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NHS

Community Infection Prevention and Control Policy for General Practice

(also suitable for adoption by other healthcare providers, e.g. Podiatry)

Patient placement and assessment for infection risk

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This Policy has been adopted by:

Organisation: .....

Signature: ..... Name: .....

Job title: .....

Adoption date: .....

Review date: .....

Any variation to this Policy should be risk assessed, evidence-based, authorised through local governance channels and documented below. The Community Infection Prevention and Control (IPC) Team, Harrogate and District NHS Foundation Trust, cannot endorse or be held responsible for any variations.

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PATIENT PLACEMENT AND ASSESSMENT FOR INFECTION RISK

1. Introduction

NHS England states that the guidance in the *National infection prevention and control manual (NIPCM) for England* should be applied by all NHS staff involved in patient care, complementing guidance for General Practice settings. This Policy has been produced in accordance with this recommendation and incorporates the *NIPCM* version as referenced in this Policy with detailed General Practice specific guidance.

This Policy is one of the 'Standard infection control precautions' (SICPs).

Assessment for infection risk and subsequent correct patient placement is an essential infection prevention and control practice to prevent the spread of communicable disease within General Practice.

When caring for patients in relation to any new or emerging infections, staff should refer to the national infection prevention and control guidance.

2. Risk definitions

Confirmed risk

A 'confirmed risk' patient is one who has been confirmed by a laboratory test or clinical diagnosis, e.g. COVID-19, Meticillin resistant *Staphylococcus aureus* (MRSA), Multi-resistant Gram-negative bacteria (MRGNB), Pulmonary Tuberculosis (TB), scabies, seasonal influenza and enteric infections (diarrhoea and/or vomiting), including *Clostridioides difficile* (*C. difficile*).

Suspected risk

A 'suspected risk' patient includes one who is awaiting laboratory test results or clinical diagnosis to identify infections/organisms or those who have been in recent contact/close proximity to an infected person.

No known risk

A 'no known risk' patient does not meet either of the criteria above.

3. Signage

It is recommended that signage is displayed at the entrance to the building instructing patients with respiratory symptoms, diarrhoea and/or vomiting or other infectious conditions to inform reception staff immediately on their arrival. A 'Stop the spread of infection Poster' is available to download at

www.infectionpreventioncontrol.co.uk/resources/stop-the-spread-of-infection-for-general-practice/.

4. Assessment for isolation

Where possible, arrangements should be made to remotely review an infectious patient.

Patients attending with confirmed or suspected infection or colonisation should be prioritised for assessment and treatment, e.g. scheduled appointments at the start or end of the clinic session.

If the patient needs to be seen in the Practice, the implementation of SICPs and, where required, 'Transmission based precautions' (TBPs) will reduce the risk of the transmission of infection. Infectious patients should be separated from other patients whilst awaiting assessment and during care management by at least 1 metre. Patients with specific infections, such as chicken pox, measles, influenza, or COVID-19, should be isolated in a separate area or room away from other patients so that the risk of infection to others in waiting or communal areas is minimised.

When a room is not available, the epidemiology of the suspected infection should be considered when determining patient placement.

When assessing the need to isolate a patient, the following should be considered:

- The risk of spread to other patients and staff, e.g. airborne, faecal/oral route
- The susceptibility of others to the infection
- The patient's clinical condition
- Decontamination of the isolation facilities

If isolation in a room is required, the clinician should ensure the patient has a complete understanding of why they are being isolated and the precautions required.

On arrival at the Practice, the patient should be taken immediately to the isolation room or designated area. If a room is used, the door should remain closed.

5. Requirements for isolation

- An identified room or designated area should be used for isolation.
- A notice should be displayed on the door stating 'Isolation area - no unauthorised entry'.
- The room should be free from clutter and, where possible, equipment not required for the consultation should be removed from the room before the patient enters. Avoid carpeted areas if possible.
- Always use SICPs and TBPs, refer to the 'SICPs and TBPs Policy for General

Practice'.

- Ensure appropriate personal protection equipment (PPE) is available, e.g. disposable aprons, gloves, facial protection. Attending staff members should risk assess the PPE requirements - at a minimum, staff should wear a disposable apron and gloves. Refer to 'PPE Policy for General Practice'.
- Ensure hand hygiene facilities are available, e.g. wall mounted liquid soap, paper towels, wall mounted alcohol handrub or in a pump dispenser.
- A foot operated lidded waste bin with a liner should be available and waste disposed of as infectious waste.
- Medical devices and care equipment used in the room should be disposable. If reusable items are used, they should be appropriately decontaminated before removal from the room.
- Pillows should be encased in a cleanable plastic case and decontaminated after use.
- Where possible, ensure good ventilation by opening windows.

