**SOP Objective**

To ensure that Healthcare Workers (HCWs) are aware of the actions and precautions necessary to minimise the risk of outbreaks and the importance of diagnosing patients' clinical conditions promptly.

This SOP applies to all staff employed by NHS Greater Glasgow & Clyde and locum staff on fixed term contracts and volunteer & contractors.

**KEY CHANGES FROM THE PREVIOUS VERSION OF THIS SOP**

**Document Control Summary**

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|---|---|
| Approved by and date | Scientific & Technical Advisory Cell (STAC) |
| Date of Publication | 5 May 2020 |
| Developed by | IPCT |
| Related Documents | COVID 19 IPC Website@ https://www.nhsggc.org.uk/your-health/health-issues/covid-19-coronavirus/for-nhsggc-staff/infection-prevention-and-control/ |
| Distribution/Availability | NHSGGC Infection Prevention and Control Policy Manual and www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/ |
| Lead Manager | Board Infection Control Manager |
| Responsible Director | Board Executive Lead IPC |

**CONTENTS**

## 1. Responsibilities

**Healthcare Workers (HCWs) should**:

- Follow this guidance.
- Alert managers and senior clinicians if this guidance cannot be followed.

**Managers should**:

- Follow this guidance and carry out local risk assessments if this guidance is unable to be followed.

**Infection Prevention Control Teams (IPCTs) should**:

- Keep this information up to date.
- Advised service on the application of the guidance and complete appropriate risk assessments with service providers.

## 2. Introduction/Scope

Prevention of hospital transmission of COVID-19 relies on strict adherence to infection control practices and appropriate patient placement. In situations when single isolation room availability is limited it is accepted that certain patient groups can be cohorted in appropriate areas. This SOP describes general principles of various aspects of cohorting.

It is expected that hospitals will follow these general principles but local adaptation depending on resources available is accepted. Deviation from national guidelines needs to be risk assessed and communicated to the relevant structures of clinical governance.

This guidance provides advice on appropriate cohorting in the context of infection prevention and control precautions for patients who are:

- Positive for COVID 19
- Suspected of having COVID 19
- Contact of a person with COVID 19
- In the category of patients who require to be shielded.

## 3. General Information on COVID 19

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| ***Communicable Disease/ Alert Organism*** | Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others causing more severe disease such as Middle East respiratory syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) coronaviruses. COVID 19 is one of this group. |
| ***Clinical Condition*** | Fever, cough or chest tightness, myalgia, fatigue and dyspnoea are the main symptoms reported. A variety of abnormalities may be expected on chest radiographs, but bilateral lung infiltrates appear to be common (similar to what is seen with other types of viral pneumonia).<br><br>Emerging evidence suggests that there may be atypical presentations reported in older people e.g. delirium (hypo and hyperactive), diarrhoea, lethargy, falls and reduced appetite.<br><br>https://www.bgs.org.uk/blog/atypical-covid-19-presentations-in-older-people-%E2%80%93-the-need-for-continued-vigilance |

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| ***Case definitions*** | Patients who meet the following criteria (inpatient definition) requiring admission to hospital (a hospital practitioner has decided that admission to hospital is required with an expectation that the patient will need to stay at least one night)<br>**and**<br>have either clinical or radiological evidence of pneumonia<br>**or**<br>acute respiratory distress syndrome<br>**or**<br>influenza like illness (fever ≥37.8°C and at least one of the following respiratory symptoms, which must be of acute onset: new continuous cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing change in sense of smell or taste.<br><br>**Note:** Clinicians should consider testing inpatients with new respiratory symptoms or fever without another cause or worsening of a pre-existing respiratory condition.<br>**Clinicians should be alert to the possibility of atypical presentations in patients who are immunocompromised.**<br><br>https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection |
| ***Incubation Period*** | **1-14 days (median 5 days)** |
| ***Mode of Spread*** | Droplet and contact<br>According to current evidence, the COVID-19 virus is primarily transmitted between people through respiratory droplets and contact routes. In the context of COVID-19, airborne transmission may be possible in specific circumstances and settings in which procedures or support treatments that generate aerosols are performed (AGP). |
| ***Period of communicability*** | Approximately one week from onset of symptoms in mild cases and for longer in those severely affected or immunocompromised. |
| ***Persons most at risk*** | Those that meet the shielding criteria and the frail older person. |

