Somerset Partnership NHS
NHS Foundation Trust

CHICKEN POX AND SHINGLES POLICY

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DOCUMENT CONTROL

Reference	**Version**	**Status**	**Author**
KA/Jan17/CPS	4	Final	Infection Prevention and Control Nurse
Amendments	Amendments to staff groups and responsibilities post acquisition of Somerset Community Health. 3.2 routine update in line with regular policy review		
Document objectives: To set out the actions to be taken when caring for patients with suspected or confirmed chickenpox or shingles. To ensure that any non-immune individuals exposed are managed appropriately.			
Intended recipients: All Staff whatever their grade, role or status. Permanent, temporary, full-time, part-time staff including locums, bank staff, volunteers, trainees and students. This Policy will be available to the general public on the Trust Internet.			
Committee/Group Consulted: Infection Control Assurance Group			
Monitoring arrangements and indicators: See relevant section			
Training/resource implications: See relevant section			
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CONTENTS

1. INTRODUCTION

1.1 Varicella zoster virus is a member of the Herpes virus family and causes two common infections, chickenpox and shingles. Chickenpox (varicella zoster) is the primary infection and usually results in lifetime immunity. Around 90% of the adult population born and raised in the UK are immune.

1.2 Chickenpox and shingles are **not** notifiable diseases in England and Wales.

1.3 Following chickenpox infection the virus remains dormant in dorsal root and cranial nerve ganglia and may be reactivated at a later date causing shingles (herpes zoster).

2. PURPOSE & SCOPE

2.1 The aim of this policy is to provide healthcare workers with the necessary information in relation to:

- the infection control management of inpatients with chickenpox or shingles:
- the management of non-immune inpatients exposed to individuals with chickenpox or shingles.

2.2 The procedural document applies to all staff (including Temporary, Locum, Bank, Agency, Contracted staff).

2.3 In line with our statutory obligations, the protected characteristics of age, disability, gender reassignment, marital status/civil partnership, pregnancy and maternity, race, religion or belief, sex/gender and sexual orientation under the Equality Act 2010are recognised by the Trust and in addition, the Trust has recognised Learning Disability as a further protected characteristic. This Policy must be implemented in line with the Trust Equality and Diversity Policy.

3. DUTIES AND RESPONSIBLITIES

3.1 **The Trust Board, via the Chief Executive** will:

- ensure there are effective and adequately resourced arrangements for the management of Chicken Pox and Shingles within the Trust;
- identify a board level lead for infection control;
- ensuring that the role and functions of the Director of Infection Prevention and Control are satisfactorily fulfilled by appropriate and competent persons as defined by DH, (2008, revised 2015).

3.2 **Director of Infection Prevention and Control (DIPC)** will:

- oversee the local control of and the implementation of the Chicken Pox and Shingles Policy.

3.3 **The Infection Prevention and Control Implementation Group** will:

- ensure that the procedures for the management of Chicken Pox and Shingles are continually reviewed and improved within the Trust.

3.4 **The Infection Prevention and Control Team** will:

- advise and support clinical staff in the management of patients with chickenpox or shingles;
- carry out any necessary contact tracing and management of inpatients exposed to chickenpox or shingles in liaison with the clinical team caring for the patient;
- liaise with Staff Occupational Health regarding any patient or healthcare worker diagnosed with chickenpox or shingles so contact management of other staff can be initiated.

3.5 **Ward and Team Managers/Hospital Matrons** will:

- ensure all their staff are aware of and follow the actions of this policy;
- ensure that staff are released to attend relevant Training and for recording attendance at training in local training records. All non-attendance at training will be followed up by managers.

3.6 **All healthcare staff** will:

- ensure the infection prevention and control precautions detailed in this policy are followed for any patient with suspected or confirmed chickenpox or shingles;
- inform the IP&C Team if a patient is admitted or develops chickenpox or shingles during their hospital stay;
- informing the Staff Occupational Health provider if they are not immune and themselves develop chickenpox or shingles at work or are exposed to a case of chickenpox or shingles;
- follow the actions of this policy;
- book themselves onto and attend initial and update mandatory training.

3.7 **Staff Occupational Health Provider** will:

- liaise with the IP&C team in the event of a member of staff developing chickenpox or shingles at work so contact management of patients can be initiated;
- carry out any necessary contact tracing and subsequent management of exposed staff;
- advise staff exposed to or infected with chickenpox or shingles.

