

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	1 of 29	Approval Date: 04/09/2019
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VARICELLA ZOSTER (CHICKENPOX/SHINGLES) INFECTION CONTROL PROCEDURE	
Introduction and Aim	
<p>Varicella-zoster virus (VZV) results in a primary infection presenting as chickenpox (Varicella), or a reactivation of latent virus which presents as shingles (herpes zoster). In the UK, chickenpox is primarily a disease of childhood and is common below the age of ten, where the disease is usually mild. However, VZV infections in susceptible (non immune) neonates, adolescents, adults, pregnant women, and particularly immune-compromised individuals can cause severe disease and have a higher risk of complications.</p> <p>To inform staff of the appropriate procedures for the prevention and management of Varicella zoster virus infections (chickenpox and shingles) at all UHB hospitals.</p>	
Objectives	
<ul style="list-style-type: none"> • To provide advice on action required on the admission of a patient known or suspected to have Varicella zoster virus infection (chickenpox or shingles). • To provide advice on action required when a case of chickenpox or shingles occurs within UHB hospitals. • To provide advice on the action required during an infectious incident or outbreak situation caused by Varicella zoster virus. • To provide advice on the communications necessary whenever a cluster of cases of Varicella zoster virus infections develops. 	
Scope	
<p>This procedure applies to all of our staff in all locations including those with honorary contracts and students on placement at Cardiff and Vale UHB.</p>	
Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed, and this found there to be no impact. Key actions have been identified and these can be found incorporated within this procedure.
Documents to read alongside this Procedure	<p>C&V UHB Infection Prevention & Control Procedures on:</p> <ul style="list-style-type: none"> • Transmission Based Precautions Procedure • Standard Infection Control Precautions Procedure • Hand Hygiene Infection Control Procedure • Infection Control Procedure for Infectious Incidents and

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	2 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

	Outbreaks in UHB Hospitals
Approved by	Infection Prevention & Control Group

Accountable Executive or Clinical Board Director	Director of Nursing
Author(s)	Virology Consultant, Senior Nurse IP&C, CNS IP&C, ACNS IP&C

Disclaimer
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Summary of reviews/amendments			
Version Number	Date of Review Approved	Date Published	Summary of Amendments
3	4 Sept 2019	11 Dec 2019	New template. Contact details update. Updated use of dual detergent and chlorine based disinfectant for the environment with additional HPV cleaning.
2	June 2015	August 2015	Revised document
1	January 2002	April 2002	New document

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	3 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

Contents Page

1	Summary	4
2	Introduction	6
3	Roles and Responsibilities	7
4	Control Measures	7
5	Resources	12
6	Training	12
7	Implementation	12
8	Further information	12
9	Equality	12
10	Audit	13
11	Review	13
12	References	14
Appendix 1	Chickenpox flowchart	15
Appendix 2	Shingles flowchart	16
Appendix 3	Contact isolation sign	17
Appendix 4	Respiratory isolation sign	18
Appendix 5	Equality Health Impact assessment	19

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	4 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

1. SUMMARY

- 1.1 Varicella-zoster virus (VZV) causes both a primary infection presenting as chickenpox (Varicella) and a reactivated infection presenting as shingles (herpes zoster). Shingles is caused by reactivation of latent VZV in an individual who has had chickenpox in the past. The chickenpox rash is widespread, whereas the shingles rash is normally limited to a single dermatome. In immunocompromised patients, shingles may occur in more than one dermatome or become disseminated.
- 1.2 VZV from chickenpox is transmitted by airborne spread from respiratory secretions or direct contact with infected vesicle fluid. It causes chickenpox in a susceptible (non-immune) individual.
- 1.3 VZV from shingles can be transmitted by close/direct contact with infected vesicle fluid. VZV from patients with disseminated shingles is transmitted by direct contact with infected vesicle fluid or airborne spread from respiratory secretions. It causes chickenpox in a susceptible (non-immune) individual. Shingles itself cannot be caught.
- 1.4 The incubation period of VZV is usually between 10 and 21 days following exposure. Individuals are considered infectious for 48 hours prior to the appearance of the chickenpox rash, or from the date of onset in the case of shingles, until all the vesicles have crusted over (usually 5 to 7 days after onset of the rash). In immune-compromised individuals, infectivity may be prolonged.

Some groups of susceptible individuals, especially pregnant women, neonates or immune-compromised individuals, are at increased risk of severe disease if they acquire VZV.
- 1.5 When a known or suspected case of chickenpox or shingles is identified in either a patient or staff member, the Infection Prevention and Control Department (IPCD) and Occupational Health Department (OHD) should be informed as soon as possible so that an assessment of exposure risk can be made. Contact tracing, establishing immunity and post exposure prophylaxis will be undertaken where appropriate. (See section 4.13)
- 1.6 Patients with known or suspected chickenpox must be placed in a single room and respiratory precautions instituted. (See section 4.4)
- 1.7 A single room is preferred for patients with known or suspected shingles, especially patients with shingles in exposed, uncovered areas of the body, or immune-compromised patients with shingles. Contact precautions must be instituted and respiratory precautions for immunocompromised patients and/or patients with disseminated shingles. (See section 4.5)
- 1.8 To confirm infection with VZV send dry throat plus/or lesion swab for testing to virology. Sender must specifically request a test for VZV on the form.