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| ***Notifiable disease*** | Yes |

## 4. General Principles of Cohorting

Prevention of hospital transmission of COVID-19 relies on strict adherence to infection control practices and appropriate patient placement. It is expected that hospitals will follow these general principles but local adaptation depending on available facilities is accepted and should be developed with the advice of the IPCT.

- Deviation from national guidelines needs to be risk assessed and communicated to the relevant structures of clinical governance.
- Minimise patient movement at all times as far as possible.
- Move patients to a new clinical area only if this is a clinical necessity and has been discussed with a senior clinician, or the decision to move the patient is based on a test result.
- Promptly isolate any new positive COVID-19 cases in either in a single room or cohort in a red area.
- Contacts of the same exposure incident (eg contacts to a new positive COVID-19 patient within a 6 bedded bay) should be isolated or cohorted together in an amber (contact) ward/bay and any patient movement should be minimised as much as possible.
- In some situations (bed pressure, low number of contacts etc) contacts of different exposures can be cohorted together in the same area.
- Each group of patients is assigned a colour code to help to visualise patient pathways and the description of each group is summarised in table 1.
- Green Wards should ideally be a combination of side rooms and bays. This will ensure there are pathways for patients who are asymptomatic and side rooms for patients who require shielding.
- Amber wards should ideally if possible be a combination of single rooms and bay areas. This eliminates the need for cohorting of contacts if any patients test positive. If there are bays then these should be used for 'clusters of contacts' from green wards and patients should not be moved from these until discharged or after 14 days.
- In Red wards there are no specific requirement but consideration should be given to issues such as end of life care.
- Discharge from hospital and stepdown of IPC precautions should be followed when removing patients from red pathway (appendix 3 - Discharge from hospital and stepdown of IPC precautions).

Table 1

| **Location** | **Admission ward/ED** | | | **Downstream ward** | | |
|---|---|---|---|---|---|---|
| **Clinical or epidemiological status** | Positive COVID 19 | ? COVID 19 | Non-symptomatic | Positives | Contacts | Negatives |
| **Colour code** | Red | Amber | Green | Red | Amber | Green |
| **Action** | Isolated or cohorted | Isolated/cohort Screen and move to green or red area | Enter green area<br>If shielding required put in side room | Isolated or cohorted | Isolated or cohorted | Not isolated<br>If shielding required put in side room |

Please refer to appendix 1 & 2 on general principles for setting up a cohort area.

## 5. Patient Pathways

On admission, patients are divided in three major pathways depending on initial assessment of clinical picture - Green pathway for patients with no symptoms of COVID-19, Amber pathway for those with possible/probable COVID 19 and Red pathway for patients who have COVID-19.

It is expected that each hospital will have to create local pathways to suit their local situation – patient demographics, epidemiological situation, availability of isolation facilities and other factors but general principles should be followed. Any deviation from national guidance should be risk assessed and clinical governance structures should be informed (risk assessment template appendix 5)

An individual patient risk assessment can also be undertaken and a template for this is contained in appendix 6.

