Infection Prevention and Control

Chicken Pox and Varicella Policy
<table>
<thead>
<tr>
<th>Policy Title:</th>
<th>Chicken Pox and Varicella Policy</th>
</tr>
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<tbody>
<tr>
<td><strong>Executive Summary:</strong></td>
<td>This policy aims to promote awareness of Chicken Pox and shingles and enable early identification, and isolation of patients, which are all essential steps in reducing the risk of infections, to improve patient and staff safety</td>
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<tr>
<td><strong>Supersedes:</strong></td>
<td>Chickenpox and Varicella Policy 2012</td>
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<tr>
<td><strong>Description of Amendment(s):</strong></td>
<td>Updated to reflect National Guidelines</td>
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<tr>
<td><strong>This policy will impact on:</strong></td>
<td>Clinical Staff</td>
</tr>
<tr>
<td><strong>Financial Implications:</strong></td>
<td>Increased Screening due to identification of new cases</td>
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</tbody>
</table>

| **Policy Area:** | Infection Prevention and Control Trust Wide |
| **Version Number:** | V2 |
| **Effective Date:** | September 2015 |
| **Issued By:** | Infection Prevention and Control Group |
| **Review Date:** | October 2017 |
| **Authors:** | Anita Swaine  
Lead Nurse Infection Prevention and Control |
| **Impact Assessment Date:** | September 2015 |

**APPROVAL RECORD**

<table>
<thead>
<tr>
<th>Committees / Group</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation:</td>
<td>Infection Prevention and Control Group</td>
</tr>
<tr>
<td>Approved by:</td>
<td>DIPC</td>
</tr>
<tr>
<td>Received for information:</td>
<td>Service Line SQS Groups</td>
</tr>
<tr>
<td>Contents</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>1 Introduction</td>
<td>4</td>
</tr>
<tr>
<td>2 Purpose</td>
<td>4</td>
</tr>
<tr>
<td>3 Roles &amp; Responsibilities</td>
<td>4</td>
</tr>
<tr>
<td>4 Organism and disease process</td>
<td>5</td>
</tr>
<tr>
<td>4.1 Chickenpox</td>
<td>5</td>
</tr>
<tr>
<td>4.2 Shingles</td>
<td>7</td>
</tr>
<tr>
<td>5 Infection control Precautions</td>
<td>8</td>
</tr>
<tr>
<td>5.1 Isolation</td>
<td>8</td>
</tr>
<tr>
<td>5.2 Hand Hygiene</td>
<td>9</td>
</tr>
<tr>
<td>5.3 PPE</td>
<td>9</td>
</tr>
<tr>
<td>5.4 Linen</td>
<td>9</td>
</tr>
<tr>
<td>5.5 Waste Disposal</td>
<td>9</td>
</tr>
<tr>
<td>5.6 Environmental Clean</td>
<td>9</td>
</tr>
<tr>
<td>5.7 Patient Transfer</td>
<td>9</td>
</tr>
<tr>
<td>5.8 Post Infection Clean</td>
<td>10</td>
</tr>
<tr>
<td>6 Management of individuals following significant exposure</td>
<td>10</td>
</tr>
<tr>
<td>7 Maternity/ Neonatal Unit</td>
<td>10</td>
</tr>
<tr>
<td>8 Training</td>
<td>10</td>
</tr>
<tr>
<td>9 Monitoring compliance</td>
<td>11</td>
</tr>
<tr>
<td>Legislation, Guidance and References</td>
<td>12</td>
</tr>
<tr>
<td>Equality and Human Rights Policy Screening Tool</td>
<td>13</td>
</tr>
</tbody>
</table>
1. **Introduction**

The Health and Social Care Act 2008 (DH2015) requires healthcare providers to ensure that systems and processes are in place to identify people who are at risk of developing an infection and implement appropriate management plans to prevent the transmission to others.

Chickenpox (varicella) is a highly infectious disease caused by the varicella zoster (VZ) virus. The incubation period is between 10-21 days. Chickenpox usually confers lifelong immunity, although the virus persists in a latent form in the sensory nerves. Reactivation of the latent varicella virus in later life results in shingles (Herpes zoster). It is not known what causes the virus to reactivate; reactivation can be spontaneous or follow a period of physical illness or stress.

Immunization against varicella is available. It is Trust policy to offer varicella immunisation to staff as part of the Occupational Health immunisation schedule.