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	5 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

- 1.9 Only staff members with confirmed immunity to VZV (from a history of chickenpox or laboratory confirmed immunity) should provide care for patients with chickenpox or shingles. Staff immunity will be established by the OHD, although staff members must be aware of their immune status. It is essential that susceptible (non-immune) staff, especially if they are pregnant or immune-compromised, do not provide care for patients with chickenpox or shingles.

- 1.10 Transfer or visits to other departments of patients with known or suspected chickenpox must be avoided unless there is a clear clinical need or an infection prevention and control indication i.e. transfer into single room or transfer to the Infectious Diseases Unit (ward A7). The risk is much lower in cases of shingles and there is considered to be minimal risk from covered lesions on a normal immune-competent individual. Arrangements with senior staff in the receiving department must be made prior to the transfer or visit.

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	6 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

2. INTRODUCTION

2.1 Introduction - Varicella (Chickenpox)

- 2.1.1 Chickenpox results from a primary infection with VZV and can develop following exposure to a patient with chickenpox or shingles.
- 2.1.2 In chickenpox, the VZV is readily transmissible to susceptible individuals. It is transmitted by droplet infection (airborne spread) from respiratory secretions, or from person to person by direct contact with infected vesicle fluid from skin lesions. Indirect spread might occur via items such as dressings that are freshly soiled by vesicle fluid or respiratory secretions, but the virus is only thought to persist in the environment for a short period (less than a day).
- 2.1.3 Individuals with chickenpox are considered infectious for 48 hours before the appearance of the rash (viral excretion from oropharynx) until all vesicles have crusted over (usually 5 - 7 days after rash onset). Infectivity may be prolonged.
- 2.1.4 The time period between exposure and development of symptoms is usually between 10 and 21 days. It may be prolonged in immunocompromised individuals or those who have received prophylaxis.
- 2.1.5 Infection with chickenpox usually results in life-long immunity to chickenpox. Symptomatic re-infection in immunocompetent individuals is exceptionally rare, less infectious and if suspected should be discussed with a consultant virologist.
- 2.1.6 However VZV remains latent (dormant) in all individuals who have had chickenpox and can re-activate later in life, presenting as shingles.

2.2 Introduction – Herpes Zoster (Shingles)

- 2.2.1 Shingles is caused by reactivation of latent VZV in an individual who has previously had chickenpox. Shingles cannot be caught from an individual with chickenpox.
- 2.2.2 Susceptible (non-immune) individuals can develop chickenpox following significant exposure to a person with shingles. However the risk is much lower in cases of shingles and there is considered to be minimal risk when the lesions on an immunocompetent person are covered by clothing and/or a dressing.
- 2.2.3 In shingles, VZV is transmitted primarily by direct contact with infected vesicle fluid from skin lesions. Indirect spread can occur via items such as dressings freshly soiled by vesicle fluid. However, when immunocompromised patients have shingles, or in any patient with disseminated shingles, the virus may also be transmitted by respiratory secretions (airborne spread).

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	7 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

2.2.4 Individuals with shingles are considered infectious during the vesicular stage of the rash until all lesions are dry and crusted, typically 5 - 7 days after the appearance of skin lesions. In immuno-compromised individuals, disease may be disseminated or more severe and the period of infectivity may be prolonged.

2.2.5 Susceptible individuals would be considered potentially infectious from 10 - 21 days if a significant exposure to VZV had occurred.

2.3 Known or suspected Chickenpox or Shingles in patients or staff members

2.3.1 In all cases of known or suspected chickenpox or shingles in patients or staff members there is a risk that susceptible patients or staff members may be exposed to VZV. Urgent action may be required to avoid severe (life threatening) disease in those at highest risk, including pregnant women, neonates or immunocompromised individuals

2.3.2 Inform the Infection Prevention Control Department (IPCD) as soon as possible. The microbiology doctor on call (specialist trainee or consultant) is available via switchboard if clinical advice is required out of normal working hours. If the case, or susceptible exposed individual, is a member of staff, the Occupational Health Department (OHD) must also be informed during normal working hours.

3. ROLES AND RESPONSIBILITIES

3.1 Cardiff and Vale UHB Board is responsible for the approval of the Infection Control Procedure for Varicella Zoster (chickenpox/shingles) 2018.

3.2 Individual Clinical Boards/directorates will be responsible for the implementation of the procedural document in clinical areas.

3.3 Distribution of the procedural document will be through the UHB intranet site.

3.4 Infection prevention and control is the responsibility of all staff.

4. CONTROL MEASURES

4.1 Communication

4.1.1 Communicate case information for all new known or suspected chickenpox or shingles in patients and staff members to the nurse in charge.

4.1.2 In all cases of known or suspected chickenpox or shingles, there is a risk that susceptible individuals may be exposed to VZV and could develop severe, life

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	8 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

threatening infection if not appropriately managed. Senior staff (including the nurse in charge) must be informed.

4.1.3 Inform the IPCD as soon as possible. If the case, or an exposed susceptible individual, is a member of staff the OHD must also be informed.