6. Environmental and care equipment cleaning

The isolation room or area used for isolation should be decontaminated, i.e. cleaned and disinfected, after use, refer to the relevant infection Policy, e.g. *C. difficile*, MRGNB, MRSA, 'Safe management of care equipment Policy for General Practice' and 'Safe management of the care environment Policy for General Practice'. If the room cannot be decontaminated immediately, a notice should be displayed stating 'Isolation area - awaiting deep clean, do not enter'.

7. Communication to relevant parties

Primary care practitioners are key providers of information to other health and adult social care providers concerning individual users and community outbreaks. Appropriate information should be held in the practice patient summary record.

The General Practice may share information with other providers as appropriate; this should include circumstances when:

- Referral or admission is to a hospital, adult social care or mental health facility
- A patient is scheduled for an invasive procedure
- A patient is transported in an ambulance
- There is an outbreak or suspected outbreak amongst patients

8. Referral or transfer to another health or social care provider

- If it is necessary to refer or transfer a patient to another health or social care provider, e.g. ambulance service, hospital, they should be informed of the patient's infection risk status prior to the transfer. This will enable a risk assessment to be undertaken to determine the appropriate IPC measures to be taken, e.g. transported without other patients, isolated on admission.
- Staff preparing to transfer a patient to another health or social care provider should complete a patient passport or the Inter-health and social care infection control transfer Form (available to download at www.infectionpreventioncontrol.co.uk/resources/inter-health-and-social-care-infection-control-transfer-form/). This should accompany the patient. When transferring a patient who has had diarrhoea of any cause in the past seven days, staff should ensure they include the infection risk, history of type of stool scale (Bristol stool form scale available to download at www.infectionpreventioncontrol.co.uk/resources/bristol-stool-form-scale-poster/), and frequency of bowel movements during the past week.
- If the patient is in the 'confirmed' or 'suspected' infection risk group, the person completing the transfer documentation is responsible for advanced communication, e.g. by telephone, to the transport service at the time of booking and the receiving health or social care facility prior to the transfer, to enable them to make appropriate arrangements.
- SICPs should be followed whenever transferring a patient, whether they have a confirmed infection or not.
- The completed transfer documentation should be supplied to the receiving health or social care provider and a copy filed in the patient's records.
- Ensure that care equipment used to transfer the patient, e.g. wheelchair, is decontaminated in accordance with the 'Safe management of care equipment Policy for General Practice'.

9. Evidence of good practice

It is recommended that, for assurance purposes, 'Patient placement and assessment for infection risk' is audited. This can be achieved by completing the 'SICPs Assurance: Annual IPC Audit Tool for General Practice' available to download at www.infectionpreventioncontrol.co.uk/resources/sicps-assurance-annual-ipc-audit-tool-for-general-practice/.

Following completion of the audit, an 'Action plan' should be drawn up and implemented to demonstrate continuous improvement.

10. Infection Prevention and Control resources, education and training

The Community IPC Team have produced a wide range of innovative educational and IPC resources designed to assist your General Practice in achieving compliance with the *Health and Social Care Act 2008: code of practice on the prevention and control of infection and related guidance* and CQC registration requirements.

These resources are either free to download from the website or available at a minimal cost covering administration and printing:

- 27 IPC Policy documents for General Practice
- Preventing Infection Workbook: Guidance for General Practice
- IPC CQC assessment preparation Pack for General Practice
- IPC audit tools, posters, leaflets and factsheets
- IPC Bulletin for General Practice Staff

In addition, we hold educational study events in North Yorkshire.

Further information on these high quality evidence-based resources is available at www.infectionpreventioncontrol.co.uk.

11. References

Department of Health and Social Care (Updated December 2022) *Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance*

NHS England (Updated 2025) *National infection prevention and control manual (NIPCM) for England*

NHS England (Updated November 2025) *Infection prevention and control: A to Z of pathogens resource*