3.8 **The Learning and Development Department** will:

- enter all data relating to Mandatory and Non-Mandatory training attendance onto the Electronic Staff Record (ESR) system and report non-attendance to Ward and Team Managers.

4. EXPLANATIONS OF TERMS USED

4.1 **Incubation period** – period of time from exposure to development of symptoms.

4.2 **Period of infectivity** – period of time when the individual is infectious.

4.3 **Maculopapular rash** – a large red area with confluent bumps.

4.4 **Vesicles** – small fluid filled blisters.

4.5 **Foetal varicella syndrome** – characterised by one or more of the following: skin scarring, eye defects, limb hypoplasia, neurological abnormalities, and dysfunction of bladder and bowel sphincters.

4.6 **Neonate** – baby from birth to 4 weeks of age.

4.7 **Disseminated shingles –** widespread shingles. The virus affects multiple body systems and generally only occurs in those whose immune system is not fully functioning.

5. CLINICAL FEATURES

5.1 **Chickenpox** usually begins with fever and malaise followed by a maculopapular rash progressing to vesicle formation, mainly over the trunk but extending to face, scalp and limbs. The rash often appears in 'crops' over the course of several days. The severity of chickenpox varies and it is possible to be infected but show no symptoms.

5.2 Chickenpox is usually a relatively mild infection but for adults and some groups (neonates, pregnant women, and immunosuppressed) there may be more serious complications. These include viral pneumonia, secondary bacterial infections and encephalitis. In addition there are risks to the foetus or neonate if women develop chickenpox during pregnancy. The risks are related to gestation at the time of infection.

5.3 **Shingles** is caused by the reactivation of an individual's varicella virus and is a local infection. It begins with increased sensitivity or a burning sensation over an area of skin that follows the line of a nerve. A red vesicular rash then occurs over the same area. It most commonly occurs over one side of the chest, abdomen or around the eye (ophthalmic or facial shingles).

6. IMMUNITY

6.1 Chickenpox infection usually results in lifetime immunity to the virus so re-infection is very rare. A definite history of chickenpox or shingles indicates immunity however, this is a less reliable predictor of immunity for those born and raised outside of the UK and serology testing for the presence of varicella zoster antibodies may be required. A documented history of varicella vaccination (i.e. 2 doses of vaccine) is also satisfactory evidence of

immunity. Post Vaccination testing is only considered in staff working with highly vulnerable patients.

6.2 For those who are immunosuppressed a past history of chickenpox or shingles is not a definitive indication of immunity. For these individuals exposure to cases of chickenpox and sometimes shingles, often requires serological confirmation of immunity and should be considered.

7. TRANSMISSION AND INFECTIVITY

7.1 **Chickenpox** is highly infectious. The virus is shed from both the nasal-pharynx and vesicles on the skin, therefore transmission occurs via:

- Airborne spread of respiratory secretions
- Direct contact with vesicles and vesicular fluid
- Contact with clothing, bedding, equipment etc contaminated with respiratory secretions or vesicular fluid.

7.2 The incubation period for chickenpox is between 10 and 21 days following exposure to an individual with chickenpox.

7.3 Individuals are normally regarded as infectious 2 days prior to the development of the rash and until all the vesicles have crusted over, which usually occurs around 5 days after the onset of the rash. Infectivity may be prolonged in patients with altered immunity.

7.4 Significant exposure to chickenpox is assessed as:

- Face to face contact with a case of chickenpox (e.g. having a conversation).
- Being in the same room, bay or whole ward (if nightingale) for 15 minutes or longer with a case of chickenpox.
- Direct contact with a case of chickenpox at any point in the period of time 48 hours before the rash appears until all the vesicles have crusted over.

7.5 **Shingles** occurs from reactivation of the varicella virus that has lain dormant in nerve tissue following previous infection with chickenpox. Shingles cannot be passed from person to person, however individuals with shingles will shed varicella zoster virus from the vesicles. This can result in the development of chickenpox in those who have never had chickenpox before.

7.6 The route of transmission of varicella virus from an individual with shingles is via direct contact with vesicles or vesicular fluid.

7.7 Individuals are not infectious until appearance of the rash and remain infectious until all the vesicles have crusted over. This is usually about 7 days after onset of the rash.