2. **Purpose**

The purpose of this policy is to ensure that all East Cheshire NHS Trust staff working in hospital and community settings are aware of the management of patients with chickenpox or shingles and receive appropriate care in line with national guidance and best practice. In addition this policy is to ensure that other susceptible patients, staff; visitors are protected against the risk of cross infection from known cases of chickenpox or shingles.

3. **ROLES & RESPONSIBILITIES**

3.1 **Responsibilities**

- **The Chief Executive** has ultimate responsibility for the implementation and monitoring of the policies in use in the Trust. This responsibility may be delegated.

- **The Director of Nursing, Performance and Quality/ Director of Infection Prevention and Control (DIPC)** will take the lead responsibility for the development and implementation of this policy with support of the Lead Nurse Infection Prevention and Control and the Infection Prevention and Control Doctor. In addition as the DIPC they will oversee the implementation of the policy, challenge poor practice. Providing assurance to the board that systems and process are in place to ensure compliance with agreed standards.

- **The Infection Prevention and Control Team (IPCT)** will have responsibility for ensuring the policy is implemented and monitored across the Trust in addition they will ensure compliance with any national initiatives or directives. Providing and supporting a sustainable programme of audit and education across the health economy.

- **All Employees** are responsible for ensuring standards of Infection Prevention and Control is maintained in line with Trust policy and procedures. Infection Prevention and Control training and standards will be monitored via the appraisal process.
### 4. Organism and disease process

#### 4.1 Chickenpox

<table>
<thead>
<tr>
<th>Causative organism</th>
<th>Chickenpox, Varicella Zoster virus (VZV)</th>
</tr>
</thead>
</table>
| Clinical Presentation       | • May initially begin with flu-like symptoms  
                              • Raised temperature  
                              • Intensely itchy vesicular rash. Clusters of vesicular (blisters) spots appear over 3-5 days, which start on the face and scalp, spread to the trunk, abdomen and limbs.  
                              • It is possible to be infected but show no symptoms.  
                              • Diagnosis can usually be reliably made on clinical examination; swabs/specimens are not usually required. |
| Incubation period           | 10-21 days.                               |
| Period of infectivity       | 1-2 days before the onset of the rash until the vesicles (blisters) are dry/crusted which is usually 4 - 5 days after the onset of rash. This may be prolonged in immunosuppressed patients. susceptible individuals should be considered infectious for a period of 10-21 days |
| Mode of transmission        | • Direct contact with an infected person,  
                              • Droplet or aerosol spread from vesicular fluid from skin lesions.  
                              • Secretions from the respiratory tract (the virus enters the individual through the upper respiratory tract).  
                              • Indirectly via contaminated articles e.g. clothing / bedding. |
| Period of communicability   | Up to 4 days but usually 1-2 days before the rash appears and until vesicles have crusted over. |
| Groups susceptible to chickenpox | Most commonly seen in children under ten years old. In healthy children the illness is usually mild with no complications.  
                                Non immune adolescents and adults are at increased risk of severe disease. |
| Definition of a significant exposure to chickenpox | Non immune individuals who have had:  
                                • Contact in the same room as a person with chickenpox (e.g. in a house, classroom or within a hospital bay) for a significant period of time (15 minutes or more).  
                                • Face to face contact (more than 5 minutes), |
with a person with chickenpox for example while having a conversation (remember that they may be infectious up to 48 hours before the rash appears).

### Management of patients exposed to chickenpox

- Patients who have had significant contact with a person who has chickenpox should be assessed by a clinician to determine the risk they may have of contracting chickenpox.
- In an exposed individual it may be appropriate using a combination of vaccination and immunoglobulin to prevent the onset of symptoms. Information on prophylaxis can be found in The Green Book: chapter34
- Advice may be sought from a Consultant Microbiologist if required.
- Further advice can be obtained from the Infection Prevention and Control Team especially if transmission is suspected.

### Groups at increased risk of severe disease

- Pregnant women
- Neonates-born to non-immune mothers who have been exposed to chickenpox or shingles in the first month of the baby’s life
- Immunocompromised patients, including but not limited to:
  - Patients on long term steroids
  - Patients with symptomatic HIV/AIDS
  - Persons who have received a bone marrow transplant in the last 6 months.

