Clinical Guideline: Guidance for infection prevention & control and inter-hospital transfers.

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For use in: East of England Paediatric Departments

Used by: Paediatric medical and nursing staff, local IPC teams

Key Words: IPC, repatriation

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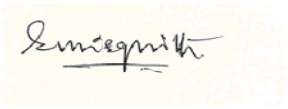
Clinical Lead Dr Ronald Misquith	

Supported by:

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Regional Provider IPC Leads	

Ratified by the East of England Paediatric Critical Care Clinical Oversight Group:

Date of meeting	7 September 2026

Contents

1. Scope

EoE region; all paediatric services requesting or receiving patients for repatriation/ inter-hospital transfer.

2. Purpose

- Improve clinical care and experience for sick children and their families
- Facilitate safe and timely transfers to and from critical care units
- Highlight and communicate infection risks for appropriate patient pathways
- Avoid unnecessary delays to transfer related to infection prevention and control (IPC) concerns.
- Avoid referrals or repatriations being refused because of colonisation / infection concerns; appropriate IPC precautions and prioritisation should be in place to facilitate patient flow.

For all staff and carers, good hand hygiene practice, cleaning of multiuse equipment and appropriate use of PPE remain key to infection prevention and control.

3. Principles

Screening swabs results

There is no requirement for discharge screening before transfer.

Screening swabs including viral respiratory panel results for patients with respiratory symptoms (including SARS CoV-2 and Influenza) taken in other hospitals across the region should be accepted by the receiving Trust if documentary evidence of recent results are provided by the referring unit. This should include:

• When the sample was taken

• All samples should have been taken within the last 7 days, samples outside of this window should be discussed with the microbiology and IPC team.

• The result of the sample

• The type of microbiological test completed e.g. PCR.

• Any current infection prevention and control concerns on the unit for example infection or colonisation outbreak.

Use of cubicles / side rooms

- Routine isolation of children in cubicles when transferred from one hospital to another without a known or suspected infection risk is not required, **however standard infection control precautions must be maintained.**

- Some children will require a cubicle, but others can be safely cared for in a ward area (this should follow an appropriate risk assessment and discussions with the medical/ID/IPC teams).

- In the case of infections spread by airborne route (e.g., measles, VZV, TB etc) it is necessary to care for children in cubicles / side rooms to prevent spread to other patients.

- In some circumstances, cubicles or side rooms may be required for specific reason such as end-of-life care, or other complex psychological / social or family concerns.

During periods of high prevalence of respiratory viruses, cubicles should be considered to reduce the risk of transmission of all viruses to the most clinically vulnerable, including children with:

1. Uncorrected congenital heart disease up to 2 years of age.

2. Chronic lung disease (bronchopulmonary dysplasia) or other lower respiratory tract pathologies necessitating home oxygen or long-term ventilation, up to 2 years of age.

3. Upper airways pathologies requiring ventilatory support, up to 2 years of age.

4. Severe neuromuscular conditions (i.e. SMA type 1) requiring night-time ventilatory support or regular use of airway clearance technologies (up to school age).

5. Significant immunosuppression e.g. - severe combined immunodeficiency (until immune reconstituted), post BMT: 1st 6 months post allogeneic BMT, or 1st 3 months post autologous BMT, post solid organ transplantation: in the 1st 6 weeks following transplant or on significant immunosuppressant treatment.

6. Newly diagnosed leukaemia during induction (1st month) or relapsed leukaemia (case by case decision based on intensity of treatment for relapse).

Children with the following conditions (NB important not to mix infections) may be cared for in an open ward / bay / cohorted area with careful IPC measures, depending on a local risk assessment and consultation with the local IPC team:

1. Infants under 6 months old (e.g., cohorting infants with bronchiolitis)

2. CRO (but not CPE) / MRSA / VRE / ESBL/C. Auris positive on screening swabs or clinical samples

Managing children with bronchiolitis or viral induced wheeze
Respiratory infections in infants drive significant pressure on paediatric beds. Nosocomial spread occurs due to direct contact with the patient or patient environment. Thus, appropriate infection prevention and control precautions negate the need for a cubicle in every case.

Refer to the RCPCH National guidance for the management of children in hospital with viral respiratory tract infections (2025). A flow chart for managing children is included in the guidance. National guidance for the management of children in hospital with viral respiratory tract infections (2025) | RCPCH

- Any locally available validated test should be used for respiratory infections prior to ward admission so that children can be admitted to a cubicle / cohorted as appropriate. • Standard IPC (SIPCs) precautions / Transmission based precautions (TBPs) must be undertaken at all times by staff and parents whether infection is known or not.

- Admission without virology results – infants with unidentified respiratory illnesses should be admitted to a cubicle. However, where cubicles are limited, to maintain patient flow and after a local risk assessment, it may be necessary to admit the child to a “respiratory cohort bay”. Consider setting up age appropriate, “bronchiolitis and / or “viral wheeze” bays.

- Admission with virology results – if cubicles are scarce, infants with identified respiratory illnesses may be cohorted in a bay according to the relevant viral infection (e.g., RSV, Flu etc.).

- Resident carers present more risk of spreading respiratory viruses than infants. Manage parents and carers presence on the unit according to local policy. Any parent or carer with respiratory symptoms should be encouraged to go home. If they must stay, they should wear a fluid-repellent surgical mask (FRSM).

Reporting delays in inter- hospital transfers related to IPC issues
Please report to your relevant network via the email address below, any transfers delayed for respiratory or infection control reasons where you consider this guidance has not been followed. We will support you if needed with local negotiations and review relevant cases at our clinical governance meetings.

Delays or any incidents of concern should be reported to: add-tr.eoepccodn@nhs.net

4. Definitions

IPC	Infection prevention and control
ID	Infectious Diseases
C. Auris	Candidozyma auris
CRO	Carbapenem Resistant Organisms
VRE	Vancomycin Resistant Enterococci
ESBL	Extended-Spectrum –β-lactamase producing Enterobacteriaceae
MRSA	Methicillin Resistant Staphylococcus Aureus
RSV	Respiratory Syncytial Virus
VZV	Varicella zoster virus
SMA	Spinal muscular atrophy
BMT	Bone marrow transplant
RCPCH	Royal College of Paediatrics and Child Health

References

National guidance for the management of children in hospital with viral respiratory tract infections (2025) | RCPCH

Paeds-Networks-Advice-for-Patient-Transfers-2025.pdf

Contributors

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Disclaimer

Exceptional Circumstances Form

Form to be completed in the **exceptional** circumstances that the Trust is not able to follow ODN approved guidelines.

Details of person completing the form:	
Title:	Organisation:
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Surname:	Telephone contact number:
Title of document to be excepted from:	
Rationale why Trust is unable to adhere to the document:	
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