Document Control Report

Title			
Patient Isolation and Staff Exclusion Policy			
Author Infection Control Team		**Author's job title**	
Directorate Nursing	**Sub-directorate**	**Department**	**Team / Specialty** Infection Control

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1.0	Mar 2004	Final	Ratified by Trust Board.
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2.1	Aug 2008	Revision	Final amends to ensure corporate identity requirements.
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2.4	May 2011	Revision	Changes required by Risk Management Committee 17.3.11. Changes required by integration of NDHT and DPS on 1.4.11 – additions to section 1 introduction, section 6.1 isolation prioritisation and table of isolation room equipment requirements & Appendices A&C. Amends by Corporate Affairs.
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3.1	Oct 2011	Revision	Minor amendments by Corporate Governance to document control report, formatting for document map navigation, headers & footers and table of contents.
3.2	Nov 2012	Revision	Minor amendments to guidelines for management of staff or patients with scabies. Minor amendments by Corporate Governance to document control report. Formatting for semi-automatic table of contents.
3.3	Aug 14	Revision	Date Extension to allow for full review in light of CQC report

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1 Introduction

This document sets out Northern Devon Healthcare NHS Trust's system for the control of scabies infection on patients and staff. It provides a robust framework to ensure a consistent approach across the Trust.

This is a merged policy reflecting the incorporation of community services in Exeter, East and Mid Devon with Northern Devon Healthcare NHS Trust in April 2011.

2 Purpose

The purpose of this document is inform and guide staff on the care of patients requiring isolation in order to prevent the spread of infection from patients to other patients, staff and visitors or to prevent especially vulnerable patients acquiring avoidable infections.

This document will also inform and guide staff on their responsibilities to report personal illness that may represent an infection risk to others. Infection Prevention and Control Team and Occupational Health will advise if exclusion from the workplace is necessary.

This will enable the Trust to comply with recommendations made in the **Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings** (Centres for Disease Control, 2007), The Health and Social Care Act 2008 (December 2009)

The policy applies to all Trust staff that work or interact with clinical wards and departments.

Implementation of this policy will ensure that avoidable outbreaks of infection are prevented.

3 Definitions

3.1 Cohort Nursing

Moving patients who have symptoms likely to be from the same source into a bay or an area of the ward, when single room isolation is not possible.

3.2 Direct Contact

The transfer of micro-organisms from an infected person to another person. Examples include prolonged skin to skin contact, sexual contact and needlestick injury.

3.3 Indirect Contact

The transfer of micro-organisms through a contaminated object or person. Examples include equipment used between patients and inadequately sterilised surgical instruments.

3.4 Pathogens

Micro-organisms having the ability to cause infection.

4 Responsibilities

4.1 Role of Executive Directors

The Directors are responsible for:

- Acting as a second point of contact to support
- Ensuring that a replacement main contact is identified should the original author be re-deployed or leave the organisation.

4.2 Infection Prevention and Control Team

The Infection Prevention and Control Team undertake to provide education and clarification to support the utilisation of this policy when requested to do so by the Senior Nurse or Manager. They will also provide the Patient Management Team with updates on single room usage across the Trust during weekdays while working closely with the Patient Management Team on use of single rooms and bay and ward closures for control of outbreak of infection.

4.3 Ward/ Departmental Manager

Responsibility for implementation of this policy lies with the Senior Nurse (usually Ward Sister) or Departmental Manager in charge of the areas to which these statements apply unless specifically stated otherwise in the text.

4.4 Role of the Clinical Site Management Team

The Clinical Site Management Team will work closely with the Infection Control Team on matters of isolation of patients and use of single rooms taking into account this policy and the Bed Management Policy. They will utilise information provided by the Infection Control Team on the prioritisation of single room use. Additionally, they will contact the Infection Control Team (in hours) or the on-call Consultant Microbiologist (out of hours) if they are unable to satisfy competing demands for single rooms or need to close bays or wards to control the potential for spread of infection.

4.5 Role of All Staff

All healthcare staff are required to adhere to the information, guidelines and procedures contained within this policy, which provide a framework for safe and best practice, aimed at preventing the spread of infection.

4.6 Occupational Health

All healthcare staff have a professional obligation to ensure that they are protected against common communicable diseases and this is assessed on employment by Occupational Health Department. All staff must report any illness that may represent an infection risk to the Occupational Health Department and the Infection Prevention & Control Department.

5 Infection Prevention and Control Team

The Infection Prevention and Control Team can be contacted in hours on 01271 322680 (ext 2680 internal at North Devon District Hospital), via bleep 011 or out of hours by contacting the on-call Medical Microbiologist via North Devon District Hospital switchboard.

6 Patient Isolation and Staff Exclusion Policy

6.1 General Principles

Isolation of patients in a single room who have a known or suspected communicable disease, or cohort nursing of patients with symptoms believed to be from the same source, is required in order to prevent further spread of infection to others.

In circumstances where you are unable to isolate a patient who requires this contact Infection Control during working hours or out of hours contact the on-call Microbiologist for advice on prioritization of single rooms.

Staff with infection that may represent a risk to their own health, or the health of others will be excluded from work for a period of vulnerability or communicability after risk assessment by Occupational Health and Infection Prevention & Control Team.

Standard precautions (see below for details) should be applied routinely by all staff to all patients/ clients regardless of their diagnosis or infectious status.

Additional isolation precautions should be followed for patients with suspected or confirmed infection. This will prevent the spread of potentially pathogenic organisms to other individuals:

- Via direct contact with the patient, their excretions and secretions -

  (**contact precautions**)
- Via indirect contact with the environment or equipment which may be contaminated by blood and/ or body fluids - (**contact precautions**)
- Via close respiratory or mucous membrane contact with respiratory secretions of an infected patient (e.g. coughing, sneezing, performing chest physiotherapy, suctioning) - (**droplet precautions**)
- By reducing exposure to airborne organisms - (**airborne precautions**).

Patients who do not have a confirmed organism or infection, but have increased risk of transmitting an infection must also be isolated as soon as possible, examples of this include:

- Exfoliating skin conditions e.g. psoriasis, eczema.
- Productive cough.
- Diarrhoea and/or vomiting.
- A heavily exuding/discharging wound that is difficult to contain within wound dressings.

If a patient is known or suspected to have any of the following conditions, the Infection Control Team must be contacted immediately (out of hours infection control advice is given by the on-call Consultant Medical Microbiologist). These patients may require negative pressure isolation which may involve subsequent transfer to another hospital:

- Multi-drug resistant TB.
- SARS.
- Avian or pandemic influenza.
- Viral Haemorrhagic Fever.
- Diptheria.

Side rooms

Patients with the following conditions/ symptoms should be prioritised for side room isolation:

- Known or suspected open pulmonary TB - inform Infection Control.
- Chicken Pox - must be isolated in a side room – Shingles can be nursed in an open ward if lesions are covered.
- Diarrhoea and/ or vomiting with a known or suspected infective cause.
- Known MRSA positive patients in orthopaedic and general surgical wards.