4.1.4 A risk assessment will be made by IPCD for each case of suspected or confirmed chickenpox or shingles to assess the risk of VZV exposure for susceptible (non-immune) patients and staff members. Contact tracing, establishing immunity and post exposure prophylaxis will be undertaken when risk of exposure for susceptible (non-immune) patients and staff members is significant. (See section 4.13)

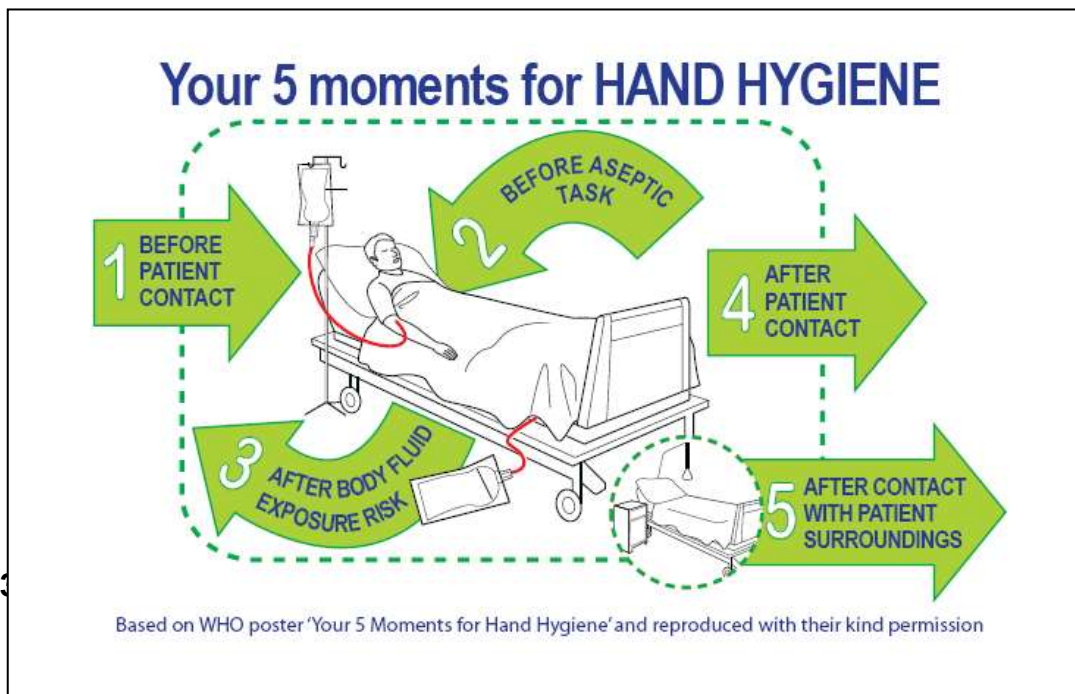
4.1.5 Contact Virology for diagnostic and clinical management advice as appropriate. The microbiology doctor on call (specialist trainee or consultant) is available via switchboard if clinical advice is required out of normal working hours. (See section 4.10)

4.2 Hand Decontamination

4.2.1 Hands must be decontaminated by either washing with liquid soap and water and then applying an alcohol rub or washing with a hand disinfectant (See Hand hygiene procedure).

4.2.2 The key time for general hand decontamination is at the point of care, applying the 5 moments for hand hygiene:

- Before entering an isolation room
- Before and after contact with the patient and environment
- After contact with potentially infected materials/removal of gloves
- Before leaving the room



Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	9 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

4.3.1 A single isolation room **must** be used for patients with suspected or confirmed chicken pox or for patients with shingles in exposed areas of the body. This should **NOT** be a positive pressure room. A single room is preferred for patients with suspected or confirmed shingles that is covered.

- Appropriate signage should be placed on the outside of the isolation room door. Respiratory isolation sign for chicken pox (appendix 4), or a contact isolation sign for shingles (appendix 3).
- The door of the room should be kept closed at all times unless the clinical need of the patient dictates otherwise.
- Visitors and members of staff from other departments such as Physiotherapy or Radiology must report to the Nurse-in-Charge before entering the room.
- Patients should not leave the room to attend other departments without prior arrangements.

4.3.2 Consider transferring adult patients in UHW to the Infectious Diseases Unit particularly if they are immuno-compromised.

4.3.3 The IPCD will consider cohorting patients in the unlikely event of several patients having VZV infection, or VZV exposure, at the same time.

4.4 Personal Protective Equipment (PPE)

- Gloves should be worn if there is any risk from contamination with the rash, blood or body fluids. Hands must be washed after glove removal.
- Plastic aprons must be worn when soiling is likely.
- Fluid repellent surgical masks must be put on before entering the room, by all members of staff.
- Visors or goggles should be worn if there is a risk of splashing from blood/body fluids and/or secretions.
- Staff should ensure that there is an adequate stock of PPE and order sufficient stock in advance in anticipation of weekends and bank holidays.

4.5 Patient Testing

4.5.1 Virological testing to confirm infection in the patient or to establish immune status in the individual who has been in contact with a case.

4.5.2 Diagnostic testing to confirm chickenpox or shingles may be performed if required. A dry (red-topped) throat swab and/ or vesicle fluid swab or the base of a vesicle is normally required for VZV testing. The Virologist may also advise testing contacts for the presence of VZV antibodies if their immune status is uncertain. This test requires a clotted blood sample. The virology department should be notified if tests are urgent.