### Complications

- Secondary bacterial infections of skin lesions
- Pneumonia,
- Encephalitis

### Immunity

The majority of people will have been infected in childhood and remain immune to chickenpox for life.

### Vaccine preventable

Yes, clinical staff who are concerned about their immunisation status should speak to Occupational Health who will advise them of their immunity and assess the need for immunisation as per Occupational Health Policy.

### Treatment

- Antiviral treatment started within 24 hours of the onset of rash may reduce the duration and severity of symptoms in otherwise healthy adults and adolescents.
- Immunocompromised individuals will also certainly benefit from treatment with IV acyclovir this should be discussed with the Consultant Microbiologist.
It may be appropriate to prescribe prophylaxis with Varicella Zoster immunoglobulin (VZIG) in asymptomatic individuals at higher risk of developing severe disease further advice must be sought from the Consultant Microbiologist.

**Notifiable Disease**

No, however the Infection Prevention and Control team must be informed to support staff in the management of patients and contacts.

### 4.2 Shingles (Varicella Zoster Virus)

<table>
<thead>
<tr>
<th>Causative organism</th>
<th>Shingles/ Varicella Zoster virus (VZV)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Presentation</strong></td>
<td>Previous infection with chickenpox is necessary before a person can develop shingles. It appears following reactivation of chickenpox virus which lies dormant in dorsal root ganglia (spinal nerve tissue) – often for decades.</td>
</tr>
<tr>
<td></td>
<td>• Pain in the area of the affected nerve is often the first symptom followed by a dermatomal (one sided) rash of fluid filled vesicles (blisters).</td>
</tr>
<tr>
<td></td>
<td>• Diagnosis can usually be reliably made on physical examination; swabs/specimens are not usually required</td>
</tr>
<tr>
<td><strong>Period of infectivity</strong></td>
<td>From the appearance of vesicles until all vesicles have crusted over.</td>
</tr>
<tr>
<td><strong>Mode of transmission</strong></td>
<td>• Direct contact with an infected persons vesicles fluid which is then transferred by the mucous membranes of a non-immune individual.</td>
</tr>
<tr>
<td><strong>Groups susceptible to Shingles</strong></td>
<td>Individuals who have had chickenpox previously may develop shingles at any time in their lives although it does seem to be associated with older age and conditions which suppress the immune system including stress.</td>
</tr>
<tr>
<td><strong>Management of patients exposed to Shingles</strong></td>
<td>Patients who have had significant contact with a person who has shingles should be assessed by a clinician to determine the risk they may have of contracting chickenpox. Further advice must be sought from the Consultant Microbiologist for patients who are immunocompromised as Varicella vaccine may be appropriate.</td>
</tr>
<tr>
<td></td>
<td>Further advice can be obtained from the Infection Prevention and Control Team especially if transmission is suspected.</td>
</tr>
</tbody>
</table>
Groups at increased risk of severe disease
- Pregnant women and their baby, when the woman has no immunity to chickenpox (a pregnant woman who has shingles presents no risk to her unborn baby).
- Neonates born to non-immune mothers who come into direct contact with a person with shingles may develop chickenpox
- Immunocompromised individuals may suffer more severe and prolonged

Vaccine preventable
Yes, Individuals over 70 years of age have been offered a vaccine since 2013.

Treatment
- Shingles can be effectively treated with oral antiviral drugs; systemic antiviral treatment can reduce the severity and duration of pain, reduce complications, and reduce viral shedding.

  Treatment should be started within 72 hours of the onset of rash usually for 7-10 days.

  - Immunocompromised patients at high risk of severe infection should be treated with a parenteral antiviral drug. Further advice must be sought from the Consultant Microbiologist.

Notifiable Disease
No, however the Infection Prevention and Control Team must be informed, to support staff in the management of patients and contacts

(NB: This policy should be read in conjunction with the Hand Hygiene and Universal Precautions for Infection Prevention and Control Policy).