Patients whose symptoms of diarrhoea and/ or vomiting have resolved can be moved out of a side room after 72 hours – this also applies to patients with known *Clostridium difficile.*
Staff should assess patients thoroughly regarding the cause and duration of the diarrhoea before requesting a side room.

Open/ uncontrolled bleeding (whether or not blood borne viruses have been identified) that may result in splashing or extensive environmental contamination e.g. epistaxis, oesophageal varices.
Patients with a known or suspected infection/colonisation, e.g. MRSA, Group A Streptococcus, ESBL and any patient with an exuding wound, productive cough or severe eczema psoriasis.

Although our policy is to isolate patients with MRSA, it may be possible that a patient with MRSA in a wound that can be easily contained/ occluded can be moved from a side room in order to prioritise a patient with greater priority. Contact the Infection Control Team for advice/ risk assessment.

Immuno-compromised patients
Immuno-compromised patients remain a priority for side room providing they meet the neutropaenic levels i.e. *have a haematological malignancy and neutrophil count of less than 0.5 x 10 ^{9} / litre'*. These patients must be cared for using protective precautions.

When planning patient care, patients' needs must be balanced against recognised modes of transmission of the organism(s). These are usually defined as:

- Airborne transmission
- Contact transmission – direct contact or indirect contact
- Droplet transmission

Care provided must be concentrated on isolating the organism and not the patient. This should relate to the recognised modes of transmission of the organism(s) and the associated precautions required.

All staff caring for patients will understand the principles of isolation and mode of spread of the organism(s). Risk assessment will determine need for isolation.

Staff must attend to patients' psychological as well as physical needs to minimise stress and anxiety during the period of isolation.

Meticulous hand hygiene should be observed in order to prevent hands from becoming a vehicle for cross infection. The same standard applies to all patient interactions by all staff irrespective of the need to isolate a patient in a single room.

Clear signage should be placed outside the room/ cohort area to alert staff and visitors to infection control precautions.

Doors should be kept closed at all times for airborne precautions and protective isolation, and preferably for droplet and contact precautions, other than for necessary entry and exit to the room.

Ensure that appropriate equipment is available:

Inside the room	Outside the room
Hand cleansing facilities Gloves & Aprons Clinical waste orange bag holder/bin.	Appropriate protective clothing Alcohol hand rub.

Inside the room	Outside the room
Linen receptacle with water soluble bag.	Notes and charts
Sharps Bin (if safe to leave within room)	
Thermometer	
Sphygmomanometer, Stethoscope (if required)	
Toileting and wash facilities (if no *en suite* bathroom).	

NB The mental health of the patient may dictate that it is unsafe to leave some of this equipment within the room. Always undertake a risk assessment.

6.2 Standard Precautions

The term 'Standard Precautions' refers to the application of infection control practices to prevent exposure to and transmission of micro-organisms, which may be pathogenic. These routine practices when caring for all patients include:

- Hand decontamination
- Wearing appropriate personal protective clothing
- Safe disposal of clinical waste
- Decontamination of equipment and the environment
- Safe disposal of sharps.

For full details see Standard Infection Control Precautions Policy.

6.3 Contact Precautions

Environment

An Isolation Precautions sign must be placed on the door of patients isolated as such (see Appendix B).

Following discharge of a patient from a room/ area it will require a standard Discharge Clean, which means cleaning using detergent and water. The curtains do not need changing beyond the routine 3 monthly interval, unless they are visibly soiled or unless instructed differently on a case by case basis by the Infection Control Team.

Following cases of diarrhoea and/ or vomiting, a Chlorine Clean using a chlorine releasing agent at a strength of 1,000ppm (parts per million) is also necessary. This is for disinfection of all hard surfaces in the affected room/ area. It should be carried out on a daily basis during the admission of the affected patient and also following their discharge. Curtains should also be changed in the room/ area on the patient's discharge unless instructed differently on a case by case basis by the Infection Control Team.

Personal Protective Equipment (PPE) and Hand Hygiene

Staff should wear appropriate PPE when caring for patients in isolation (which means giving hands on care, changing bed linen). PPE means aprons and gloves, if they are going to come into contact with blood or body fluids. (See Outbreak of infection Policy and Specific Conditions Policy in the Infection Control Manual for detailed PPE requirements).

For patient contact activities (which includes handling non soiled bed linen and clothing) that do not include contact with blood or body fluids/ excreta, the use of apron alone is sufficient, followed by hand decontamination.

Personal Protective Equipment is not required if the activity during the visit is verbal only.

All staff and visitors must decontaminate their hands when leaving the isolation room. Hand-washing with soap and water is required if the hands are visibly soiled and if the patient is being isolated due to diarrhoea or vomiting. Alcohol gel may be used as an alternative to hand-washing in association with patients being isolated for reasons other than diarrhoea and vomiting.

Staff removing items to the sluice from an isolation room must decontaminate their hands immediately after the removal of Personal Protective Equipment which followed the disposal and/ or cleaning activity involved.

Equipment Cleaning

Equipment used in an isolation room can either be decontaminated after use and returned to general ward use, or retained for use by the patient in the room for the duration of the isolation episode. It will always be cleaned immediately after use if it is visibly soiled whether or not it is returned to the isolation room.

Linen

All linen should be dealt with as infected linen. (See the Laundry Policy).

Waste

All waste, other than sharps, should be discarded into clinical waste bags, and secured before being removed from the room. (See the Waste Policy).

Body fluids should be discarded directly into a toilet or macerator.

Visitors

Visitors will be informed of any risks to their health prior to visiting.

Visitors must be advised to wash their hands with soap and water (always when leaving a room where a patient is in isolation with diarrhoea and/ or vomiting) or use alcohol gel on leaving the isolation room.

Visitors do not need to wear personal protective equipment, unless they are going to come into contact with blood, body fluids, or perform physical care.

6.4 Droplet Precautions

Environment

An Isolation Precautions sign must be placed on the door of patients isolated as such (see Appendix B).

Following discharge of a patient from a room/ area, it will require a standard discharge clean. Curtains will be changed routinely at 3 monthly intervals and if visibly soiled or unless otherwise instructed by the Infection Control Team.

Explosive diarrhoea and vomiting can produce droplets. Following cases of diarrhoea and vomiting, a chlorine clean using a chlorine releasing agent at a strength of 1,000 parts per million (ppm) is also necessary. This is for disinfection of all hard surfaces in the affected room/ area. It should be carried out on a daily basis and also when the patient is discharged. Curtains should also be changed in the room/ area on the patient's discharge unless instructed differently on a case by case basis by the Infection Control Team.

Personal Protective Equipment (PPE)

As for contact precautions – see above.

Visitors

As for contact precautions – see above.

Linen

All linen should be dealt with as infected linen. (See the Laundry Policy).

Waste

All waste, other than sharps, should be discarded into clinical waste bags, and secured before being removed from the room. (See the Waste Policy).

Body fluids should be discarded directly into a toilet or macerator.