**Readmission of patients post Covid**

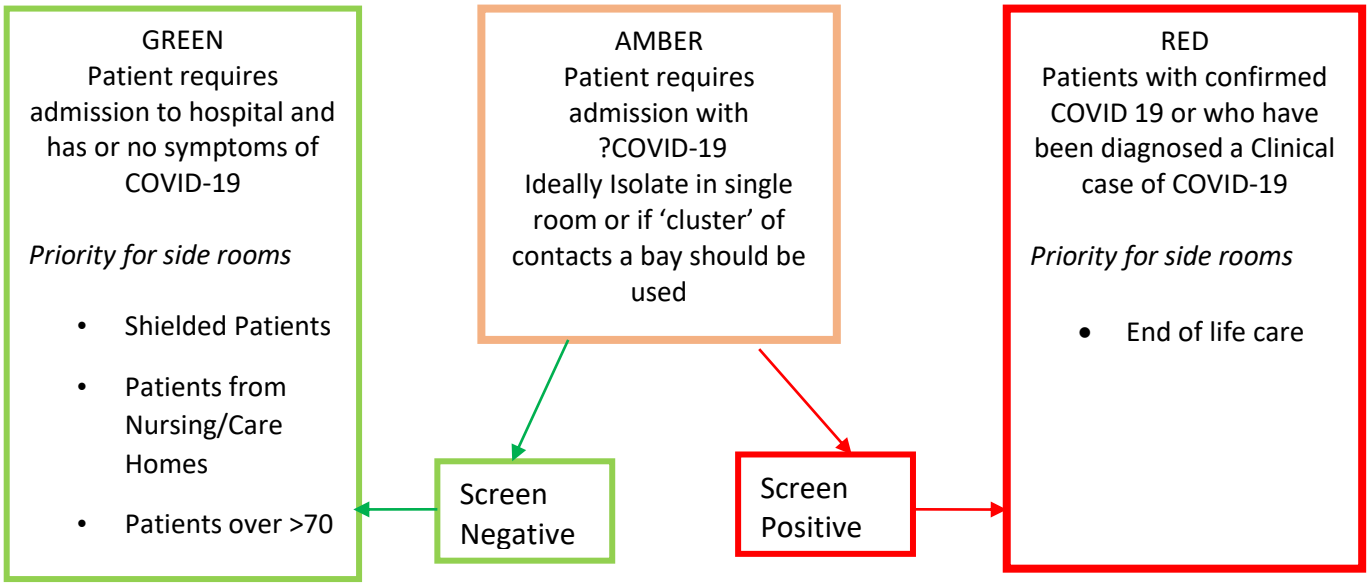
<14 days from positive sample. Patient should go into **red** pathway. **Should not be screened again.**

>14 days from positive sample and patient is not immunosuppressed and not presenting with covid like symptoms. Patient can go into **green** pathway. **Should not be screened again.**

>14 days from positive sample and patient is immunosuppressed, patient should go into **red** pathway until 2 negative screens.

>14 days from positive sample and patient is not immunosuppressed and is presenting with covid like symptoms, patient should go into **red** pathway and should be screened again.

Shielding patients who have had Covid do not need a single side room. They can go into a cohort based on above.




**New COVID-19 Patient Identified in Green pathway**

- Positive patient to red pathway
- Contacts should go to a single room/bay in amber pathway (should stay in the same cohort for 14 days or until discharged).

## 6. Prioritisation of patients for placement in single rooms (SR)

Prioritise patients to single rooms in the following order:

1. Patients who are shielding (green/amber).

2. Admitted from Residential/care home (green/amber pathway).

3. Patients who require end of life care (all pathways).

## 7. Shielded Patients

The document below (see link) sets out details of the groups considered to be at highest risk should they contract Covid-19. Patients identified are sent a detailed letter advising them of the need to take Shielding advice and the support mechanisms available to them. In hospital we should maintain additional precautions for shielded patients to minimise the risk of contracting COVID-19 so shielded patients should, as a matter of clinical priority, be isolated in single rooms. There are circumstances that may be beyond our control that mean that this is not always possible. Where the clinical team and site management have exhausted the possible provision of single room accommodation then to provide additional protection the patient should wear a fluid resistant surgical mask if tolerated. A clinical assessment to determine the level of protection each individual may require, should be undertaken by the clinician with the responsibility for their care with the support of the IPCT if required. If a single room is not available then consideration should be given to the possible transfer of these patients if it is clinically appropriate to maintain patient safety and the effectiveness of care to do so but this should be guided by the clinical assessment of the patient.