7.8 Significant exposure to shingles is assessed as:

- contact with a case of disseminated shingles;
- contact with immunocompetent individuals with exposed vesicles (e.g. ophthalmic shingles);
- contact with immunosuppressed individuals with shingles on any part of the body (viral shedding will be greater in these individuals);
- contact with the case between the period of onset of rash until all vesicles are crusted over.

8. VACCINATION AND TREATMENT

8.1 Currently there is no widespread varicella vaccination programme in the UK however; since 2003 the Department of Health recommend chickenpox vaccination for all non-immune healthcare workers. Vaccination may also be considered prophylactically (within three days of exposure) on advice of the Consultant Occupational Health Physician.

8.2 Chickenpox infection is usually self-limiting and management is usually based on symptom reduction. For some groups at risk of developing serious complications may require antiviral drugs or immunoglobulin. Treatment of shingles with antiviral drugs may reduce symptoms. The decision to initiate treatment of either chickenpox or shingles will be made by the clinician responsible for the patient. Advice is available from the Consultant Microbiologists.

9. ACTION TO BE TAKEN IN EVENT OF CHICKEN POX / SHINGLES OCCURING ON WARD

9.1 Only staff with a definite history of chickenpox / shingles or a blood test demonstrating immunity should provide care for any patient with suspected or confirmed chickenpox or shingles.

9.2 Patients with suspected or confirmed chickenpox or infectious shingles **must not** be nursed near other patients who are immunosuppressed (see section 15). In the event of a symptomatic patient or an asymptomatic patient without prior immunity but whom has had contact with Chicken Pox or infectious shingles requiring transfer to a setting with high numbers of potentially immunocompromised patients, such as Oncology, further advice must be obtained from the IP&C Team or on call microbiologists prior to the transfer.

9.3 For patients with suspected or confirmed chickenpox or shingles on a ward the following action should be taken (see Appendix A):

- isolate patient (index case) immediately. Difficulty in isolating should be escalated to the Service Manager and IP&C Team;
- instigate infection prevention and control precautions as detailed in Appendix C;
- inform IP&C Team;

- in conjunction with IP&C Team make a list of any individuals (patients, staff and visitors) that may have had contact with the index case (contacts).

10. MANAGEMENT OF CONTACTS

10.1 In the event of a patient developing chickenpox or shingles during their stay other patients, visitors and staff may be at risk of chickenpox infection if their exposure has been significant and they do not have immunity.

10.2 Managing contacts of an index case involves the following process:

- assessment of immunity status of all contacts;
- assessment of the significance and timing of the exposure of potentially non-immune contacts;
- deciding if prophylactic varicella zoster immunoglobulin (VZIG) is required.

10.3 The following process should be followed for all potential contacts:

- assess the immunity status of all the potential contacts using assessment criteria in Appendix B;
- assess the significance and timing of the exposure of all potentially non-immune contacts using assessment criteria in Appendix D;
- all individuals who are potentially non-immune and are assessed as having had significant exposure should be listed on the form contained in Appendix E. These names should be given to either the Staff Occupational Health Provider or IP&C Team, i.e.
    - **staff** contacts who are not immune and have had significant exposure should be referred to the Staff Occupational Health Provider. Exclusion from work may be required from 8 to 21 days after exposure;
    - **patient** contacts who are not immune or for whom immunity is not definitive and have had significant exposure will be followed up by the IP&C Team. The need for prophylactic VZIG will be made by the Clinician responsible for the patients care in liaison with a Consultant Microbiologist. These patients should be managed as potentially infectious from 8 to 21 days after exposure to the index case. If VZIG is given they should be managed as potentially infectious from 8 to 28 days since VZIG extends the incubation period.

- **visitors or close family contacts** to the index case will be assessed by the IP&C Team who will liaise with the Public Health England (Southwest/South) as necessary.

11. DECIDING IF PROPHYLACTIC VZIG IS REQUIRED

11.1 Varicella Zoster Immunoglobulin prophylaxis is recommended for individuals who fulfil **all** of the following 3 criteria:

- significant exposure to chickenpox or shingles;
- a clinical condition that increases the risk of severe varicella, including immunosuppressed patients, neonates, pregnant women;
- no antibodies to varicella zoster virus.

12. VARICELLA ZOSTER EXPOSURE IN PREGNANCY

12.1 The majority of pregnant women will already be immune to chickenpox. If immune, exposure to individuals with either chickenpox or shingles presents no risks to mother or the foetus and no action is required.