6.5 Airborne Precautions

Environment

An Isolation Precautions sign must be placed on the door of patients isolated as such (see Appendix B) and the door kept shut. On admission to A&E or Medical Assessment Unit (MAU) and in subsequent wards, a single room is required and the patient is required to wear a surgical mask to reduce droplet spread of the pathogen when outside an isolation room.

Following discharge of a patient from a room/ area it will require a standard discharge clean. Curtains will be changed routinely at 3 monthly intervals and if visibly soiled or unless otherwise instructed by the Infection Control Team.

Personal Protective Equipment (PPE)

As for contact precautions plus see PPE requirement in the Specific Condition Policy e.g. Tuberculosis.

Visitors

As for contact precautions – see above.

Airflow Control Isolation Rooms – North Devon District Hospital

Airflow control isolation rooms for use with serious pathogens with outbreak potential that are spread via the airborne route are available for children on Caroline Thorpe (2 rooms with negative or positive pressure airflow – rooms work as a pair and require to be switched to negative pressure for source isolation cases – they do not conform with current guidance but will be better than a standard single room without any airflow control).

Negative pressure is required for isolation of patients known or suspected to be carrying the following:

- MDR Tuberculosis (open pulmonary cases).
- Diphtheria (throat and/ or cutaneous).
- Viral haemorrhagic fevers (transmission from person to person is via contact with body fluids rather than airborne contamination. However, national policy dictates highest possible containment until removal to specialist hospital (Coppetts Wood, London)).
- Pulmonary anthrax.
- SARS.

NOTE: There are currently no negative pressure rooms on the medical wards. Patients must be nursed in a single room with the door shut on admission if known or suspected to be carrying any of the above.

The advice of the Infection Control Team and/ or on-call Consultant Microbiologist must be sought as soon as the patient is admitted as they may require transfer to another healthcare site with the appropriate isolation facilities. Negative pressure isolation facilities are available at Royal Devon and Exeter Hospital. Further advice on isolation facilities can be sought from the Health Protection Agency Consultant in Communicable Disease Control (CCDC) contact via North Devon District Hospital switchboard for on-call CCDC.

Negative pressure can, in conjunction with the Infection Control Team, be considered for use with the following:

- Chickenpox (ordinary single room usually sufficient).
- Measles.
- Avian influenza.
- Tuberculosis (open pulmonary cases) never care for open TB cases even in single rooms under airborne precautions on wards with severely immunosuppressed patients – see 6.6 below - and those with HIV.

If a case of any of the above serious respiratory pathogens is admitted to North Devon District Hospital, contact tracing and staff follow up would be undertaken by the Infection Control and Occupational Health Teams.

Linen

All linen should be dealt with as infected linen. (See the Laundry Policy).

Waste

All waste, other than sharps, should be discarded into clinical waste bags, and secured before being removed from the room. (See the Waste Policy).

Body fluids should be discarded directly into a toilet or macerator.

6.6 Protective Precautions

Protective precautions are taken to prevent immuno-compromised patients from acquiring an infection while in hospital. Patients requiring protective isolation will normally have a haematological malignancy and neutrophil count of less than 0.5×10^{9} / litre.

Environment

An Isolation Precautions sign (see Appendix B) should be placed on the outside of the door of any patient in protective isolation**.**

Protective isolation will be carried out in a single room with either positive or standard air pressure. Positive pressure isolation rooms are available on Caroline Thorpe Ward for children. Adult patients should be nursed in a single room on MAU, until a single room becomes available on Staples Ward.

Room doors to be kept closed. Windows may be opened as the patient wishes, providing there is no building work in the immediate vicinity or unless advised by Infection Control Team.

The Ward Manager must be given advanced notice of any building/ maintenance works in their area of responsibility. An appropriate risk assessment will then be carried out identifying ‘at risk’ patients.

Immuno-compromised patients may need to be moved to another ward during building/ maintenance works.

Cleaning schedules will aim to keep dust to a minimum. This must include decontamination of equipment as well as the environment. (See the Decontamination Policy in the Infection Control Manual).

Health of Carers

Healthcare workers with infections (including the common cold) must not care for patients in protective isolation.

Hand Hygiene and PPE

Hands must be washed before and after contact with the patient and susceptible sites (e.g. wounds, intravascular devices, urethral catheters).

Non-sterile gloves (see the Gloves Policy) and plastic disposable apron should be worn when in contact with blood or body fluids. Staff, patients or visitors do not require masks.

Equipment and Linen

Equipment (e.g. sphygmomanometers, tourniquets and stethoscopes) must remain in room for duration of protective isolation.

Linen should be disposed of according to the Laundry Policy. Flannels should be either single use or laundered daily.

Waste

All waste other than sharps should be disposed of into clinical waste bags. See the Waste Policy.

Food and Drink

For vulnerable patients in protective isolation fruit and salads should be supplied by the Catering Department who will ensure these are appropriately decontaminated before use using low level chlorine rinsing.

Pepper will be supplied in sachets to areas caring for immuno- compromised patients in protective isolation.

Visitors wishing to bring food from home will be given advice on appropriate foods and their preparation.

Fridges in isolation rooms must be defrosted at least weekly and maintained according to the Food Hygiene Policy.

Drinking water will be either carbonated bottled water or boiled water.

Specimen collection

Microbiological specimens will only be necessary when signs of infection are evident and not routinely unless advised by a Consultant Medical Microbiologist.

An aseptic technique will be used to obtain specimens from invasive devices or wounds.

Skin decontamination prior to venepuncture, cannulation or administering intra-muscular injections will take place using an alcohol impregnated swab firmly wiped over the site multiple times and allowed to dry for 30 seconds.

Visitors

Visitors should be advised against visiting if they have an infection, even mild upper respiratory infections.

Visitors must wash their hands before entering the room.

Gloves and aprons do not need to be routinely worn by visitors unless in contact with blood and body fluids.

6.7 Staff Health / Illness

6.7.1 Immunisation

All staff must be aware of the Staff Screening and Immunisation Policy and their professional obligation to ensure that they are protected against common communicable diseases, thus providing a safeguard both for themselves and their service users. Contact the Occupational Health Department for full guidance on immunization against infectious diseases.

Annual influenza vaccinations will routinely be offered to staff.

6.7.2 Blood Borne Viruses (Hepatitis B, Hepatitis C, HIV)

All staff should be aware of the Staff Screening and Immunisation Policy which contains full guidance on screening for blood borne viruses, Hepatitis B vaccination and management of staff who have a blood borne virus. All staff who carry out duties in clinical areas should receive Hepatitis B vaccination. Mandatory for those performing exposure prone procedures. Staff with known BBVs must declare this to Occupational Health and follow policy especially the Prevention of Inoculation Injury Policy and exposure prone procedures.

6.7.3 Gastrointestinal Illness

All staff with gastroenteritis must remain off duty until 48 hours have elapsed from their last symptom. In certain cases, i.e. in those who have returned from foreign travel, whose symptoms are persistent or unusual, e.g. bloody diarrhoea, or where there is the need to investigate a cluster of cases, a stool specimen may be required. After certain bacterial infections, clearance specimens may be necessary before an individual can return to work.