4.6 Movement of patients - Transfer to other wards

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	10 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

- 4.6.1 Transfer of patients with known or suspected chickenpox (or shingles) must be avoided unless there is a clear clinical need or an infection prevention and control indication i.e. transfer into single room.
- 4.6.2 The Nurse-in-Charge of the ward is responsible for informing a senior member of staff in the receiving ward/department before transfer of patients with known or suspected chickenpox (or shingles).
- 4.6.3 Visits to other departments for patients with known or suspected chickenpox (or shingles) must be avoided unless there is a clear clinical need.
- 4.6.4 Patients should be treated at the end of the working session and should spend the minimum time in the department. They should only be sent for when the receiving department is ready and not left in a waiting area with other patients. These guidelines should never jeopardise clinical need.
- 4.6.5 Patients with known or suspected chickenpox, those with disseminated shingles and immuno-compromised patients with shingles should wear a surgical mask when visiting other departments.

4.7 Health care personnel with chickenpox or shingles

- 4.7.1 Any staff member with known or suspected chickenpox or shingles must not report for duty. They must inform the Occupational Health department as soon as possible for a risk assessment. Individuals with covered shingles may be able to work, following assessment.

4.7 Staff / Patient contact tracing and immunity testing

- 4.7.1 Only immune (non-susceptible) staff members should care for patients with known or suspected chickenpox or shingles. It is essential that susceptible staff, especially if they are pregnant or immune-compromised, do not provide care for patients with chickenpox or shingles. Immunity will be established by the OHD (See section 4.13).
- 4.7.2 A risk assessment will be made by IPCD for each case of suspected or confirmed chickenpox or shingles to assess the risk of VZV exposure for susceptible (non-immune) patients or staff members. Several aspects of exposure are relevant to establish significant risk
- type of VZV in index case (chickenpox or shingles)
 - timing of exposure in relation to onset of rash in index case
 - closeness and duration of contact
 - immune status of individual exposed
- 4.7.3 Non-immune patients, who have had significant contact with VZV and are at high risk of severe disease, are likely to require prompt post-exposure

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	11 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

prophylaxis. The IPCD will liaise with virology and the patient's clinical team to provide this, if indicated.

- 4.7.4 Contact tracing, establishing immunity and post exposure prophylaxis will be undertaken when risk of exposure for susceptible (non-immune) patients or staff members is significant. For patients this will be done by IPCD in conjunction with ward staff and the virology department. For staff members this will be carried out in conjunction with OHD and virology.
- 4.7.5 Occupational Health and/or IPCD staff will contact the ward/clinical area to request a list of staff contacts. The list must include all staff members who had contact with the index case during the infectious period (from 2 days before the appearance of the rash until all the vesicles have crusted over (usually 5 to 7 days after rash onset.)). OHD will be responsible for coordinating staff immunity results.
- 4.7.6 Staff members or patients who are pregnant, or immune compromised, and have been exposed will be counselled if required and immunity testing carried out if indicated. This may need to be done rapidly, to allow administration of post-exposure prophylaxis. The decision to issue post-exposure prophylaxis with Varicella Zoster Immunoglobulin (VZIG) will be made by a Consultant Virologist, with the Consultant Occupational Health Physician as appropriate.
- 4.7.7 Any non-immune staff member will be contacted by OHD and advised of their status. The appropriate manager will be informed, and the period of potential infectivity highlighted to them. A decision to exclude the staff member from work during the infectious period (usually 8 - 21 days from first contact) or relocation to other duties will be taken by the Consultant Occupational Health Physician after consultation with the staff member's manager and if necessary a Consultant Virologist or the Director of Infection Prevention and Control.
- 4.7.8 The OHD will check the chickenpox history of all new UHB employees as part of their pre-employment screen. Staff members who give a negative history for chickenpox will have a blood sample taken and, if shown to be non-immune, will be offered VZV vaccination if not contra-indicated.

4.8 Disposal of waste

- 4.8.1 All infected waste must be disposed of into an infected clinical waste bag for incineration (WHTM 07-01, Welsh Health Technical Memorandum, and Safe Management of Healthcare Waste 2013) should be securely tied and labelled according to the UHB waste management policy.

4.9 Decontamination

- 4.9.1 The patient's room must be cleaned twice daily using an appropriate combined detergent and chlorine releasing agent (such as Actichlor plus). Following the patients discharge the room is to have a terminal clean using an

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	12 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

appropriate combined detergent and chlorine releasing agent (such as Actichlor plus).

4.9.2 Curtains must be changed on discharge.

4.9.3 Hydrogen Peroxide Vapour is advisable as an additional level of disinfection where possible. This can be requested by contacting the facilities department.

5. RESOURCES

5.1 The necessary resources for the management, training, risk assessments, monitoring and auditing for Varicella zoster are already in place and the implementation of this procedure will not entail additional expenditure.

6. TRAINING

6.1 Mandatory Infection and Prevention and Control training updated every two years.

6.2 Further departmental based training as identified by training needs analysis.

7. IMPLEMENTATION

7.1 The document will be available on the UHB intranet site and the Infection Prevention and Control clinical portal site. Individual directorates will be responsible for the implementation of the procedure document in clinical areas.

