

SECTION 6

RISK MITIGATION: PATIENT PLACEMENT

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6 Risk assessing for patient placement

“If you are transferring patients lots of times you are moving bugs around the hospital”
Nursing Times, 2010 (147)

ESTABLISH THE CONTEXT

IDENTIFY INFECTION RISKS

ASSESS THE RISK OF INFECTION

CONTROL THE RISK OF INFECTION

REVIEW EFFECTIVENESS OF CONTROL MEASURES

To ensure the safe and timely placement of a patient with a known or suspected transmissible infection (including multidrug-resistant organism colonisation or infection), 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 or single rooms or dedicated areas for other important uses beyond the management of infectious diseases, such as providing end-of-life care, falls risk or ensuring appropriate patient security and safety. The decision to place a patient in isolation should be determined by the following principles:

- Route(s) of transmission of the known or suspected microorganism
- Risk factors for transmission in the infected patient
- Risk factors for adverse outcomes resulting from a HAI in other patients
- Availability of single rooms

[Section 7.4.1](#)

Patient placement (MRO)

Where a patients' presentation involves vomiting, diarrhoea or other high levels of body substance exposure, in the absence of a proven infective process should be considered for an isolation room with dedicated bathroom facilities as priority over other patients that may be considered as lower risk of transmission.

When single rooms with dedicated toilet is not available a dedicated commode should be assigned. Cleaning and disinfection of patient care items and surfaces is especially important in this scenario.

The need for isolation (30) should be reassessed based on transmission period and clinical signs and symptoms of patient.

Table 16. Isolation Room Types

AusHFG	As detailed in HB260 (Standards Australia 2003c)
Class S - Standard	Standard isolation – Type 4
Class P- Positive pressure	Patient protection - Type 3
Class N- Negative pressure	Respiratory isolation – Type 5
Class Q- Quarantine	Quarantine isolation – Type 5 plus airlock

Guidance on the factors to consider when making patient placement decisions is included in Table 16.

Table 17. 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 Vomiting Fever Rash 	<ul style="list-style-type: none"> Wandering Cognitive impairment Incontinence Diarrhoea Broken skin Open wound Invasive devices 	<ul style="list-style-type: none"> Neutropenic patients Transplant recipients Immunosuppressed 	<ul style="list-style-type: none"> Patients requiring high security or one on one observation Patients requiring end-of-life care Existing cohorts

*See [NSW Health PD Environmental Cleaning Policy](#) for functional area risk ratings

6.1 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 well described in the literature. Local risk assessment should determine the appropriate room placement in light of any and all other patient safety risks (e.g. falls risk, other co-morbidities, mental health) (1).

[NHMRC](#)

Australian Guidelines for the Prevention and Control of Infection in Healthcare

Putting a patient in isolation may increase the risk of stress, depression and anxiety (148, 149) and where isolation is required, the reason for isolation should be clearly explained to the patient and their carers to minimise these risks. A decision to isolate the patient should be made carefully with consultation among treating clinicians and the IPC service and/or an ID team. Isolation of a patient should not compromise clinical care. An information sheet should be made available to patients. 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.

The following order of prioritisation should be considered with all patient allocations:

FIRST: Airborne precautions - negative pressure room first priority or single room with door closed and dedicated bathroom facilities

SECOND: Droplet Precautions – transmission risk assessment to be conducted.

THIRD: Contact Precautions – transmission risk assessment to be conducted

Table 8 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 [Clinical Excellence Commissions Infection Prevention and Control Considerations for Patient Placement](#).

[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 with the IPC service and/or the ID service where possible, as guidance may be provided based on seasonal outbreaks.

Table 18. Suggested prioritisation of resources based on infection risk

Note: Patients with significant neutropenia and transplant recipients may require protective isolation - see [Section 9.1, Immunocompromised patients](#). For patients with cystic fibrosis, see [Section 9.2, Cystic Fibrosis](#).

Priority#	Disease or presentation* (in alphabetical order)	Precautions**
FIRST	Chickenpox/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 Enterobacterales)	Contact
	Infectious diarrhoea†, vomiting 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 (localised & uncovered)	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.

6.2 Patient placement in a cohort or mixed inpatient area

Where single rooms are not available in a high risk clinical area, cohorting patients with the same confirmed infectious agent may need to occur. A decision to cohort patients should be made carefully with consultation between treating clinicians and the IPC service and/or an ID physician. Refer to Table 8 as a guide. If placement in mixed gender accommodation is being considered, refer to the [NSW Health PD Same Gender Accommodation](#).

In lower risk areas such as rehabilitation units, long term care settings, outpatient day treatment settings or patient transport services, a risk analysis should be undertaken to establish the level of risk and benefit to patient treatment (1).

[NSW Health PD](#)
Same Gender Accommodation

[Section 7](#)
Risk mitigation: Precautions for multi-resistant organisms and *Clostridium difficile*

[NHMRC](#)
Australian Guidelines for the Prevention and Control of Infection in Healthcare

Based on local infection prevention and control needs, a HO 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 HWs in maintaining standard precautions and transmission-based precautions, as required when caring for patients suspected or confirmed with a communicable disease.

6.3 Staffing

Risk assessment should consider the appropriate allocation of HW. This may involve dedicating HWs to specific patients or cohort groups as able.

Where this is not possible, adherence to hand hygiene, standard and transmission based precautions is essential to reduce the risk of any cross transmission.

HW should be excluded from clinical areas or removed from the facility as appropriate if suspected or proven communicable disease present or exhibiting signs and symptoms indicating potential infective process.

Refer to Infectious diseases table in Section 11 [Appendix 1: Common and important infectious diseases requiring isolation in hospitals](#)