6.7.4 Other infections / symptoms

Staff with confirmed or suspected infection with symptoms e.g. sore throat, rashes, fever, wounds and skin lesions etc. must report to Infection Prevention & Control Team and Occupational Health as exclusion from work for a period of time may be required. Guidance for exclusion is contained in Appendix C. Similarly staff with an infection or condition which makes them more susceptible to infection must contact Occupational Health and Infection Prevention & Control Team for risk assessment.

6.7.5 Pregnant Staff

Pregnancy does not make an individual more likely to contract an infection than others. It is likely that some pregnant staff are exposed to more infections especially childhood illnesses if they have other children and contact with nurseries and school settings. However, illness may be more severe in the mother and have a poor outcome for the baby. Pregnant staff can care for most patients with infection. The table in Appendix C highlights exceptions to this and if in doubt staff must contact Infection Prevention & Control Team.

7 Monitoring Compliance With and the Effectiveness of Procedural Documents

7.1 Process for Monitoring Compliance and Effectiveness

Monitoring compliance with this policy will be the responsibility of the Lead CNS Infection Control. This will be undertaken by weekly review of incident forms by the Infection Control Team and daily operational oversight by Infection prevention and control Nurses during hours and out of hours by on-call Microbiologist.

For staff exclusion matters there will be case by case liaison with Occupational Health. Where non-compliance is identified, support and advice will be provided to improve practice. This may involve additional training to specific groups of staff; increased frequency of audit; and observation of clinical practice.

7.2 Standards/ Key Performance Indicators

Key performance indicators comprise:

- Reduction of the number of incident report forms relating to incidents of incorrect or lack of isolation of patients who require it
- No cases of serious respiratory pathogens being transmitted to secondary cases are reported.

8 Equality Impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age			X	
Disability			X	
Gender			X	
Gender Reassignment			X	
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment), marriage and civil partnership			X	
Pregnancy			X	
Maternity and			X	

Breastfeeding				
Race (ethnic origin)			X	
Religion (or belief)			X	
Sexual Orientation			X	

9 References

- Department of Health (2005) **Promoting Equality and Human Rights in the NHS - A Guide for Non-Executive Directors of NHS Boards**
- Department of Health (2007) **Saving Lives: Isolating Patients with Healthcare-associated Infection**. Department of Health. London
- Department of Health (2009) **The Health and Social Care Act 2008**. Department of Health. London
- **Disability Discrimination Act 1995 amended 2005**. London: The Stationery Office
- Frewin R., Richards D. (2004) **Protocol for the Management of Neutropenic Patients at North Devon District Hospital**. Northern Devon Healthcare Trust
- Heymann, D. (Ed) (2004) **Control of Communicable Disease Manual**. American Public Health Association. Washington, USA
- Mc Culloch, J. (Ed) (2001) **Infection Control Science, Management and Practice**. Whurr Publishers. London
- Siegel, J., Rhinehart, E., Jackson, M., Chiarello L. and the Healthcare Infection Control Practices Advisory Committee (2007) **Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings**. Centers for Disease Control (CDC) Atlanta, Georgia, USA.

10 Associated Documentation

- Bed Management Policy
- Decontamination Policy
- Food Hygiene Policy
- Gloves Policy
- Incident Reporting Policy
- Laundry Policy
- Outbreak of Infection Policy
- Prevention of Inoculation Injury Policy
- Specific Conditions Policies – Infection Control Manual
- Staff Screening and Immunisation Policy
- Standard Infection Control Precautions Policy
- Waste Policy

Appendix A – Type and Duration of Precautions Required for Specific Conditions - INPATIENTS

Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
AIDS (see HIV)					
Anthrax (pulmonary, systemic and cutaneous expressions of the disease)	Airborne and inoculation	Respiratory secretions, blood, wound exudate depending on disease symptoms	Contact (cutaneous cases)	Duration of disease	Inform Infection Control Hand-washing is preferable to alcohol based products which are not sporicidal.
Aspergillosis	Airborne (but not person to person spread)	Environmental sources		Do not isolate	Immuno-compromised patients at risk from spores raised in dust from building and agricultural work.
Botulism	Ingestion	Contaminated food		Do not isolate	No person to person spread.
Bronchiolitis/ RSV/ Croup	Airborne and contact	Respiratory secretions	Contact	Duration of disease	Respiratory protection for aerosol generating procedures

Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
Brucellosis	Ingestion (and direct contact in some occupations e.g. vets, farmers, abbatoir workers)	Contaminated milk or unpasteurised dairy products		Do not isolate unless draining lesion present	No person to person spread unless draining lesion present (use contact precautions)
Campylobacter	Ingestion (person to person spread is rare)	Diarrhoea	Contact	Until 48 hours symptom free of diarrhoea	Give hand and food hygiene advice especially if food handler
Candidiasis	Contact	Secretions from infected mucosal/ skin surface		Do not isolate	
Chickenpox/ Shingles	Airborne and contact	Respiratory secretions and/ or secretion from vesicles	Airborne and contact for Chickenpox, Contact for Shingles	Until vesicles become dry and crusted	Call Infection Control for advice on non-immune contacts
Chlamydiosis	Sexual and vertical (mother to child during birthing)	Sexual fluids		Do not isolate	

Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
Cholera	Ingestion	Contaminated food and water	Contact	Until 48 hours symptom free of diarrhoea	Inform Infection Control – food handlers may require microbiological clearance before return to work Notifiable
Clostridium difficile	Contact (faecal oral)	Diarrhoea	Contact	Isolate until 48 hours symptom free	Precipitated by antibiotic use Staff taking antibiotics should avoid caring for patients isolated with symptomatic C difficile infection.
Creutzfeld Jakob disease (CJD and vCJD – see Transmissable Spongiform Encephalopathies)	Inoculation including transplantation	Human tissues including CSF		Do not isolate	Inform Infection Control
CMV (Cytomegalovirus)	Contact	Saliva, urine, contaminated human tissues, vaginal secretions	Contact	Consider isolation of infected mothers/ babies in Maternity and SCBU	Inform Infection Control
Cryptococcosis	Airborne	Pigeon droppings – aerosolisation often during cleaning roosting sites		Do not isolate	Estates inform Infection Control before proceeding with pigeon clearance work

Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
Cryptosporidiosis	Ingestion	Contaminated food and water – person to person spread possible	Contact	Isolate until 48 hours symptom free of diarrhoea	Give hand and food hygiene advice especially to food handlers.
Dengue fever	Inoculation/ insect vector	Mosquitoes in affected geographical areas		Do not isolate as no person to person spread	
Diarrhoea and/ or vomiting (suspected or proven infection)	Contact (Droplet for profuse projectile vomiting)	Faeces Aerosolised vomit	Contact	Until 72 hrs symptom free (interpreted as 3 clear days)	Give hand and food hygiene advice especially to food handlers.
Diphtheria	Airborne and contact	Respiratory secretions	Airborne	Duration of positive culture status	Inform Infection Control Negative pressure isolation required Exclude non-immune visitors Notifiable
Dysentry (shigellosis)	Ingestion	Diarrhoea	Contact	Until 48 hours symptom free of diarrhoea	Inform Infection Control Notifiable

Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
Ebola virus (see VHF)	Blood and all body secretions	Blood and all body secretions	Airborne (as per national guidance)	Duration of illness	Inform Infection Control urgently for suspected or confirmed cases
Epiglottitis	Airborne	Respiratory secretions	Airborne	48 hrs after start of appropriate therapy	Prophylaxis required for households with a child under 4 years of age
Encephalitis (suspected airborne)	Contact	Faeces	Contact	Duration of illness	Notifiable
GISA (Glycopeptide Intermediate-resistant S. aureus)	Contact	Skin and contaminated body secretions	Contact	Isolate	Inform infection control, to obtain advice on decolonisation
Glandular fever	Contact	Saliva (kissing)	Contact	Do not isolate	
GRSA (Glycopeptide Resistant S. aureus)	Contact	Skin and contaminated body secretions	Contact	Isolate	Inform Infection Control
Hepatitis A	Ingestion	Diarrhoea and contaminated food	Contact	Until 48 hours symptom free of diarrhoea	Advise on food and hand hygiene especially with food handlers

Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
Hepatitis B	Inoculation and sexual	Blood, sexual fluids		Do not isolate	Consider vaccination for close contacts and provide advice about the risks of transmission
Hepatitis C	As B above				No vaccine available
Hepatitis D	As B above				No vaccine available
Hepatitis E	As A above				
Herpes simplex Type I & II	Contact with lesions and via shared towels	Lesion contact	Contact	Do not isolate	Single room may be required if patient has extensive lesions.
Herpes zoster	See Shingles				
HIV	Inoculation, sexual, vertical (mother to child)	Blood, sexual fluids, amniotic fluid, synovial fluid, breast milk		Do not isolate unless bleeding uncontrollably	
Infestations					
Human Fleas	**Contact** with patient and bedding and clothing		Contact	Duration of treatment	Recommend limiting visitors to those who have already had contact until treated Human fleas are extremely uncommon.

Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
Cat/dog fleas	**N/A**			Do not isolate	Treat animals and environment
Lice (Body)	Contact with patients, clothing, bedding, towels etc		Contact	Duration of treatment	Recommend limiting visitors to those who have already had contact until treated Body lice live in the seams of clothing.
Lice (Head)	Contact (head to head) and via shared combs, head wear, pillows		Contact	Duration of treatment	Advise visitors to avoid head to head contact
Lice (pubic)	Contact (usually sexual)		Contact	Do not isolate	As this is usually STD consider referral to GUM clinic for screening
Influenza	Airborne droplets and contact	Respiratory secretions	Airborne	Isolate while symptoms persist	Consider vaccination issues – inform Infection Control
Impetigo	Contact	Skin lesions	Contact	48 hrs after start of appropriate therapy	
Leishmaniasis	Inoculation (insect vector)	Blood		Do not isolate	

Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
Legionnaire's disease	Airborne	Aerosols from contaminated shower heads and cooling towers and air conditioning plant		Do not isolate	No person to person spread Notifiable
Leptospirosis	Contact with contaminated water via mucous membranes	Contaminated food and water		Do not isolate (unless incontinent of urine)	Notifiable
Leprosy	Contact	Respiratory secretions	Contact	Isolate until 3 days (rifampicin) or 3 months (dapsone or clofazimine) of effective therapy	Notifiable
Listeriosis	Ingestion	Contaminated foods (particularly soft cheeses and pate)		Do not isolate	Food advice to pregnant women and elderly
Lyme disease	Inoculation/ insect vector	Tick bite		Do not isolate	Educate on tick bite prevention (use of long trousers on grassy/ bracken upland areas)
Malaria	Inoculation/ insect vector	Bites from infected mosquitoes		Do not isolate	

Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
		Blood			
Marburg virus (see VHF)	Inoculation and contact	Blood and all body secretions	Airborne (as per national guidance)	Strict isolation – **negative pressure**	Inform Infection control urgently for suspected and confirmed cases Notifiable
Measles	Airborne and contact	Respiratory secretions	Airborne	Isolate until 4 days after appearance of rash	Contact precautions Notifiable
Meningococcal meningitis and septicaemia	Airborne	Respiratory secretions		Isolation not required for control of infection – consider single room for patient comfort	Use standard surgical facemask for airway management tasks until completion of the first 24 hours of antibiotic therapy. Inform Infection Control of known or suspected cases so contact tracing can be completed. See Outbreak Policy Notifiable
Mononucleosis (glandular fever)	Contact	Saliva		Do not isolate	Educate on intimate contact (kissing) and hand

Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
					hygiene
MRSA	Contact	Skin scales and body fluids	Contact	See Outbreak Policy	See Outbreak Policy
Multi-resistant organisms	Contact	Commonly contact with contaminated body fluids notably urine – but will vary according to organism and condition	Contact	Isolate initially– but call Infection Control to discuss each case individually	Described as 'very resistant isolate' on laboratory report form– Call Infection Control to discuss management, isolation may not be necessary in all cases
Mumps	Airborne and contact	Respiratory secretions	Airborne	Isolate until 9 days after onset of swelling	Notifiable
Mycoplasma pneumonia	Airborne	Respiratory secretions	Airborne	Isolate until 10 days after onset	Patients are usually no longer infectious by the time the diagnosis is confirmed
Polio	Contact	Respiratory secretions and faeces	Contact	Isolate until 7 days after onset	Notifiable Virus may persist in faeces for up to 3-6 weeks
Psittacosis	Airborne	Respiratory secretions		Do not isolate	Person to person spread very rare
PUO – Pyrexia of Unknown Origin	As cause unknown	Respiratory secretions,	Airborne and	Review when diagnosis	Malaria, typhoid and Hepatitis A are the