8. FURTHER INFORMATION

8.1 Guidelines on the immunisation of patients and staff members is given in; "Immunisation against Infectious Diseases", 2006 (Department of Health) commonly known as the Green Book. It is accessible online here: <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book> this guidance has been used in the preparation of this document, which also takes into account local circumstances within the UHB.

9. EQUALITY

9.1 This procedure has had an equality impact assessment and has shown there has been no adverse effect or discrimination made on any particular or individual group (See Appendix 5).

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	13 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

10. AUDIT

- 10.1 Audit of compliance with the procedure document, will be carried out by the Infection Prevention and Control Department, as part of their procedure audit programme.

11. REVIEW

- 11.1 This procedure will be reviewed every three years or sooner if immunisation guidelines are updated.

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	14 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

12. REFERENCES

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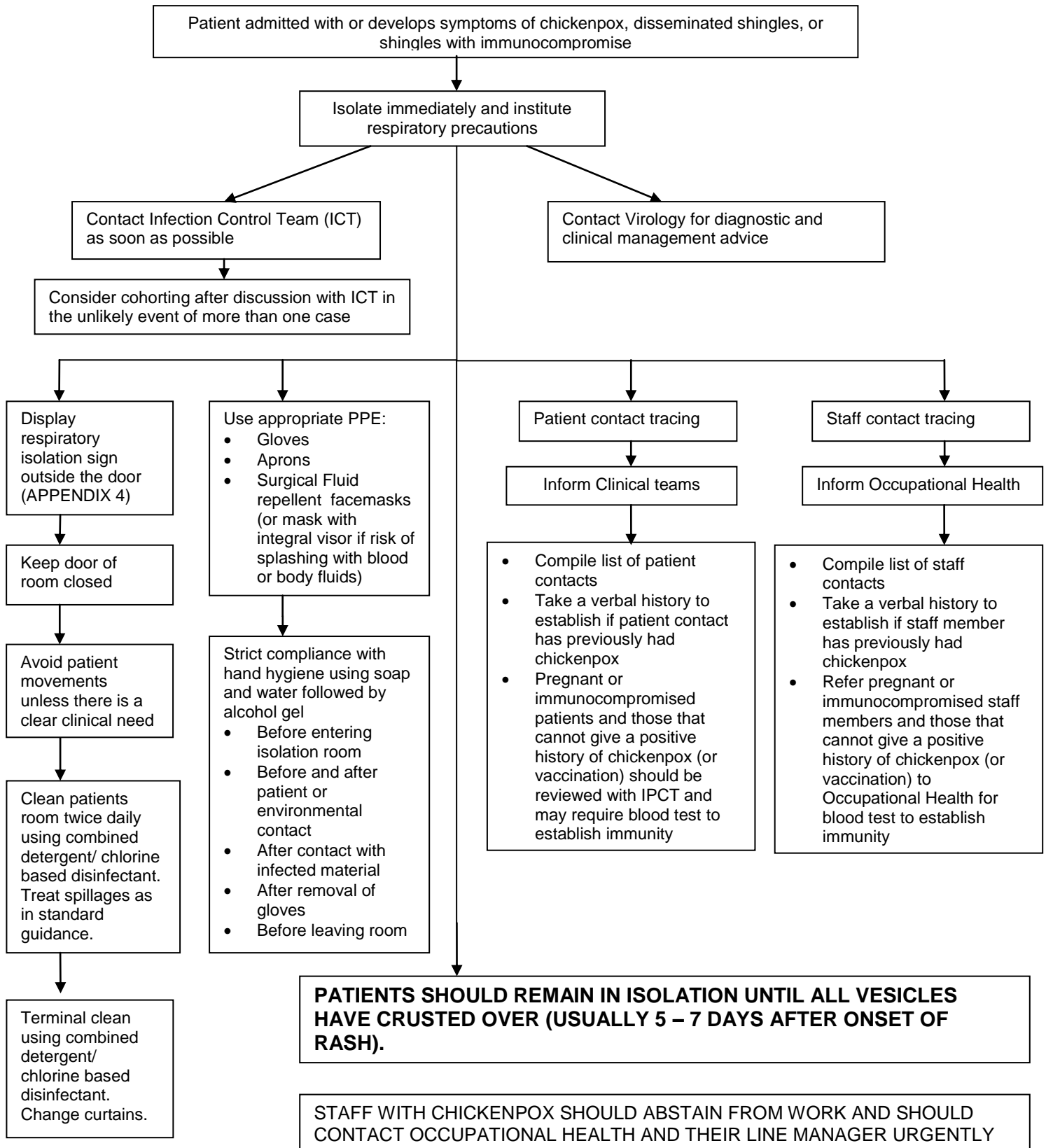
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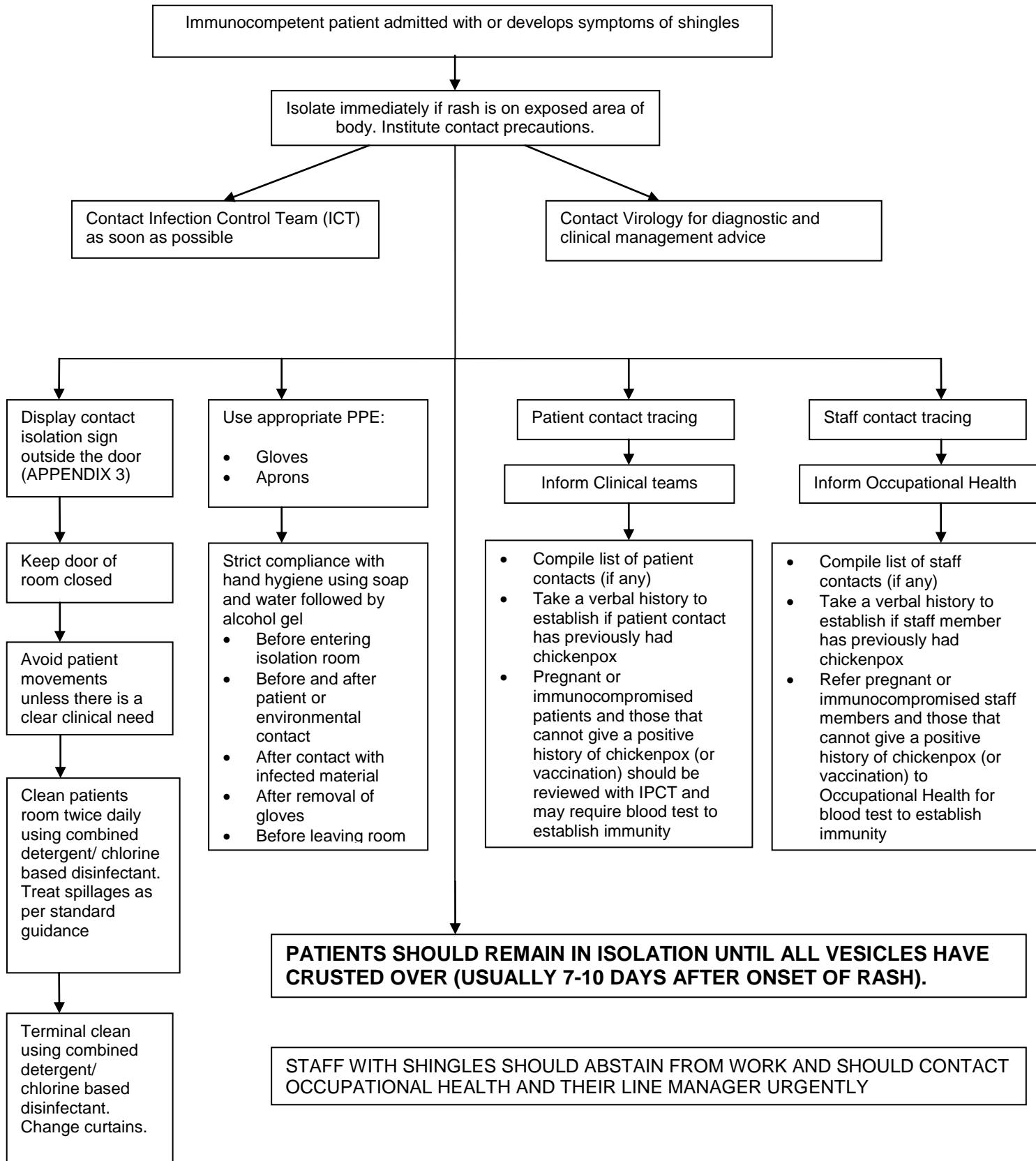
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APPENDIX 1: Flowchart for known or suspected cases (and patient/staff contacts) of Varicella (Chickenpox), disseminated Zoster/Shingles, or shingles in immunocompromised patients