12.2 Pregnant women who have never had chickenpox should avoid exposure to anyone with either chickenpox or shingles during the infectious period.

12.3 Pregnant women who have never had chickenpox or have no recollection of previous chickenpox or shingles who have contact with a case of chickenpox or shingles must have serology testing to check for presence of varicella zoster (VZ) antibodies. VZIG is recommended for all VZ antibody negative pregnant contacts exposed at any stage of pregnancy, providing VZIG can be given within 10 days of exposure.

12.4 If VZIG is given the pregnant woman should be managed as potentially infectious from 8-28 days after administration of VZIG. If VZIG is not given the pregnant woman should be managed as potentially infectious from 8-21days after exposure to the index case.

12.5 Any pregnant woman who has any exposure to chickenpox or shingles (regardless of whether or not they have received VZIG) should be asked to notify their Dr or midwife immediately if a rash develops.

12.6 VZIG has a short duration of effect and therefore a second dose may be required if a further exposure is reported and 3 weeks have elapsed since the last dose.

12.7 VZIG is not required as prophylaxis for non-immune women after delivery of the baby since they are no longer at high risk for complications of chickenpox once they have delivered.

13. VARICELLA INFECTION IN PREGNANCY

13.1 Pregnant women who develop chickenpox are at greater risk of complications themselves which may require hospitalisation e.g. viral pneumonia, haemorrhagic rash. The severity of complications seems to increase in later gestation.

13.2 Pregnant women with chickenpox must not be admitted to the maternity unit unless there is an overriding obstetric need. If admission to the maternity unit is required they must not mix with other mothers or babies whilst still infectious. The same infection control measures should be applied as outlined in Appendix C.

13.3 Varicella zoster immunoglobulin (VZIG) has no therapeutic benefit once chickenpox has developed so is not indicated for maternal chickenpox during pregnancy. The use of antivirals should be made on an individual basis by the Clinician responsible for the patient with advice available from the Consultant Microbiologists.

13.4 There are risks to the foetus and / or newborn if the mother develops chickenpox during pregnancy. The severity of these risks depends on gestation at the time of infection.

13.5 Chickenpox in the first trimester does not increase the risk of miscarriage.

13.6 Chickenpox in the first 28 weeks of pregnancy is associated with foetal varicella syndrome. This is a serious condition that affects foetal development.

13.7 Maternal chickenpox around the time of birth exposes the neonate to varicella zoster virus and there is a risk the baby may be born with chickenpox. Elective delivery (including caesarean) should be avoided, where clinically possible, until 5-7 days after the onset of maternal rash to allow for the passive transfer of antibodies from mother to child.

14. NEONATAL EXPOSURE OR INFECTION

14.1 Neonates born to mothers who were immune to chickenpox will have passively acquired immunity. They are not at risk if exposed to cases of chickenpox or shingles unless they were born before 28 weeks gestation or weighed less than 1 kg at birth as they may lack these maternal antibodies.

14.2 Neonates born before 28 weeks gestation or who weigh less than 1 kg at birth will require VZIG prophylaxis if exposed to a case of chickenpox (e.g. chickenpox in a sibling) regardless of maternal immune status.

14.3 Neonates born to mothers who develop shingles around the time of delivery will have passively acquired immunity. They are not at risk of developing chickenpox unless they were delivered before 28 weeks gestation or weigh less than 1kg when they may lack these maternal antibodies. Neonates delivered prematurely to mothers with shingles around the time of delivery should be given VZIG.

14.4 Neonates born to mothers with no immunity to chickenpox will not be immune themselves if exposed to a case of either chickenpox or shingles. If there is contact to a case within the first 7 days of life VZIG should be given to the neonate.

14.5 Maternal chickenpox around or soon after delivery will expose the newborn to infection. If birth occurs within 7 days of onset of maternal chickenpox rash, or if the mother develops the rash within 7 days of birth, the neonate should be given VZIG prophylaxis.

14.6 Administration of VZIG does not guarantee the prevention of chickenpox in the neonate and extends the incubation period of chickenpox up to 28 days post exposure. All neonates who have received VZIG should be monitored for signs of infection up to 28 days from exposure or in the case of maternal chickenpox 28 days from onset of chickenpox in the mother.