The need for shielding should be confirmed by senior clinical staff. Discuss with IPCT if rooms are occupied by patients for other infection control reasons, e.g. loose stools, other infectious disease etc.

https://hpspubsrepo.blob.core.windows.net/hps-website/nss/3008/documents/1_covid-19-search-criteria-highest-risk-patients.pdf

## 8. Management of contacts of a positive COVID-19 case

- If a patient tests positive for COVID-19 within a green or amber area they should be transferred to a red cohort. All patients in the same bay area are assumed to be contacts of the new positive case and should be cohorted together in an Amber cohort (single rooms or bay). They should be kept together as far as possible and observed for the development of symptoms for 14 days from the day the index patient was tested positive, or the day the index patient displayed COVID-19 symptoms.

- All contacts from the same exposure should be cohorted together if possible. Occasionally contacts from different exposures can be cohorted together but this may result in an extension to the time patients need to be monitored for COVID 19, e.g. if a bay has three patients on day 7 post exposure and a new contact is admitted and tests positive then the clock 'resets' for the others i.e. they would need to isolated for another 14 days. For this reason, it is preferred to have only contacts from one exposure cohorted together to minimise the risk of extended isolation.
- There is no requirement to test asymptomatic contacts routinely but occasionally this will be requested by IPCT to assist with appropriate patient placement and incident management.
- Certain groups of patients will require a negative COVID-19 test before they can be discharged from isolation (please refer to Appendix 3 & 4 Discharge from hospital and stepdown from infection prevention and control precautions).
- When discharged from isolation, contacts can enter a Green pathway but each individual case should be assessed for risk factors e.g. immunosuppressed patients shedding virus for longer.
- If there is a clinically suspected case that has a negative test the clinical team should seek advice from Infectious Disease consultant if required.

## 9. Opening Wards closed due to COVID 19

There is currently no available guidance with regards to reopening wards closed due to unexpected clusters of COVID 19. Assessment is based on the following criteria but this list is not exhaustive:

- Number of patients still symptomatic
- Results of screening
- Number of isolation rooms/bays
- Number of patients in cohort that require shielding
- Clinical specialty

Reopening of wards is therefore based on local risk assessment by the site/sector IPCT and the local clinical and managerial teams.

## 10. Inter-hospital Transfer

At this time there is no national guidance in relation to inter-hospital transfer guidance. This may be considered by local teams in certain circumstances but the

decision to implement should be reviewed by the appropriate clinical governance forum.

## 11. Evidence base

All information related to COVID 19 can be found at:

https://www.hps.scot.nhs.uk/a-to-z-of-topics/wuhan-novel-coronavirus/

## 12. Appendixes

### Appendix 1 - COVID 19 Cohort in General Ward Cohort Information V.1.6

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|---|---|
| **Planning and communications** | On each hospital site, wards and wards with suitable bed bays will be identified and a pathway agreed from ED to discharge. This will be communicated to the appropriate staff at huddles/briefs to support patient/bed management. Daily updates on bed spaces on cohort wards/bays should be available to support patient transfers from ED and acute receiving. Wards with cohort bays will not be closed to other admissions. |
| **Definition of a cohort ward or bay** | A cohort area is a bay/ward in which a group of patients (cohort) with the same infection are placed together. Patient cohorting may be appropriate when single rooms are not available and there is more than one patient with the same confirmed infection. If necessary it is possible to cohort a suspected COVID 19 cases where bed spacing is optimal e.g. 2.7 metres apart. |
| **Decision to create a COVID-19 cohort** | If a ward has bed bays and a number of confirmed COVID-19 patients, those patients should be nursed in a single bay as a cohort. If there are empty beds in that cohort, they can be used for COVID-19 patients from other areas. The decision to set up a cohort should be discussed with local IPCT. Out of hours - on call Microbiologist prior to being implemented. |
| **Setting up the cohort** | The cohort bay should have dedicated equipment as far as possible such as blood pressure, oxygen saturation and temperature recording devices within the cohort bay. A trolley with fresh linen, tissues, waste bags and commonly used disposable equipment such as oxygen tubing and masks will be useful for staff working in the cohort. linen should be covered if out in the ward area Use the IPC yellow sign at the entrance of the cohort. |
| **Staffing (cohort nursing)** | Cohort nursing (dedicated teams) should be implemented to minimise the risk of contamination between groups of symptomatic and non-symptomatic patients if staff resource allows. If not, contact the local IPCT who will help to undertake a risk assessment. |
| **Bed spacing** | Patients should be separated by at least 2.7 metres from each other in a cohort area, and bed curtains can be drawn as an additional physical barrier if possible. |