APPENDIX 2: Flowchart for known or suspected cases of Herpes zoster (Shingles) in immunocompetent patients (and patient/staff contacts)



APPENDIX 3

STOP

Contact isolation **KEEP DOOR CLOSED**

unless ward sister/charge nurse instructs otherwise



Instructions for all staff and visitors

Hands must be washed
when entering and before leaving room



Wear orange plastic apron
when entering the room



Wear gloves when risk of contamination
from blood, body fluids or secretions



Wear Goggles/Visor
if there is a risk of splashing from blood or body fluids



PPE disposal:
Dispose of gloves, apron and face protection
into orange labelled waste bin before leaving room.



Wash your hands before leaving room



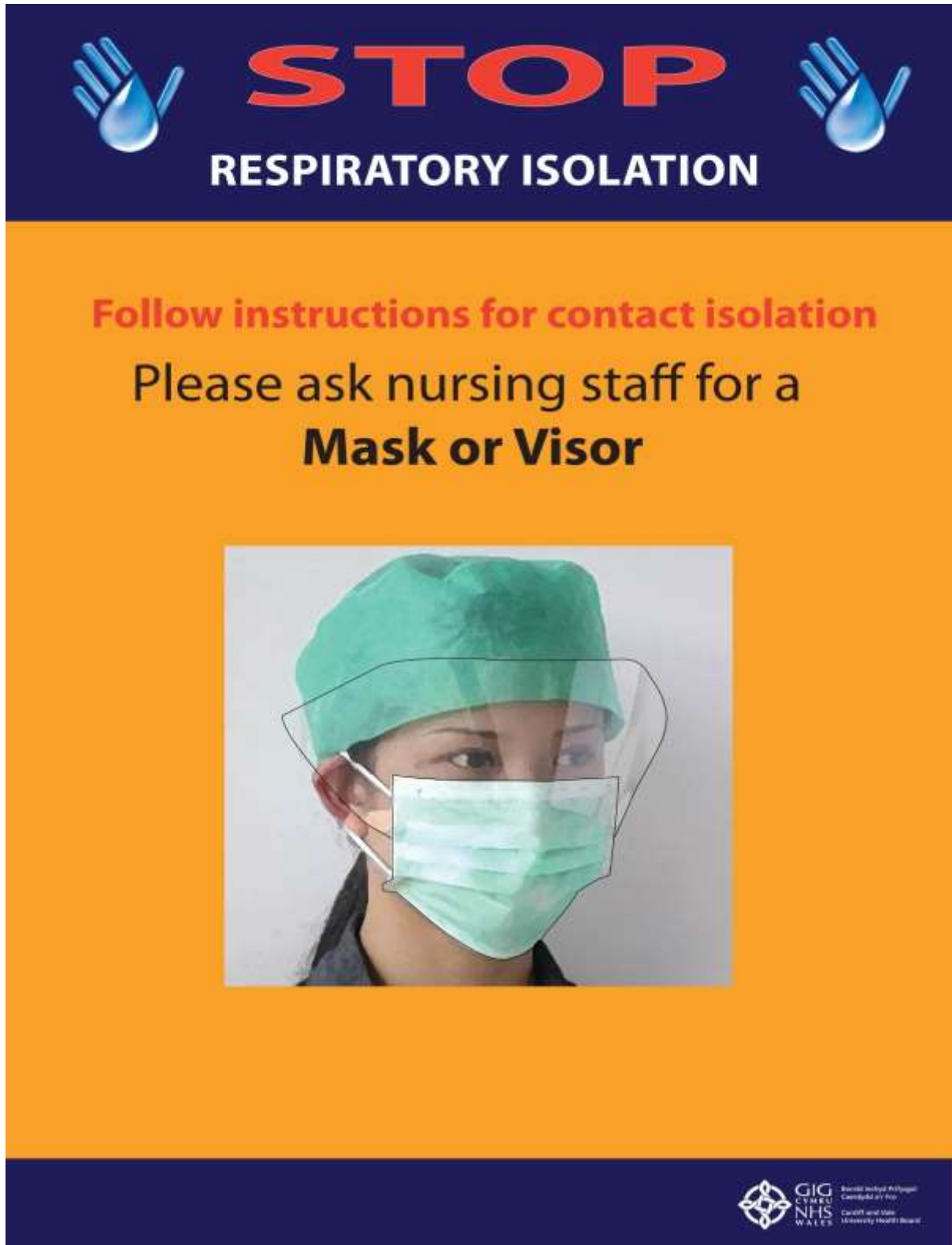
 **GIG Cymru NHS WALES** Bwrdd Iechyd Prifysgol Caerdydd a'r Ffyn
Cardiff and Vale University Health Board

Cardiff and Vale UHB

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Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	18 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

APPENDIX 4




STOP

RESPIRATORY ISOLATION

Follow instructions for contact isolation

Please ask nursing staff for a
Mask or Visor



GIG CYMRU NHS WALES Welsh and English NHS Wales Cardiff and Vale University Health Board

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	19 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

APPENDIX 5

Equality & Health Impact Assessment for

VARICELLA ZOSTER (CHICKENPOX/SHINGLES) INFECTION PREVENTION & CONTROL PROCEDURE

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Varicella Zoster (Chickenpox/Shingles) Infection Control Procedure
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Corporate Directorate Ellen Davies Associate Clinical Nurse Specialist for Infection Prevention and Control Contact Telephone number: 02920 716261
3.	Objectives of strategy/ policy/ plan/ procedure/ service	To provide appropriate advice to staff regarding the prevention and management of Varicella zoster virus infections (chickenpox and shingles) across all UHB hospitals based on NICE guidelines.
4.	Evidence and background information considered. For example <ul style="list-style-type: none"> • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development 	Cardiff and Vale University Health Board accepts its responsibility under the Health and Safety at Work Act 1974 and the Control of Substances Hazardous to Health Regulations 2002, to take all reasonable precautions to prevent exposure to an infectious disease in patients, staff and other persons working at or using its premises. In order to prevent the possible spread of infection amongst patients and staff it is recognised that the UHB requires procedural documents to ensure effective management of infection. The procedure is supported by the UHB's: <ul style="list-style-type: none"> • Transmission Based Precautions Procedure • Standard Infection Control Precautions Procedure • Hand Hygiene Infection Control Procedure • Infection Control Procedure for Infectious Incidents and Outbreaks in UHB Hospitals Please be advised that all the below lists and links are not an exhaustive list of the available evidence and information but provides an indicative summary of the evidence and information applicable to this policy.