NHS England (2025) *National Standards of Healthcare Cleanliness 2025*

12. Appendices

Appendix 1: A-Z of infections

Suspected or confirmed pathogen	Disease	TBPs required	PPE	Duration
Bordetella pertussis	Whooping cough	Droplet	Gloves, apron, eye protection and FRSM. FFP3 for AGPs*	3 weeks after onset of paroxysmal cough or 48 hours after appropriate antibiotic treatment commenced
Campylobacter	Gastroenteritis	Contact	Gloves and apron	Until symptom free for 48 hours
Chlamydia psittaci	Psittacosis	TBPs not required	SICPs	N/A
CPE (Carbapenemase-producing Enterobacterales)	Colonisation of bowel, urinary infection, catheter associated sepsis	Contact	Gloves and apron	Until active infection and/or diarrhoea resolves. Refer to 'MRGNB, including CPE Policy for General Practice'
Clostridioides difficile (C. difficile)	*Clostridioides difficile* infection or colonisation	Contact	Gloves and apron	Refer to '*C. difficile* Policy for General Practice'
COVID-19	Respiratory	Droplet Airborne	Gloves, apron, eye protection and FRSM. FFP3 for AGPs*	Most patients are no longer infectious after 5 days, but longer if immunocompromised
Gastrointestinal infections, e.g. salmonella/food poisoning	Gastroenteritis	Contact	Gloves, apron, eye protection and FRSM if vomiting present	Until symptom free for 48 hours
Giardiasis	Gastroenteritis	Contact	Gloves, apron, eye protection and FRSM if vomiting present	Until symptom free for 48 hours
Hepatitis A virus	Hepatitis, gastroenteritis	Contact	Gloves, apron, eye protection and FRSM if vomiting present	1 week after onset of jaundice or 10 days from start of symptoms if no jaundice
Hepatitis B or hepatitis C virus	Hepatitis	TBPs not required	SICPs	Refer to 'BBVs Policy for General Practice'
Herpes zoster (varicella-zoster)	Shingles	Contact	Gloves and apron	If required - until lesions are crusted
	Chicken pox	Droplet Airborne	Gloves, apron, eye protection and FRSM. FFP3 for AGPs*	Until lesions are crusted
Influenza virus	Influenza	Contact Droplet Airborne	Gloves, apron, eye protection and FRSM. FFP3 for AGPs*	Refer to 'Respiratory illnesses Policy for General Practice'
Legionella	Legionnaires disease	TBPs not required	SICPs	N/A
Measles virus	Measles	Droplet Airborne	Gloves, apron, eye protection and FRSM. FFP3 for AGPs*	Until 5 days after onset of rash
Mpox virus	Mpox	Contact Droplet	Gloves, long sleeve gown, FFP3 mask, eye protection	Until lesions have healed
MRGNB (Multi-resistant Gram-negative bacteria)	Colonisation of bowel, urinary infection, catheter associated sepsis, wound infection	Contact	Gloves and apron	Until active infection or diarrhoea resolves. Refer to 'MRGNB, including CPE Policy for General Practice'

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Suspected or confirmed pathogen	Disease	TBPs required	PPE	Duration
MRSA (Meticillin resistant *Staphylococcus aureus)*	Colonisation or infection (skin, wound, pneumonia, osteomyelitis, UTI, sepsis)	Contact	Gloves and apron	Until active infection resolves. Refer to 'MRSA Policy for General Practice'
Mumps virus	Mumps (infectious parotitis)	Droplet	Gloves, apron, eye protection and FRSM. FFP3 for AGPs*	Until 5 days from onset of parotid swelling
Mycobacterium tuberculosis	Extrapulmonary TB (Tuberculosis)	Contact	Gloves and apron	Seek advice from local Community IPC or UKHSA Team
	Pulmonary TB	Droplet Airborne	Gloves, apron, eye protection and FFP3 and AGPs*	Seek advice from local Community IPC or UKHSA Team
Norovirus	Gastroenteritis	Contact	Gloves, apron, eye protection and FRSM if vomiting present	Refer to 'Viral gastroenteritis/Norovirus Policy for General Practice'
Parainfluenza virus	Respiratory tract infection	Contact Droplet	Gloves, apron, eye protection and FRSM. FFP3 for AGPs*	Until 5 days after onset. Refer to 'Respiratory illnesses Policy for General Practice'
Parvovirus B19	Slapped cheek syndrome	Contact Droplet	Gloves, apron, eye protection and FRSM. FFP3 for AGPs*	Until rash and/or arthralgia has developed
RSV (Respiratory syncytial virus)	Respiratory tract infection	Contact Droplet	Gloves, apron, eye protection and FRSM. FFP3 for AGPs*	Refer to 'Respiratory illnesses Policy for General Practice'
Rotavirus	Gastroenteritis	Contact	Gloves and apron	Refer to 'Viral gastroenteritis/Norovirus Policy for General Practice'
Rubella virus	German measles	Droplet	Gloves, apron, eye protection and FRSM. FFP3 for AGPs*	Until 6 days after onset of rash
Scabies mite	Crusted scabies	Contact	Gloves and apron	Refer to the 'Scabies Policy for General Practice'
	Classical scabies	Contact	Gloves and apron for close contact	Refer to the 'Scabies Policy for General Practice'
Group A *Streptococcus* (including iGAS)	Respiratory tract infection, impetigo, Scarlet Fever	Droplet	Gloves, apron, eye protection and FRSM. FFP3 for AGPs*	Resolution of symptoms and completion of 24 hours of appropriate antibiotic treatment
	Bacteraemia	Contact	Gloves and apron	
Varicella virus	See Herpes Zoster above			

* AGPs (aerosol generating procedures) in General Practice are rare).