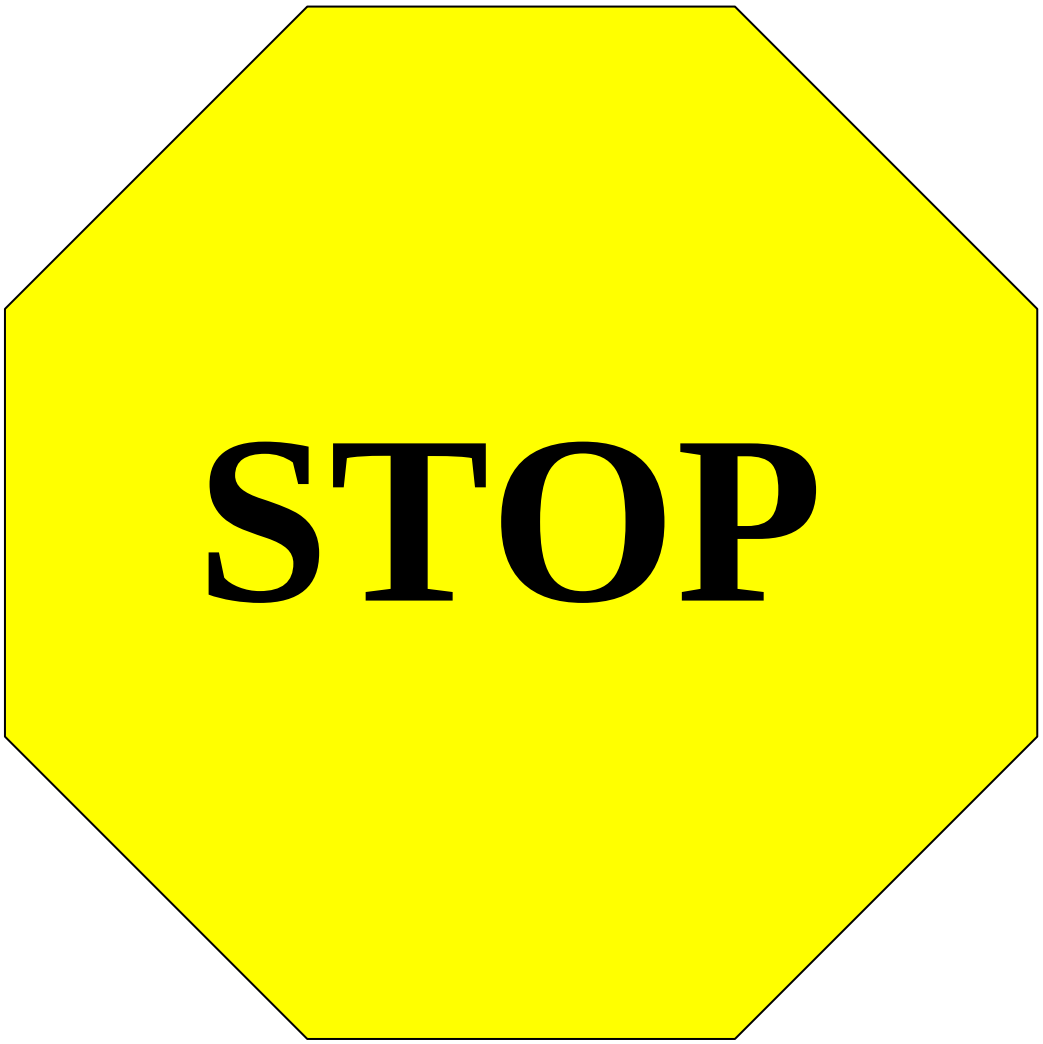
Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
with recent travel abroad	airborne and contact routes must be considered	all body fluids	contact	confirmed	commonest causes of PUO in returned travellers BUT always consider possibility of Viral Haemmorhagic Fever. Also refer VHF guidance
Rabies	Contact via percutaneous exposure to saliva Droplets of saliva to conjunctiva/mucosa.	Saliva	Contact; masks and eye protection if coughing	Until clinical recovery	NOTIFIABLE DISEASE Contact Microbiologist and Infection Control Team if suspected. Person to person transmission is only a theoretical risk but because of the implications of acquisition strict adherence to isolation precautions must be observed.
Ringworm (extensive)	Contact with skin scales, nail and hair and via associated equipment e.g. hair clippers, shavers	Skin	Contact		Own bath shower facilities desirable.
Rubella	Airborne	Respiratory secretions	Airborne	Isolate from 7 days after contact and until at least 4 days after onset of rash	Notifiable

Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
Scabies	Prolonged skin to skin contact	Skin	Contact	Isolation until first treatment completed	See Scabies policy
Norwegian/crusted scabies	skin to skin contact	**Skin scale and bedding**	Contact	Isolation until second treatment completed	See Scabies policy
Smallpox	Contact with vesicles Airborne via respiratory droplet nucleii	Respiratory secretions and vesicle fluid	Airborne and contact	Until informed by the Infection Control Team	NOTIFIABLE DISEASE CONTACT MICROBIOLOGIST AND INFECTION CONTROL IMMEDIATELY ON SUSPICION Implement Major Incident Plan
Streptococcus Group A	Contact and airborne	Wound discharges Respiratory secretions	Contact	48 hrs after start of appropriate therapy	
Streptococcal Group B (Neonatal)	Contact via faeces, skin sites	Faeces and skin	Contact	Do not isolate	
Syphyllis					
Early congenital Primary Secondary	Contact with lesions, secretions, blood	Lesions secretions and blood	Contact	24 hrs of effective therapy	

Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
Latent & Late	No person to person spread				
Tuberculosis (pulmonary)	Airborne and contact	Respiratory secretions	Airborne	Isolate - see Outbreak Policy – see also TB policy	Airborne precautions (see Outbreak Policy) Inform Infection Control Notifiable
Typhoid/ Paratyphoid	Contact (faecal-oral)	Faeces	Contact	Isolate until 48 hrs after formed stool	Inform Infection Control Notifiable
Typhus	Insect vector	Infestation with lice, or bites from fleas carrying infective organism	Contact	Until infestation treated	Contact precautions Notifiable
Very resistant isolate (as described on laboratory report form) – see Multi-resistant Organisms	Contact	Contaminated body fluids – commonly urine	Contact	Isolate initially	Contact Infection Control to discuss individual case management – isolation may or may not be necessary
Viral haemorrhagic fevers (VHF)	Contact and airborne	Blood/ body fluids/ respiratory secretions	Airborne (as per national guidance)	Duration of disease/ 7 days after starting antibiotics	See VHF Policy Notifiable

Disease or Organism	Method of Spread	Infective Material	Precautions required	Duration of Isolation	Comments
					Inform Infection Control
VRE (Vancomycin Resistant Enterococcus)	Contact	Contaminated body secretions – mostly faeces, wound exudate, urine	Contact	Isolate	Inform Infection Control Contact precautions
VRSA (Vancomycin Resistant S. aureus) – see GRSA	Contact	Skin and contaminated body fluids	Contact	Isolate	Inform Infection Control Contact precautions
Whooping Cough	Airborne	Respiratory secretions	Airborne	Isolate until 7 days after starting antibiotics	Notifiable
Yellow Fever	Contact - percutaneous exposure	Blood	Contact	5 days after onset	Notifiable

Appendix B - Isolation Precautions Door Sign



PLEASE SEE NURSE IN CHARGE BEFORE ENTERING

Appendix C - Guidelines for management of staff with infection or exposure to infection

Guidelines for management of staff with infection or exposure to infection

Key to abbreviations used throughout the text:
CMM: Consultant Medical Microbiologist
IP: Incubation period i.e. the interval between contact with the infection and the development of the symptoms and signs of infection
PC: Period of Communicability i.e. the time during which the person is infectious to others