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| **Cohort patients** | Patients who have confirmed COVID-19 can be nursed in a COVID-19 cohort until they have been deemed no longer infectious. However, It should be noted that patients being nursed together in a cohort should all have confirmed COVID-19. Patients who remain symptomatic but are well enough to be discharged can be sent home with advice on how to self-isolate. Patients who have COVID-19 and another infection e.g. diarrhoea or MRSA, should be nursed in a single room. |
| **Testing** | Laboratory testing will identify patients with COVID-19. |
| **PPE** | When entering a cohort area, don a FRSM, if within 2 metres of patient, wear a disposable plastic apron, gloves and eye protection. Apron and gloves should be changed between patients and HH performed<br>You do not need to change your mask unless it becomes moist or you have finished working in the cohort.<br>If patient requires AGP's this should not be done in a cohort. If this is not possible staff should wear full PPE – FFP3 mask, long sleeved fluid repellent gown, 1 pair disposable gloves and eye protection to carry out the procedure and for a maximum of 2 hours following the AGP procedure (please refer to local guidance on number of air changes in specific area). |
| **Equipment** | As far as possible, dedicated equipment should remain in the cohort bay for use on cohort patients only. For equipment that cannot be dedicated, items should be cleaned with a solution containing 1,000 ppm active chlorine e.g. Actichlor Plus and dried before removal from cohort. Casenotes should be left outside the room if at all possible. |
| **Ward rounds** | Ward rounds within a cohort will consist of 1 member of medical team entering the cohort in appropriate PPE to examine the patient only. Once exam completed, removal of PPE and hand hygiene should be performed. Any equipment used will either stay in the cohort or be decontaminated before removal. |
| **Linen** | Bed linen should be managed as infected linen<br>Curtains should be changed if visibly contaminated or weekly. |
| **Waste** | Waste should be managed as healthcare waste |

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| **Cleaning of Environment** | Domestic services, wearing apron, gloves and a FRSM, should clean the cohort bed bay/ ward twice daily with a solution containing 1,000 ppm active chlorine e.g. Actichlor Plus. (Consideration should be given to a dedicated cleaning team on each site). Disposable cloths and reusable mop heads should be used. Bucket and mop pole will be cleaned after use with Actichlor Plus.<br>If an AGP has been carried out, staff will restrict facility staff access to the cohort area for 2 hours following AGP. |
| **Visitors** | Please refer to GGC guidance on visitors. |