14.7 VZIG is of no benefit once neonatal chickenpox has developed.

14.8 Mothers with chickenpox should be allowed to breast feed. If they have lesions close to the nipple, they should express milk from the affected breast until the lesions have crusted. This expressed milk can be fed to the baby if they are covered by VZIG and / or antivirals.

15. IMMUNOSUPRESSED PATIENTS

15.1 Immunosuppressed patients are at risk of severe varicella infection. Vesicles may arise for several weeks prolonging the period of infectivity in these patients. There is an increased risk that the virus will disseminate throughout the organs of immunosuppressed individuals. In addition any that develop chickenpox or shingles will shed higher levels of the virus and therefore become a higher risk to other individuals that are not immune to chickenpox.

15.2 Immunosuppressed patients include the following conditions:

- a primary immune deficient clinical condition;
- malignant disease treated with immunosuppressive chemotherapy or radiotherapy (classed as immunosuppressed for at least 6 months after terminating such treatment);
- all patients who have received a solid organ transplant and are currently on immunosuppressant treatment;
- patients who have received a bone marrow transplant until at least 12 months after finishing all immunosuppressant treatment or longer if the patient develops graft-versus- host disease;
- all patients receiving systemic high-dose steroids until at least 3 months after treatment has stopped;
- all patients receiving other types of immunosuppressant drugs (e.g. azathiopine, methotrexate, etc.);
- all patients with immunosuppression due to HIV infection.

15.3 Any immunosuppressed patient that is exposed to a case of chickenpox or shingles should undergo the same process of assessment as any other contacts (see section 9 of this policy).

15.4 The decision to give prophylactic VZIG is made on an individual basis. For paediatrics, appropriate specialist advice would be sourced via the appropriate medical clinician based within the Somerset Acute NHS Foundation Trusts. Wherever possible, immunosuppressed contacts should be tested for varicella zoster antibodies regardless of a previous history of chickenpox. If testing for antibodies will potentially delay the administration of VZIG beyond 7 days after initial contact with the index case, then VZIG should be given on the basis of a negative history of chickenpox. If the patient has a positive history of chickenpox, serology results should be obtained first.

15.5 VZIG is not indicated in immunosuppressed contacts with detectable varicella zoster antibodies.

15.6 Patients with no detectable varicella zoster antibodies do require VZIG. The decision to administer VZIG should be made by the Clinician responsible for the patient in liaison with the Consultant Microbiologists.

16. TRAINING REQUIREMENTS

16.1 The Trust will ensure that all necessary staff (qualified, unqualified, other clinical staff and bank staff) are appropriately trained in line with the organisation's training needs analysis.

- Trust Induction Training
- Hand Decontamination Training
- Infection Prevention and Control Training
- Untoward Event Reporting Training

17. EQUALITY IMPACT ASSESSMENT

17.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

17.2 Patients and carers should fully understand their illness and the treatment for this. This may necessitate the use of professional interpreting and translation. Written information may be needed in a range of languages and formats.

17.3 Capacity to consent to treatment must be a consideration.

18. MONITORING COMPLIANCE AND EFFECTIVENESS

18.1 Monitoring arrangements for compliance and effectiveness

- Overall monitoring will be by the Infection Prevention and Control Assurance Group

18.2 Responsibilities for conducting the monitoring

- The Infection Prevention and Control Assurance Group will monitor procedural document compliance and effectiveness where they relate to clinical areas.

18.3 Methodology to be used for monitoring

- The Infection Prevention and Control Team will monitor isolation practice for patients with Chicken Pox and Shingles through routine surveillance including adherence to the procedures outlined within this policy. Any actions identified will be implemented and monitored via the Infection Prevention and Control Assurance Group.

- incident reporting and monitoring

- Isolation practice is regularly audited by the Infection Prevention and Control Team

18.4 Frequency of monitoring

- The Infection Prevention and Control Assurance Group reports to the Clinical Governance Group quarterly.

18.5 Process for reviewing results and ensuring improvements in performance occur.

Audit results will be presented to the relevant best practice groups for consideration, identifying good practice, any shortfalls, action points and lessons learnt. These groups will be responsible for ensuring improvements, where necessary, are implemented.

