



Influenza Isolation & Cohorting at UHW ICU

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Background

The document: *Pandemic Influenza: A summary of guidance for infection control in health settings (1)*, recommends the following:

- Patients with suspected or confirmed pandemic influenza should be placed in single isolation rooms.
- Negative pressure isolation rooms are not necessary.
- Patients with excessive cough and sputum production should be prioritised for isolation rooms.
- If isolation rooms are not available, cohort confirmed respiratory infected patients with other patients confirmed to have influenza.
- The prioritising of patients other than suspected or confirmed pandemic influenza patients for isolation should be decided locally, based on patient need and local resources.

UHW ICU has 2 isolation rooms versus the national recommendation for between 8 and 16 isolation rooms for its 32 beds (2). The consequence of this is that even small increases in demand for isolation facilities may cause risk and cohorting must be considered much earlier, even at levels below Pandemic. This may cause loss of operational capacity.

This document contains a framework for managing this limited resource. The final decision on the use of resources rests with the Nurse in charge, Duty Consultant and IP&C.

Guidance

- UHW has 2 isolation rooms (beds 8 and 28). At the beginning of a Flu outbreak (first confirmed UHW ICU case) it should be considered on a daily basis whether the 2-bed ward off B3S (beds 9 and 10) should be used as a 3rd isolation room. This should be used with single occupancy and clear barrier nursing signage. This will result in loss of capacity from 32 to 31 beds.
- Patients with suspected Flu should be admitted to one of the 3 isolation rooms.
- Patients who are already isolated in these beds should not be moved to achieve this, unless isolation is no longer clinically indicated. Suspected Flu patients who test as Flu negative should be moved out of isolation as soon as practical.

- In the event of a choice who to isolate, use this hierarchy of isolation list. It does not cover all individual circumstances and is a guide. Complex individual cases should be discussed between the Nurse in Charge, Duty Consultant and IP & C:
- Viral Haemorrhagic Fever / MERS
- Proven TB (open/unventilated)
- Haematology immunosuppressed
- Repatriation in from ICU outside UK or known CRO / MDR such as VRE (CRO test)
- Proven C Difficile infection
- TB, intubated, closed circuit
- Suspected flu (open circuit – risk of generating aerosols)
- Suspected flu (closed circuit)
- Proven flu (ideally move to cohort)
- Norovirus, symptomatic
- Transfer in from UK hospital ward / ICU with a known high incidence of CRO (London, Manchester) (CRO test)
- Proven MRSA infection / colonisation
- C Difficile colonisation with diarrhoea
- Clinically suspected TB
- Clinically suspected Influenza
- Clinically suspected C Difficile
- Transfer in from UK hospital ward / ICU without a known CRO issue (CRO test)
- Transfer in following short admission to any outside A&E <12 hours
- Patients needing privacy (disruptive behaviour, request, age 16-18)
- End of life care
- If a patient cannot be isolated there should be a sign at the bedside that barrier / flu precautions should be attempted at their bed-space.
- When there is a risk the 3 isolation rooms will be exhausted by confirmed Flu patients, a cohort area should be created into which Flu positive patients should be decanted. Only confirmed Flu positive (not suspected) patients should be admitted to a cohort area. These should be non-thoroughfare areas, there are 2 options:
 - 4 bed A3S (beds 29-32)
 - 7 bed B3N (beds 1-7)
- A plan should be made to ensure the cohort area is adequately equipped and that movement of equipment in and out of the cohort area is minimised.
- The choice of escalation area should be based on the number and clinical need of the confirmed Flu patients and the expected scale of Flu based on information from Public Health Wales. It is recognised that the 4 bed areas falls well below national standards for ICUs presenting difficulties in providing care to some patients with multi-organ failure, and early consideration of cohorting in B3N is recommended. Additionally providing dedicated equipment to multiple cohort areas is difficult. If B3N is used resulting in loss of overall capacity, there should be consideration of temporarily suspending PACU activity to redistribute non-Flu patients into PACU, utilising PACU staff.

- It is likely that the 3 isolation rooms will quickly be exhausted. It is imperative that Flu testing and bedspace cleaning / decontamination are expedited to ensure rapid turnaround.
- Patients may be moved from isolation / cohorting at resolution of Flu signs and symptoms, typically around 7 days, though this may be longer in the immunocompromised.

Communication:

- The Nurse in charge and Duty Consultant(s) should meet at least twice a day to discuss how to best risk manage the available isolation / cohort resource.
- A Datix form should be completed for each patient who (for any clinical reason) should be isolated, who cannot be. A combined Datix form should be completed for cohorted patients too.
- Any loss of operational capacity due to incompletely utilised cohort areas, should be escalated through Specialist Services Clinical Board.
- Staff should be made aware of the current isolation / cohort plan at handover. Adequate signage should support identification of cohort areas.
- If there is insufficient overall capacity for all patients requiring Intensive Care, consult the main ICU escalation plan.

References:

1. Pandemic Influenza: A summary of guidance for infection control in health settings. DoH 2019
2. Welsh Health Building Note 04-02 (2016)