## Appendix 2 - COVID Aide Memoire Cohort

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| **Planning and communications** | On each hospital site, ICU/AGP hot spots will be identified and a respiratory pathway agreed from ED to discharge. This will be communicated to the appropriate staff at huddles/briefs to support patient/bed management. Daily updates on bed spaces on cohort wards/bays should be available to support patient transfers from ED and acute receiving. Wards with cohort bays will not be closed to other admissions. |
| **Definition of a cohort ward or bay** | A cohort area is a bay/ward in which a group of patients (cohort) with the same confirmed or on occasion's probable infection are placed together. Patient cohorting may be appropriate when single rooms are not available and there is more than one patient with the same confirmed infection. If necessary it is possible to cohort a suspected COVID cases where bed spacing is optimal e.g. 2.7 metres apart. It might be necessary to cohort patients with respiratory symptoms/illness without test results. |
| **Decision to create a COVID-19 cohort** | If a ward has bed bays and a number of confirmed COVID-19 patients, those patients should be nursed in a single bay as a cohort. If there are empty beds in that cohort, they can be used for COVID-19 patients from other areas. The decision to set up a cohort should be discussed with local IPCTon call Microbiologist prior to being implemented. |
| **Setting up the cohort** | The cohort bay should have dedicated equipment as far as possible such as blood pressure, oxygen saturation and temperature recording devices within the cohort bay. A trolley with fresh linen, tissues, waste bags and commonly used disposable equipment such as oxygen tubing and masks will be useful for staff working in the cohort. |
| **Staffing (cohort nursing)** | Cohort nursing (dedicated teams) should be implemented to minimise the risk of contamination between groups of symptomatic and non-symptomatic patients if staff resource allows. If not, contact the local IPCT who will help to undertake a risk assessment. |
| **Bed spacing** | Patients should be separated by at 2.7 metres from each other in a cohort area, and bed curtains can be drawn as an additional physical barrier if required. |

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| **Cohort patients** | Patients who have confirmed COVID-19 can be nursed in a COVID-19 cohort until they have been deemed no longer infectious. However, It should be noted that patients being nursed together in a cohort should all have confirmed COVID-19. Patients who remain symptomatic but are well enough to be discharged can be sent home with advice on how to self-isolate. Patients who have COVID-19 and another infection e.g. diarrhoea or MRSA, should be nursed in a single room. |
| **Testing** | Laboratory testing will identify patients with COVID-19. |
| **PPE** | Before entering the cohort ward / bay, don respiratory PPE including 1 pairs of disposable gloves, long-sleeved gown, FFP3 mask and full face visor/goggles. For direct care, a plastic apron should be worn over the gown and changed along with gloves between patients. ABHR must be used between glove changes. |
| **Equipment** | As far as possible, dedicated equipment should remain in the cohort bay for use on cohort patients only. For equipment that cannot be dedicated, items should be cleaned with a solution containing 1,000 ppm active chlorine e.g. Actichlor Plus and dried before removal from cohort. For small items e.g. stethoscopes alcohol wipes can be used. Case notes should be left outside the room whenever possible. |
| **Ward rounds** | Ward rounds within a cohort will consist of 1 member of medical team entering the cohort in appropriate PPE to examine the patient only. Once exam completed, removal of PPE and hand hygiene should be performed. Any equipment used will either stay in the cohort or be decontaminated before removal. |
| **Linen** | Bed linen should be managed as infected linen. Curtains should be changed when visibly contaminated or weekly. |
| **Waste** | Waste should be managed as healthcare waste. |
| **Cleaning of Environment** | Domestic services, wearing respiratory PPE, should clean the cohort bed bay/ ward twice daily with a solution containing 1,000 ppm active chlorine e.g. Actichlor Plus. (Consideration should be given to a dedicated cleaning team on each site). Disposable cloth and mop heads should be used. Bucket and mop pole will be cleaned after use with Actichlor Plus. |
| **Visitors** | Follow the NHSGGC COVID Visiting Restrictions |

## Appendix 3 – Discharge from hospital and stepdown of IPC precautions

### COVID-19 – Discharging from hospital and stepdown of infection prevention and control precautions

#### DISCHARGE TO HOME

**When stable/improving respiratory function and ongoing care needs can be met at home**

Patient factors:
- **ICU/HDU during admission?**
- **Severe immunosuppression?**
- **Shielding?**

No → Self-isolate **7** days[1,2] from discharge

Yes → Self-isolate **14** days[1,2] from discharge

[1] if fever persists, continue self-isolation beyond 7/14 days until no fever for 48 hours
[2] If patient has already completed stepdown as outlined below, self isolation is not required