19. COUNTER FRAUD

19.1 The Trust is committed to NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

20. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

20.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 18:	Staffing
Regulation 20:	Duty of candour

20.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 11:	General

20.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

21. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

21.1 **References**

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- Nicholson, A, 2007. Chickenpox Treatment and Prevention. Child Health, Vol 15, Issue 4.
- Perry, C. 2008. Infection Prevention and Control. Blackwell Publishing.
- Royal College of Obstetricians and Gynaecologists, 2007. Chickenpox in Pregnancy - Green Top Guideline No 13.
- The Equality Act, 2010

21.2 **Cross reference to other procedural documents**

- Hand Hygiene Policy
- Infection Control Standard Precautions Policy
- Outbreak of Infection – Policy for management and Control
- Health and Safety policy
- Record Keeping and Records Management Policy
- Risk management Policy and Procedure
- Risk Management Strategy
- Waste Management Policy
- Untoward Event Reporting Policy and Procedure
- Equality and Diversity Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

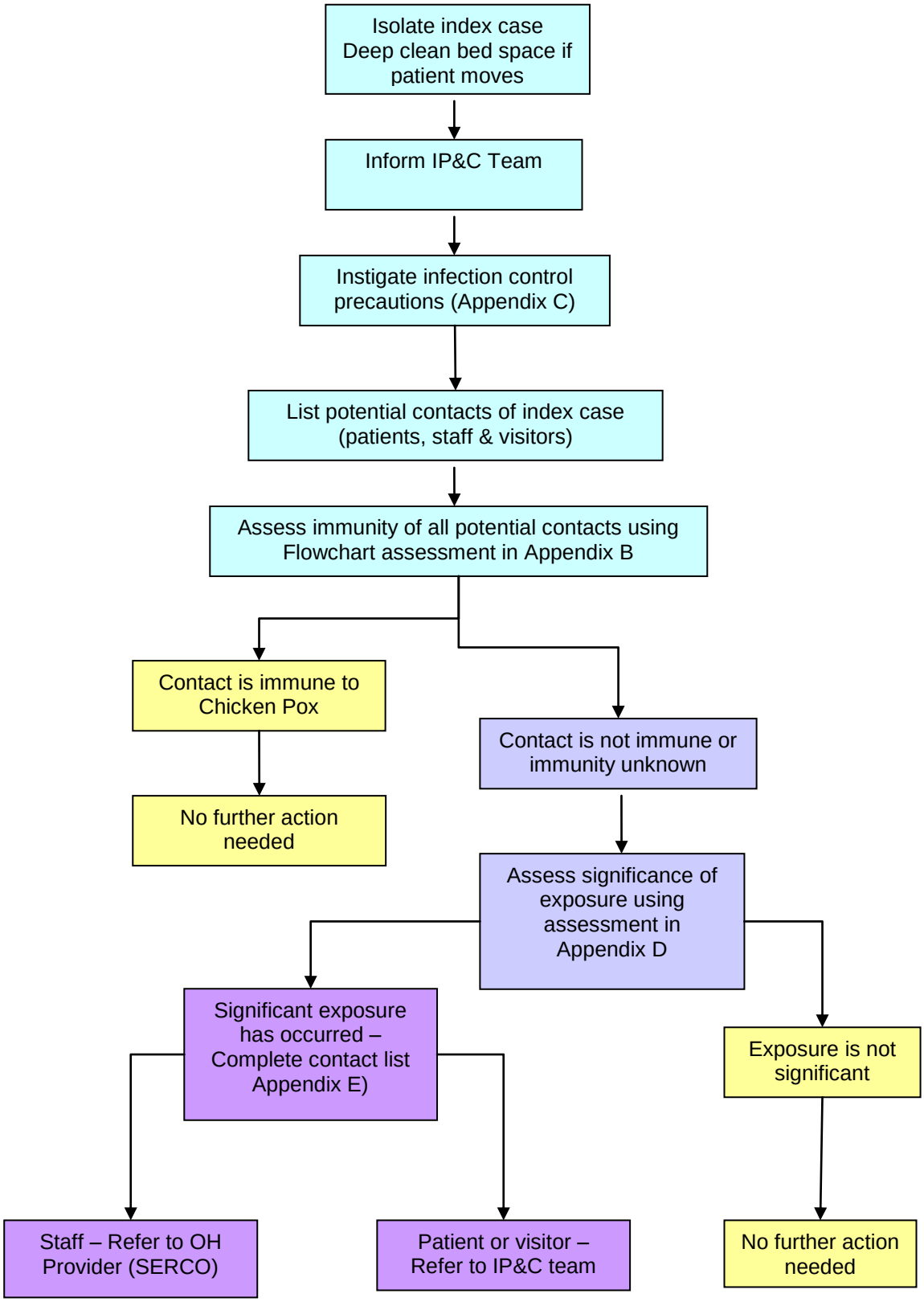
22. APPENDICES

21.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A	Action to be Taken In The Event of a Case Of Chicken Pox or Shingles On a Ward
Appendix B	Assessment of Immunity Flowchart
Appendix C	Isolation Precautions
Appendix D	Assessment of Significant Exposure
Appendix E	Contact List