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
CAMPYLOBACTER	IP: 1-11 days PC: variable	Eating or handling of contaminated food or water. Person to person spread is not a common mode of spread	Exclude until symptom free (formed stool) & feels well. NO CLEARANCE SPECIMENS NEEDED	None		
CAT SCRATCH FEVER	IP:3-14 days PC: Unknown Not directly transmitted from person to person	Scratch/bite/lick or other exposure to a healthy, usually young cat/kitten	No restriction	None		Rare disease mainly affects children/young adults

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
CLOSTRIDIUM DIFFICILE		Faecal oral route – spores may be present in both liquid stool and scattered in the environment of an isolation room	Exclude from work until 2 clear days symptom free	None		Staff taking antibiotics should avoid caring for patients isolated with symptomatic C difficile infection.
CHICKENPOX (VZV) (see also "Shingles") Exposure defined as patient contact for more than 15 minutes or face to face contact (conversation)	IP: 10-21 days (infectious for 1-2 days before rash appears) PC: until last crop of vesicles have dried	Respiratory	Exclude until last crop of vesicles / lesions have dried	a) If VZV immune on serology: no action b) If staff state they have had VZV: no action c) If VZV antibody negative: contact infection control who will assist in risk assessment	Pregnant staff should not care for patients with this infection but if exposed, contact infection control team to discuss investigation as there is a potential risk to baby's health. If no history of chickenpox then test for IgG and exclude until result.	If VZV antibody negative: inform infection control. Susceptible staff should not work with patients with chickenpox or zoster. Vaccine available.

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
					Discuss with CMM if IgG neg and exposure to vesicles / lesions or exposure 2 days before vesicles / lesions	
COLD SORE	See Herpes Simplex Type 1					
CONJUNCTIVITIS - acute bacterial	IP: Usually 24 - 72 hours PC: during the course of active infection	Contact with discharges from the conjunctivae or upper respiratory tracts of infected persons	Exclude until acute symptoms resolved	None		Good handwashing especially after contact with eyes will prevent spread. Treatment of affected eyes is essential
CONJUNCTIVITIS - Adenoviral (red-eye)	IP: Usually 4 - 12 days PC: during the course of infection	Direct contact and contact with surfaces contaminated by eye secretions	Exclude until acute symptoms resolved	None		Good handwashing especially after contact with eyes will prevent spread.
CYTOMEGALOVIRUS (CMV)	IP: Variable - depends on mode of acquisition. Typically 3 - 6 weeks	Contact with breast milk, saliva, body fluids, blood	No restriction	None	Pregnant staff should not care for patients with this infection	Acute illness in adults may last 2 - 3 weeks. CMV is not easily transmissible -

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
	PC: variable				but if exposed contact infection control team to discuss investigation as there is a potential risk to baby's health.	attention to good hand hygiene
DIARRHOEA AND OR VOMITING OF UNKNOWN CAUSE (EG Viral gastroenteritis)	IP: Variable PC: depends on cause	Usually faecal oral (faeces to mouth) Halation of infected droplets from close contact with symptomatic individual	Exclude until symptom free and feels well. (48 hours) (If symptoms persist, request specimen)	Report to Occupational Health & Infection Control if symptoms develop		***In an outbreak situation, as defined by Infection Control, it is important that staff are advised to remain off work until 48 hours asymptomatic***
DIPHTHERIA	IP: 2 - 5 days PC: Variable	Respiratory & direct contact	Exclude until culture negative	Surveillance swabs, antibiotic & booster vaccine may be required		Inform Department of Public Health & Infection Control
E.COLI 0157	IP: 12-72 hours PC: during diarrhoeal stage and several days thereafter	Faecal - oral	Exclude until 3 negative stool specimens	Suggest stool culture for E coli 0157. If positive - discuss with infection control		

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
FIFTH DISEASE (see Parvovirus B19)						
GIARDIA	IP: 5-25 days, usually 7-10 days PC: variable	Faecal - oral	Exclude until stools are formed	None		Advise good handwashing after using toilet & before patient/food contact
GROUP A STREPTOCOCCAL INFECTION (can manifest as: - Tonsilitis - Scarlet fever - Scarletina - Infected skin lesions)	IP: 2 - 4 days PC: 10 - 21 days in untreated conditions	Direct contact via hands	Exclude until 24 hours of antibiotics. Exclusion is particularly important if staff member works in Maternity, SCBU, burns unit, operating theatres	Exclusion only if they develop symptoms. If so, obtain specimen e.g. throat swab		Good handwashing should be emphasized
GLANDULAR FEVER (Infectious Mononucleosis / Epstein-barr virus)	IP: 33 - 49 days PC: Pharyngeal excretion of virus may persist for a year or more after infection	Close contact with pharyngeal secretions: kissing	May return to work once staff member feels well enough to do so	None		Reinforce good hand hygiene

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
HAND, FOOT AND MOUTH DISEASE (enterovirus)	IP: 3 - 5 days PC: during acute stage of illness	Direct or close contact with nasal or throat secretions and faeces & aerosol droplet spread	Exclude whilst skin lesions / blisters present or until well. If working in a high risk area (see introduction for definition) - contact ICT	None, but advise to observe for symptoms and report to GP / Occupational Health if confirmed		Encourage good hygiene when caring for family members with disease, particularly hand washing. Largely a disease of infants. Most adults are immune.
HEPATITIS A	IP: 15 - 50 days (average 25 - 30 days) PC: 1 week before symptoms until the 7th day after onset	Faecal - oral	Exclude until 7 days after onset of jaundice and feels well	None		Notify Public Health who will consider immunoglobulin or vaccine for high risk (household) contacts
HEPATITIS B					Contact infection control team to discuss investigation as there is a potential risk to baby's health	***Refer to specific guidance from Department of Health re blood borne viruses & health care workers***

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
HEPATITIS C					Contact infection control team to discuss investigation as there is a potential risk to baby's health	***Refer to specific guidance from Department of Health re blood borne viruses & health care workers***
HERPES SIMPLEX TYPE 1 (cold sores; Herpetic whitlow)	IP: 2 - 12 days (or reactivation) PC: variable	Contact with infected secretions (usually saliva)	Cold sores: In **general areas:** No exclusion, but **STRICT ATTENTION TO HAND HYGIENE.** In **high risk** areas (see definition) stay off work until 24 hours of aciclovir or until vesicles area dry. Whitlow; exclude until lesions fully healed	None		Advice may vary according to where staff member works/how large the lesions are, duration of antiviral therapy. Infection control will advise
HIV						***Refer to specific guidance from Department of Health re blood borne viruses & health care workers***

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
IMPETIGO (Staphylococcus aureus / Group A Streptococcus)	IP: variable & indefinate (4 - 10 days) PC: as long as purulent lesions continue to drain	Direct contact	Exclude until lesions are dry and non-draining. (or 24 hours after treatment)	None		
INFLUENZA see: Respiratory symptoms - generalised						
LICE	IP: 7 - 10 days PC: As long as lice or eggs remain viable on the infested person or families (may survive 7-10 days away from host)	Direct or close contact / head to head contact	No restriction (Advise combing of hair / treatment)	None. If a family contact, should comb/treat hair		Brushing / combing hair at night can reduce numbers of head lice