5 Infection control Precautions
5.1 Isolation
- Patients with Chickenpox/Shingles must be nursed in a side room until all spots/vesicles have dried and crusted, and no new crops have appeared for patients with Chickenpox. A risk assessment must be undertaken by the Nurse in Charge of the ward to establish clinical priority for allocation of a side room.
- Patients who are immunocompromised may require a longer period of isolation.
- Patients can be discharged to their own homes if medically fit. They should be advised to avoid contact with non-immune people until their lesions are dried and crusted.
- Patients with shingles can be discharged home if medically fit, they may not necessarily be required to stay off work e.g. if the rash can be covered with dressings or clothing, and they can comply with strict hand hygiene advice and are not working with people at high risk of contracting chickenpox.
- Clinical staff diagnosed with symptoms of shingles or chickenpox must contact Occupational Health for advice on continuing to work.
5.2 Hand Hygiene
- All clinical staff must decontaminate their hands before and after any patient contact, or with contact with the patient environment. This must be done with liquid soap and water or alcohol hand gel as per the Trust Hand Hygiene policy.
- Patients must be offered hand hygiene facilities prior to eating and after using the toilet or commode (This must occur for all patients regardless of their infection status).
- Visitors/ Carers must also be asked to wash their hands on entering and leaving the side room and if they are undertaking any patient contact.

5.3 Personal Protective Equipment (PPE).
- All healthcare staff must wear single use gloves and aprons when in contact with the patient or their environment. PPE to be applied before entering the isolation room and removed inside the isolation room followed by hand decontamination before exiting the room.
- Visitors are not required to wear PPE unless giving direct patient care.

5.4 Linen
- Patient’s bed linen must be changed on a daily basis. Relatives should be asked to provide clean night attire and towels as part of this daily change.
- Used linen to be placed in a red alginate bag and then into a white outer bag. Used linen to be removed from the isolation room and disposed of as quickly as possible.
- Patients own clothing can be washed as normal on the hottest temperature for the fabric. This should be placed in the patients locker and relatives asked to take home as soon as practicable.

5.5 Waste disposal – waste to be placed into clinical waste bin in patient’s room as per Trust policy, this must be emptied twice daily.

5.6 Environmental Cleaning
- Once a patient is moved into isolation ISS must be informed via the hotline number 1999 that “infection cleaning” is required.
- All horizontal, vertical surfaces including frequent touch point areas for example bedside tables, door handles must be cleaned twice daily using a sporicidal product e.g. Tristal.
- Dedicated equipment must be used for patients requiring isolation, however this will not always be practicable for example hoists. On these occasions the equipment must be cleaned immediately after use. (It may be necessary to refer to the manufacturer’s instructions for any specialist equipment to ensure correct decontamination occurs). For the majority of items commodes, chairs, Tristal or sporicidal wipes will be appropriate.
- As far as practicable keep items to a minimum in the side room, this includes patient’s personal items, it may be appropriate to request extra items are sent home.

5.7 Patient Transfer
- Patients diagnosed with Shingles or Chicken Pox should not be identified as an outlier to other clinical areas. If they require transfer due to their clinical condition the receiving area must be informed of their infection status and they must be transferred into a side room.
5.8 Post Infection Clean
- Contact ISS on 1999 to request a post infection clean, this should include the time the room will be available to clean.
- Nursing staff to remove and clean any dedicated equipment from the room.
- All unused dressings to be disposed of.

6 Management of individuals following significant exposure
Patients identified as high risk of developing serious complications from Chickenpox or shingles need to be risk assessed as they may need antiviral drugs and or prophylactic immunoglobulin (VZIG), this should be done in liaison with the Consultant Microbiologist. This may prevent the patient developing severe illness. Patients in this group include:

- Immunocompromised patients
- Pregnant woman (pregnant staff members should not care for patients with Chickenpox unless they know their immune status).

The purpose of post exposure management is to protect the high risk individual from developing severe chickenpox and reduce the risk of transmission to others.

VZIG is a blood product therefore the nature of this preventative treatment MUST be discussed with the patient by their Consultant prior to prescription, the patient may then give either verbal consent or refuse, the final decision must be clearly documented by the medical staff in the patients notes (further advice must be obtained from the Consultant Microbiologist). VZIG should be considered a treatment within 10 days of exposure therefore this is not a clinical emergency out of hours.

7 Maternity/ Neonatal Unit
Pregnant woman with Chickenpox should not be admitted to the maternity unit unless there is a clinical need; they must then be admitted into a side room. The immune status of mothers exposed to a suspected or confirmed case of either Chickenpox or Shingles should be assessed. Pregnant contacts that have a history of chicken pox do not require VZIG. Patients with a negative history must be tested for VZ antibody before VZIG is given.