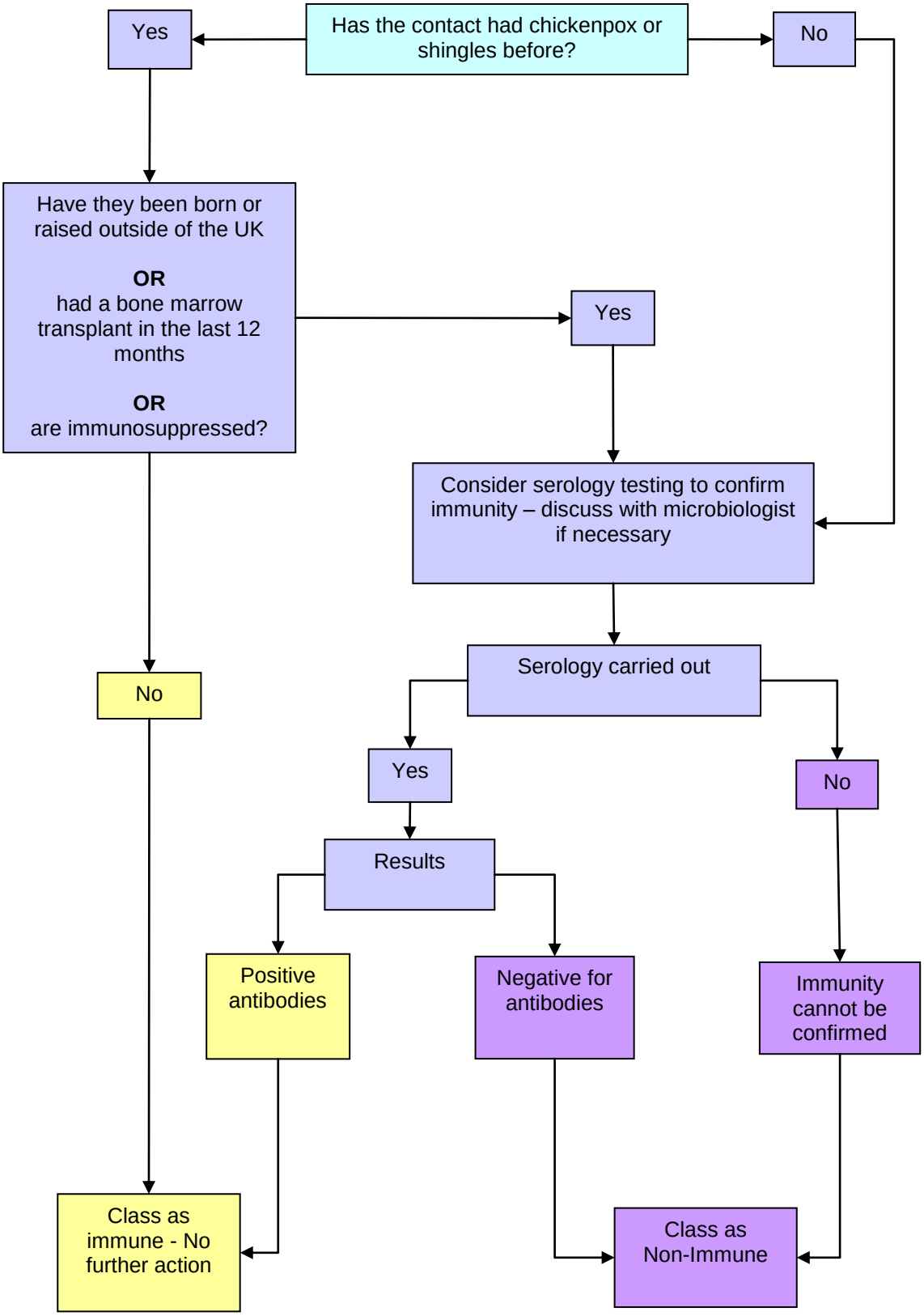
APPENDIX A

Action to be taken in the event of a case of Chickenpox or Shingles on a Ward



APPENDIX B

Assessment of Immunity Flowchart



APPENDIX C

Infection Prevention and Control Precautions

Suspected or confirmed Chickenpox of Shingles

1 **Isolation –** all patients with suspected or confirmed chickenpox should be placed in a single room with the door closed. They should remain in isolation until all the vesicles have crusted over. For patients with shingles, isolation in a single room is still recommended, particularly if lesions cannot be covered with a dressing.

2 **Shingles lesions –** Should be covered with a dressing wherever possible.

3 **Personal Protective Equipment (PPE) –** Aprons and gloves should be worn for all direct contact with the patient, contaminated linen and equipment. Masks are not required even when managing patients with chickenpox as only staff with known immunity should be caring for the patient.

4 **Equipment –** Wherever possible dedicated and single use equipment should be used. All re-usable equipment must be decontaminated before use on another patient. Crockery and cutlery may be washed in the dishwasher as normal.

5 **Cleaning –** No specific cleaning regimes are required. The daily detergent clean should occur as normal and a terminal clean performed when the patient is no longer infectious or discharged from the room. Cleaning staff should wear aprons and disposable gloves when cleaning. Masks are not required as cleaning staff without immunity to chickenpox should not be cleaning the room.

6 **Linen & Waste –** An alginate bag should be used for all linen and placed in a red bag prior to removal from the room. Varicella virus has a short survival time in the environment therefore the normal rules of segregation of domestic and clinical waste apply. Items such as newspapers, flowers etc may still be disposed of as domestic waste. PPE such as gloves and aprons should be disposed of as clinical waste.

7 **Hand Hygiene –** Alcohol gel or soap & water are equally effective methods of hand hygiene when caring for patients with either chickenpox or shingles.

8 **Transfer / Attendance to Other Departments –** Patients with chickenpox **should not** be transferred to other departments e.g. X-ray unless clinically essential. If required, the following precautions should be in place:

- transporting staff or those in the receiving department should only have contact with the patient if they are immune to chickenpox;
- porters **do not** need to wear gloves and aprons while pushing beds, trolleys or chairs. They only need to use PPE if required to have direct contact with the patient;

- trolleys or wheelchairs should be decontaminated between each patient use;
- during the transfer, patients with chickenpox should be asked to wear a fluid repellent surgical mask. Masks are not required for patients with shingles;
- patients should not wait in holding or communal areas in departments.

9 **Visitors –** Visitors should be advised not to visit unless they have had chickenpox or shingles themselves. Visitors do not need to wear any PPE when visiting but should be instructed to decontaminate their hands before leaving the room.

10 **Deceased –** No special precautions are required.

APPENDIX D

Assessment of Significant Exposure

There are two aspects to the assessment of significant exposure, first the type of exposure and secondly when that exposure occurred.

Tick the answer to each question in box 1. If the answer is yes to any of the questions in box 1 proceed to box 2.

Box 1: Type of Exposure	**Yes**	**No**
Face to face contact with a case of chickenpox (e.g. having a conversation)		
In the same multi occupancy room with a case of chickenpox for 15 minutes or longer		
Contact with a case of disseminated shingles and exposed vesicles		
Contact with immunosuppressed individuals that have shingles on any part of their body (viral shedding will be greater in these cases)		

If the answer was **NO** to all of the above significant exposure **has not** occurred and no further action is required.

If the answer was **YES** to any of the above significant exposure **has** occurred, please proceed to box 2 to identify if the exposure has occurred during the infectious period.

Box 2: Timing of Exposure	**Yes**	**No**
Did contact with the case of chickenpox occur between the period 48 hrs prior to onset of rash and until all vesicles are crusted		
Did contact with the case of shingles occur between the period of onset of rash and until all vesicles are crusted		

APPENDIX E

Contact List
(Individuals that have no immunity and have had significant contact with index case)

Ward / Department……Date……

Type of Contact (e.g. Chickenpox or Shingles)…….

Name	DOB	Designation (Patient / Staff)	Date of Contact