Household members should complete **14** day stay at home period
- If vulnerable person(s) in household see 'Stay at home' guidance on NHS Inform
- If 'extremely vulnerable' (shielding) person(s) in household consider discharge to different home until completed self-isolation period

See full HPS guidance for:
1. Transport options for discharge
2. Definition of severe immunosuppression
3. Ongoing medical needs after discharge

#### STEPDOWN OF INFECTION CONTROL PRECAUTIONS IN HOSPITAL

**Stepdown can be considered 14 days from symptom onset (or first positive test if symptoms are undetermined) with absence of fever for 48 hours (without the use of antipyretics) OR in severely immunocompromised patients following two -ve clearance PCR tests at least 24 hours apart.**

If testing earlier than 14 days is needed to allow patient flow, two –ve PCR tests are required at least 24 hours apart

Clinical improvement and no fever for 48 hours

Yes → Severe immuno-suppression

No → Stepdown IPC precautions

No → Continue IPC precautions

Yes → PCR test*

+ve PCR – Repeat after 7 days

-ve PCR – Stepdown IPC measures

*sputum/lower respiratory samples for PCR are preferable wherever possible

#### DISCHARGE TO CARE/RESIDENTIAL HOME

**When stable/improving respiratory function and ongoing care needs can be met at care facility. Patient should be isolated for a minimum of 14 days from initial +ve PCR test or symptom onset and require two negative tests required prior to discharge.**

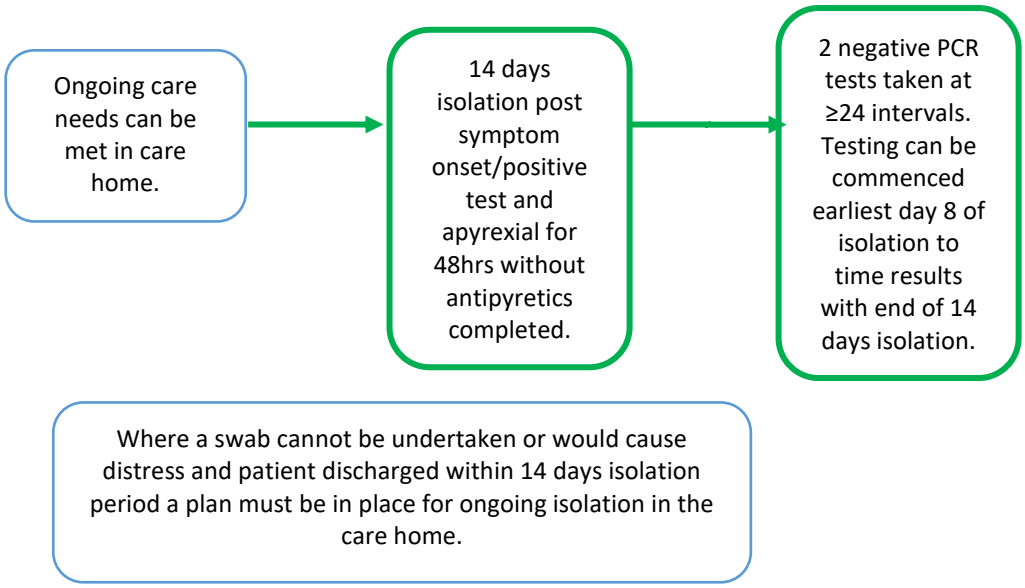
HPS Guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings (accessed 13/04/2020)

