolation rooms required for the clinical management of other patients? • Are single rooms with designated toilet facilities available? • Are there other patients infected or colonised with the same species and strain? • Is this an extreme risk rated area*? |
| THINGS TO LOOK OUT FOR | <ul style="list-style-type: none"> • Suspected or confirmed acute respiratory infection • Public health notification • Diarrhoea • Fever | <ul style="list-style-type: none"> • Wandering • Cognitive impairment • Incontinence • Diarrhoea • Broken skin • Open wound • Invasive devices | <ul style="list-style-type: none"> • Neutropaenic patients • Transplant recipients | <ul style="list-style-type: none"> • Patients requiring high security or one on one observation • Patients requiring end-of-life care • Existing cohorts |

*See *Environmental Cleaning Policy* ([PD2012_061](#)) for functional area risk ratings

References

1. NHMRC. *Australian Guidelines for the Prevention and Control of Infection in Healthcare*, 2010. Commonwealth of Australia.
2. Catalano G, Houston SH, Catalano MC, Butera AS, Jennings SM, Hakala SM, Burrows SL, Hickey MG, Duss CV, Skelton DN, Laliotis GJ. Anxiety and depression in hospitalized patients in resistant organism isolation. *Southern Medical Journal*, 2003. 96(2): 141-145.
3. Tarzi S, Kennedy P, Stone S, Evans M. Methicillin-Resistant *Staphylococcus aureus*: psychological impact of hospitalization and isolation in an older adult population. *Journal of Hospital Infection*, 2001. 49(4): 250-254.

Table 2. Suggested prioritisation of resources based on infection risk#

Note: Patients with significant neutropaenia and transplant recipients may require single room isolation with protective precautions – see *CEC Infection Prevention and Control Practice Handbook*. For patients with cystic fibrosis, see *CEC Infection Prevention and Control Practice Handbook*.

| Priority | Disease or presentation* (in alphabetical order) | Precautions** |
|----------|---|------------------------------|
| FIRST | Chickenpox | Airborne + contact |
| | Disseminated varicella zoster virus | Airborne + contact |
| | Measles | Airborne |
| | Pulmonary tuberculosis | Airborne |
| | Respiratory viruses of concern e.g. Middle East respiratory syndrome coronavirus (MERS-CoV), pandemic influenza | Airborne + contact + droplet |
| | Viral haemorrhagic fever | Airborne + contact + droplet |
| SECOND | <i>C. difficile</i> infection | Contact |
| | Carbapenem-resistant organisms (e.g. carbapenem-resistant Enterobacteriaceae) | Contact |
| | Infectious diarrhoea† including norovirus | Contact + droplet |
| | Influenza | Contact + droplet |
| | Meningococcal disease | Droplet |
| | Mumps | Droplet |
| | Pertussis | Droplet |
| | Respiratory syncytial virus (RSV) | Droplet |
| THIRD | Other multi-resistant organisms as designated by your facility (e.g. MRSA, VRE) | Contact |
| | Scabies | Contact |
| | Shingles | Contact |

May not be applicable to all facilities - check with your local infection prevention and control service.

* Not an exhaustive list. Contact your local infection prevention and control unit for guidance on other diseases/presentations.

** For precautions recommended for other diseases/presentations, refer to the NHMRC Australian Guidelines for the Prevention and Control of Infection in Healthcare (2010).

† Some types of infectious diarrhoea only require contact precautions.

About the HAI Program

The CEC's Healthcare Associated Infections (HAI) program assists NSW local health districts and specialty health networks improve systems to manage and monitor the prevention and control of HAI.

For further information on the HAI program, please visit <http://www.cec.health.nsw.gov.au/programs/hai>

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