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
MALARIA	IP: Usually 10 - 15 days PC: Variable	Via the mosquito in endemic areas. Unlikely to be by direct spread from person to person. Can be transmitted by percutaneous needlestick injury in clinical settings	No restriction	None		
MEASLES	IP: 7 - 18 days PC: 3 - 5 days before rash appears, to 4 days after	Respiratory droplets	Exclude until clinically recovered (at least 4 days after rash appeared)	If immune: no action If not immune & working in high risk area (see definition in introduction), contact Infection Control & Occupational Health	Pregnant staff should not care for patients with this infection but if exposed, contact infection control team to discuss investigation as there is a potential risk to baby's health	

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
MENINGOCOCCAL DISEASE	IP: 1 - 10 days, usually 3 - 4 PC: Meningococci are killed rapidly by one dose of appropriate antibiotic	Close (household) contact / also "kissing" contact	Can return to work when well following appropriate antibiotic	None. If household contact: Public Health/CCDC will advise		
MOLLUSCUM CONTAGIOSUM	IP: 7 days to 6 months PC: unknown, probably as long as lesions persist	Direct contact and sexual transmission	No restriction	None		Viral disease of the skin (usually children)

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
MRSA	**Not relevant**	Direct contact	No restriction unless shown to cause cross infection	None		Staff are not routinely screened for MRSA. Ordinarily, carriage of MRSA will not result in staff absence from work providing staff are meticulous with handwashing. Treatment may be required for carriage in staff with skin lesions / psoriasis who would be assessed by OHD and ICT on individual basis

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
MUMPS	IP: 12 - 25 days PC: 7 days before onset of parotid swelling until 9 days after onset	Respiratory droplets	Until clinical recovery (at least 9 days after parotid swelling)	If household contact: establish immunity. If imune: no exclusion needed. If non-immune & working in a high risk area (see definition) exclude from day 10 to day 25 after exposure after discussion with Infection Control	Pregnant staff should not care for patients with this infection but if exposed, contact infection control team to discuss investigation as there is a potential risk to baby's health	
PARAINFLUENZA See respiratory symptoms - generalised						

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
PARVOVIRUS B19 (slapped cheek syndrome) Fifth disease	IP: 6 - 14 days PC: 7 - 10 days before onset of rash (not infectious once rash is apparent)	Respiratory droplets	Until staff member feels well. NB: if staff member works in maternity or with immunocompromised patients contact ICT	None	. Pregnant staff should not care for patients with this infection but if exposed, contact infection control team to discuss investigation as there is a potential risk to baby's health. Check IgG discuss with CMM (consider checking booking bloods if IgG negative	There is no effective treatment or prophylaxis after exposure. Pregnant women and patients with sickle cell disease should avoid contact with known cases
PERTUSSIS (see whooping cough)						
PITYRIASIS ROSEA						

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
RESPIRATORY SYMPTOMS - generalised (includes colds / sore throat / influenza)	IP/PC variable	Respiratory droplets & contact via hands to mucous membranes (eyes / nose etc)	***If staff member works in high risk area ie with immuno-compromised patients - consider exclusion whilst symptoms persist***	None	Pregnant staff should not care for patients with known or suspected influenza infection but if exposed there is a potential risk to Mother's and baby's health. Contact CMM	
RING WORM						
RUBELLA	IP: 14 - 23 days PC: from 7 days before rash to 5 days after onset	Respiratory droplets	Exclude until clinically recovered (at least 5 days after rash appeared)	Check Rubella titre. If non-immune: exclude from day 7 to day 21 after exposure. Vaccinate if working with pregnant women	Pregnant staff should not care for patients with this infection but if exposed, contact infection control team to discuss investigation as there is a potential risk	Contact Infection Control

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
					to baby's health	
SALMONELLA (see also Typhoid / Paratyphoid)	IP: 12 - 72 hours PC: throughout the course of infection	Eating or handling of contaminated food (faecal - oral)	Until symptom free and feels well. No clearance specimens needed	None		
SCABIES	IP: –1-12 weeks (1 - 4 days in those with previous scabies) PC: Until 24 hours after treatment	Close and prolonged skin to skin contact (more than a few minutes)	Treat. May return to work after 24 hours	None - but advise treatment if household contact		Staff should wear gloves and long sleve gowns when in contact with a patient with scabies or suspected scabies
SHIGELLA (Bacillary dysentery)	IP: 1 - 7 days PC: during acute infection (can be up to 4 weeks)	Faecal - oral	Exclude until symptom free and feels well. No clearance specimens needed	None		Advise meticulous hand hygiene
SHINGLES	PC: Until all lesions dry & crusted		On an UNEXPOSED AREA: No exclusion needed: unless working with immuno-compromised patients/neonates. If on an EXPOSED area: exclude from work until vesicles have dried	If VZV immune: No action Exclude if not immune, a significant contact has occurred and working in a high risk area (see definition in introduction), and inform Infection	Pregnant staff should not care for patients with this infection but if exposed, contact infection control team to discuss	

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
				Control	investigation as there is a potential risk to baby's health If no history of chickenpox then test for IgG and exclude until result. Discuss with CMM if IgG neg and exposure to vesicles / lesions or exposure 2 days before vesicles / lesions	
STDs (including Gonococcal infection, Syphilis, Herpes simplex type 2, genital human papillmavirus, bacterial vaginosis, chylamydia)	IP: Varies, depending on specific disease	***Sexual contact***	None	None		Emphasize basic hygiene precautions such as handwashing
TINEA						

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
TUBERCULOSIS (PULMONARY)	IP: From infection to positive skin test or active TB disease usually 4 - 12 weeks PC: depends on result of sputum test. If smear positive and productive cough - very infectious	Respiratory. Prolonged, close intimate contact with a person with "open" TB	Exclude until 2 weeks after treatment. NB: Consult Chest Physician or Infection Control Doctor to confirm period of exclusion (may vary)	None, but if "close contact" may need skin test and Occupational Health follow up		Check records for immunity
TYPHOID / PARATYPHOID	IP: 1 - 3 weeks PC: Variable	Faecal - oral	Exclude until 3 negative stool specimens. NB: FOODHANDLERS: 6 negative specimens over 12 weeks	None. Send stool sample for screening if a family member has typhoid		

Disease / infection	Incubation period/Period of communicability	How it's spread	Work Restriction / Exclusion			General Comment
			Staff diagnosed with disease / infection	Staff in contact with disease / infection but no symptoms	Pregnant Staff in contact with disease / infection	
WHOOPING COUGH (Pertussis)	IP: 5 - 21 days PC: From beginning of catarrhal stage until completion of 5 days antibiotics (may last 3 weeks if antibiotics not taken)	Respiratory droplet	Exclude until 5 days of antibiotics (and when feeling well)	The acquisition of pertussis by staff is very unusual and should it occur results in mild illness only. If any staff member develops an unusually prolonged (7 days) or severe respiratory illness and has had contact with untreated cases of pertussis, the Occupational Health Department should be informed		Encourage meticulous hand hygiene