GRI Respiratory Medicine v7 28/04/2020

**Appendix 4 – Discharge from Hospital to care home**

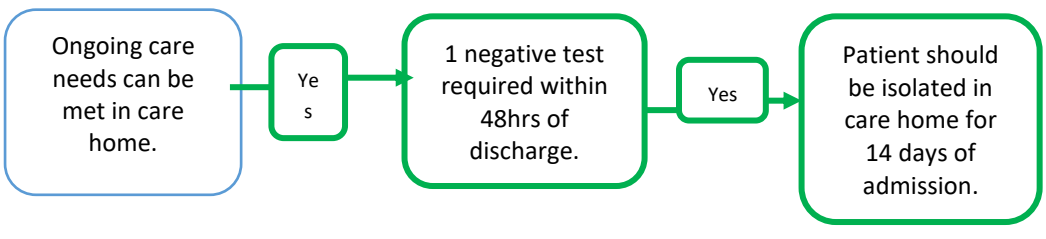
# Discharging from hospital to care home.

## DISCHARGE FOLLOWING POSITIVE RESULT




Where a swab cannot be undertaken or would cause distress and patient discharged within 14 days isolation period a plan must be in place for ongoing isolation in the care home.

## DISCHARGE WHEN NEVER KNOWN POSITIVE



**Appendix 5 – General Risk Assessment**

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|---|---|
| NHS Greater Glasgow and Clyde | **NHS Greater Glasgow & Clyde**<br><br>**Infection Prevention and Control Team – General Risk Assessment Document** |
| **Purpose:** | To describe the different risks associated with the current situation and recommend actions based on the assessment of relative risks. |
| **Completed by:** | |
| **Date:** | |
| **Subject / Situation:** | |
| **Background** | |
| **Identification of Risk (S) Associated with this Situation** | **1.** Describe risk<br><br>Assess the risk<br><br>Risk =<br>Likelihood =<br>Impact/Consequences =<br><br>Actions to mitigate this risk would be: |

| | | **Impact / Consequences** | | | | |
|---|---|---|---|---|---|---|
| | | ***Negligible*** | **Minor** | **Moderate** | **Major** | **Extreme** |
| **Likelihood** | **Almost Certain** | **Medium** | **High** | **High** | **V High** | **V High** |
| | **Likely** | **Medium** | **Medium** | **High** | **High** | **V High** |
| | **Possible** | **Low** | **Medium** | **Medium** | **High** | **High** |
| | **Unlikely** | **Low** | **Medium** | **Medium** | **Medium** | **High** |
| | **Rare** | **Low** | **Low** | **Low** | **Medium** | **Medium** |
| **Recommendations** | | | | | | |

| **Appendix 6: Infection Prevention and Control Risk Assessment**<br>(for patients with known or suspected infection that cannot be isolated)<br><br>**Daily Assessment / Review Required** | **Addressograph Label:**<br>**Patient Name and DOB/CHI:** | NHS Greater Glasgow and Clyde |
|---|---|---|

| | **C O M M E N T S** | **DATE** | **DATE** | **DATE** | **DATE** | **DATE** | **DATE** | **DATE** |
|---|---|---|---|---|---|---|---|---|
| **Daily Assessment Performed by**<br>***Initials*** | | | | | | | | |
| **Known or suspected Infection - COVID-19**<br>***Please state*** | | | | | | | | |
| **Infection Control Risk**, e.g. unable to isolate, lack of isolation rooms. Unable to use curtains to shield patients in neighbouring beds<br>***Please state*** | | | | | | | | |
| **Reason unable to isolate** e.g. falls risk, observation required, due to cognitive impairment, clinical condition.<br>***Please state*** | | | | | | | | |
| **Additional Precautions** put in place to reduce risk of transmission, e.g. trolley containing appropriate PPE at end of be. Bed spacing 2.7 metres from centre of bed to centre of bed. Ensuring that patients sitting out of bed are not next to each other.<br>Ask patient to wear a mask if tolerated ***Please state*** | | | | | | | | |
| **Infection Prevention and Control have been informed** of patient's admission and are aware of inability to adhere to IPC Policy?<br>***Yes / No*** | | | | | | | | |
| **Summary Detail of Resolution** | | | | | | | | |

**Daily risk assessments are no longer required**

**Signed** _____

**Date** _____