If a woman develops chickenpox whilst on the maternity unit she must be moved into a side room and isolation nursing commenced. A list of identified contacts must be collated and discussed with the Infection Prevention and Control Team for further action

*If mother develops chickenpox less than 7 days before delivery or up to 7 days after, her baby must be given VZIG.*

8 Training
All clinical staff must undertake Trust infection control mandatory training annually. Additional support will be provided by the Infection Prevention and Control Team.
9 Monitoring compliance
The infection prevention and control team will review and investigate incidents reported relating to this policy and audit departments screening compliance.

Non-compliance with the policy will be managed via the HR route; this will be supported by the Director of Nursing, Performance and Quality, (DIPC), and the Medical Director.
Legislation, Guidance and References

Available at:
https://www.gov.uk/dh


Nice Clinical Knowledge Summaries (2015) Via link


WHO (2006) Your 5 moments of hand hygiene [pdf]
Available at:
http://www.who.int/gpsc/tools/Five_moments/en/
Equality Analysis (Impact assessment)
Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services.
Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

| Chickenpox and Varicella Policy |

Details of person responsible for completing the assessment:

- **Name:** Anita Swaine
- **Position:** Lead Nurse Infection Prevention and Control
- **Team/service:** Infection Prevention and Control

State main purpose or aim of the policy, procedure, proposal, strategy or service: (usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

This policy aims to promote awareness of Chicken Pox and shingles and enable early identification, and isolation of patients, which are all essential steps in reducing the risk of infections, to improve patient and staff safety.

2. Consideration of Data and Research
To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

**Age:** East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.
Race:
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
- 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.

Gender:
- In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

Disability:
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at 18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (The Lesbian & Gay Foundation).
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% In 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.

- Christian: 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- Sikh: 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- Buddhist: 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- Hindu: 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- Jewish: 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- Muslim: 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- Other: 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- **None:** 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
- **Not stated:** 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

### Carers:
- In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

2.2 **Evidence of complaints on grounds of discrimination:** (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

None

2.3 **Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?**

None

### 3. Assessment of Impact

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

**RACE:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently?

Yes ☐ No √

**Explain your response:** For any patient whose first language is not English, as information needs to be provided and understood, staff will follow the trust interpretation policy.

**GENDER (INCLUDING TRANSGENDER):**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently?

Yes ☐ No √

**Explain your response:** No impacts identified.

**DISABILITY**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently?

Yes √ No ☐

**Explain your response:** Clinical staff will need to implement support for patients in isolation as this is a mandatory requirement of this policy.
Staff should follow the trust interpretation policy for people who are Deaf and involve the health facilitators for people with learning disabilities.

**AGE:**
From the evidence available does the policy, procedure, proposal, strategy or service, affect, or have the potential to affect, age groups differently?  
Yes □ No √

**Explain your response:** Visitors at the extremes of the age range should be discouraged from visiting as they may be more susceptible.

**LESBIAN, GAY, BISEXUAL:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently?  
Yes □ No √

**Explain your response:** No impacts identified.

**RELIGION/BELIEF:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently?  
Yes □ No √

**Explain your response:** No impacts identified.

**CARERS:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently?  
Yes √ □ No

**Explain your response:** May need to be involved in the support of the patient post discharge. Therefore staff must ensure they receive the appropriate information on management of Chickenpox and Varicella.

**OTHER:** EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently?  
Yes □ No □ √

**Explain your response:** No other impacts identified.

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4. Safeguarding Assessment - CHILDREN

| a. Is there a direct or indirect impact upon children? | No □ |
| b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people: |
| c. If no please describe why there is considered to be no impact / significant impact on children. This policy applies the same as for adult patients. If any concerns are noted with any |
child these would be escalated via the appropriate channels. Information would be provided to relatives to ensure they understand Chickenpox and Varicella and the need for isolation.

5. Relevant consultation
_Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?_

This policy has been ratified by the ICG which includes a member of the public. As with the majority of IC policies it is acknowledged that staff need to support individuals who require Isolation, any variance to this must be clearly documented in the patients notes as part of their clinical care.

6. Date completed: 21/9/2015 Review Date: 21/9/2016

7. Any actions identified:
_Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?_

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
</thead>
</table>

8. Approval:
At this point, you should forward the template to the Trust Equality and Diversity Lead _lynbailey@nhs.net_

Approved by Trust Equality and Diversity Lead: _[Signature]_

Date: 22.9.15