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	20 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

<p>stages</p> <ul style="list-style-type: none"> • comments from those involved in the designing and development stages <p>Population pyramids are available from Public Health Wales Observatory¹ and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need².</p>	<p>An internet search was conducted in November 2018 using the following search terms in combination "Varicella Zoster", "Chicken pox", "Procedure", "Policy" and "Equality Impact". The search revealed several equality impact assessments. Examples can be found by following the links below:</p> <p>Doncaster and Bassetlaw Hospitals NHS Foundation Trust 'Chickenpox/Shingles Management Policy' (2016) https://www.dbth.nhs.uk/wp-content/uploads/2017/07/PAT-IC-15-v-5-Chickenpox-Shingles-Management-Final.pdf</p> <p>Somerset Partnership NHS Foundation Trust 'Chickenpox and Shingles Policy' (2017) http://www.sompar.nhs.uk/media/4334/chicken-pox-and-shingles-policy-v4jan-2017.pdf</p> <p>North Devon Healthcare NHS Trust 'Chickenpox and Shingles Policy' (2017) https://www.northdevonhealth.nhs.uk/wp-content/uploads/2017/01/Chickenpox-and-Shingles-v2.1-Jan-17-final.pdf</p> <p>Royal Devon and Exeter NHS Foundation Trust 'Varicella Zoster Virus, Chickenpox and Shingles Policy' (2018) https://www.rdehospital.nhs.uk/documents/policies/varicella-zoster-virus-chickenpox-shingles-policy.pdf</p> <p>Population data has been reviewed using the Public Health Wales Population pyramid for the Percentage of Population by age and sex for Monmouthshire and Wales, 2015. http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf</p> <p>As well as the 2011 Census: A snapshot of key health, employment and qualification indicators for Cardiff and Vale and the staff and service users data, http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face</p>
<p>5. Who will be affected by the strategy/ policy/ plan/ procedure/ service</p>	<p>This procedure applies to all staff in all locations, including those with honorary contracts and students on placement within Cardiff and Vale University Health Board.</p> <p>Patients, visitors and UHB staff will benefit from compliance with the procedure in that the risk of transmission of infection will be reduced. The UHB will benefit organisationally and financially from reducing the impact and cost of the transmission of infection.</p>

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

¹ <http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf>

² <http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face>

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	21 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: <ul style="list-style-type: none"> • under 18; • between 18 and 65; and • over 65 	No negative impact	N/A	N/A
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	No negative impact	N/A	N/A
6.3 People of different genders: Consider men, women, people undergoing gender reassignment NB Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	No negative impact	N/A	N/A

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	22 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.4 People who are married or who have a civil partner.	No negative impact	N/A	N/A
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	No negative impact	N/A	N/A
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	No negative impact	N/A	N/A
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	No negative impact	N/A	N/A
6.8 People who are attracted to other people of: <ul style="list-style-type: none"> the opposite sex (heterosexual); 	No negative impact	N/A	N/A

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	23 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
<ul style="list-style-type: none"> the same sex (lesbian or gay); both sexes (bisexual) 			
<p>6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design</p> <p>Well-being Goal – A Wales of vibrant culture and thriving Welsh language</p>	No negative impact	N/A	N/A
<p>6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health</p>	No negative impact	N/A	N/A
<p>6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities</p>	No negative impact	N/A	N/A
<p>6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or</p>	No negative impact	N/A	N/A

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	24 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
service			

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No negative impact	N/A	N/A
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation,	No negative impact	N/A	N/A

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	25 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
<p>reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc</p> <p>Well-being Goal – A healthier Wales</p>			
<p>7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions</p> <p>Well-being Goal – A prosperous Wales</p>	<p>No negative impact</p>	<p>N/A</p>	<p>N/A</p>
<p>7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of</p>	<p>No negative impact</p>	<p>N/A</p>	<p>N/A</p>

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	26 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
<p>transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces</p> <p>Well-being Goal – A resilient Wales</p>			
<p>7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos</p> <p>Well-being Goal – A Wales of cohesive communities</p>	<p>No negative impact</p>	<p>N/A</p>	<p>N/A</p>

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	27 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	No negative impact	N/A	N/A

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	28 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	These guidelines are to assist in the identification and management of all aspects of infection risk involving Varicella zoster (Chickenpox/Shingles), to enable staff to minimise the risk of transmission and in doing so ensure their safety and well being as well as those of patients
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Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	No negative impacts identified therefore no actions identified			
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

Document Title: VARICELLA ZOSTER (CHICKENPOX/SHINGLES)	29 of 29	Approval Date: 04/09/2019
Reference Number: UHB 076		Next Review Date: 04/09/2022
Version Number: 3		Date of Publication: 11/12/2019

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
<p>8.4 What are the next steps?</p> <p>Some suggestions:-</p> <ul style="list-style-type: none"> • Decide whether the strategy, policy, plan, procedure and/or service proposal: <ul style="list-style-type: none"> ○ continues unchanged as there are no significant negative impacts ○ adjusts to account for the negative impacts ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) ○ stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review 	<p>The EQIA process has not identified any evidence that different groups will be affected disproportionately or any evidence or concern that this procedure may discriminate against a particular population group.</p> <p>Procedure continues unchanged as there are no significant negative impacts.</p>			