# Varicella Zoster Virus, Chickenpox and Shingles Policy

<table>
<thead>
<tr>
<th>Post holder responsible for Policy</th>
<th>Judy Potter, Lead Nurse, Infection Prevention and Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author of Policy</td>
<td>Catharine Pym, Infection Prevention and Control Nurse</td>
</tr>
<tr>
<td>Division/ Department responsible for Procedural Document</td>
<td>Specialist Services/ Infection Control</td>
</tr>
<tr>
<td>Contact details</td>
<td>Extension: 2355</td>
</tr>
<tr>
<td>Date of original document</td>
<td>1997</td>
</tr>
<tr>
<td>Impact Assessment performed</td>
<td>Yes/ No</td>
</tr>
<tr>
<td>Ratifying body and date ratified</td>
<td>Infection Control &amp; Decontamination Assurance Group: 29\textsuperscript{th} January 2018</td>
</tr>
<tr>
<td>Review date (and frequency of further reviews)</td>
<td>July 2022 (4.5 years)</td>
</tr>
<tr>
<td>Expiry date</td>
<td>January 2023</td>
</tr>
<tr>
<td>Date document becomes live</td>
<td>13\textsuperscript{th} February 2018</td>
</tr>
</tbody>
</table>

Please specify standard/criterion numbers and tick ✓ other boxes as appropriate

<table>
<thead>
<tr>
<th>Monitoring Information</th>
<th>Strategic Directions – Key Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience</td>
<td>Maintain Operational Service Delivery</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>Integrated Community Pathways</td>
</tr>
<tr>
<td>Monitor/Finance/Performance</td>
<td>Develop Acute services</td>
</tr>
<tr>
<td>CQC Fundamental Standards - Regulation: 12 and 15</td>
<td>Infection Control ✓</td>
</tr>
</tbody>
</table>

Other (please specify):

**Note:** This document has been assessed for any equality, diversity or human rights implications

**Controlled document**
This document has been created following the Royal Devon and Exeter NHS Foundation Trust Development, Ratification & Management of Procedural Documents Policy. It should not be altered in any way without the express permission of the author or their representative.
### Full History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author (Title not name)</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>1997</td>
<td>Lead Nurse</td>
<td>New Guidance</td>
</tr>
<tr>
<td>2.0</td>
<td>August 2005</td>
<td>Lead Nurse</td>
<td>Routine revision</td>
</tr>
<tr>
<td>3.0</td>
<td>August 2006</td>
<td>Lead Nurse</td>
<td>Routine revision</td>
</tr>
<tr>
<td>4.0</td>
<td>Nov 2007</td>
<td>Lead Nurse</td>
<td>Routine revision</td>
</tr>
<tr>
<td>5.0</td>
<td>Nov 2009</td>
<td>Lead Nurse</td>
<td>Routine revision</td>
</tr>
<tr>
<td>6.0</td>
<td>Nov 2011</td>
<td>Lead Nurse</td>
<td>Routine revision</td>
</tr>
<tr>
<td>7.0</td>
<td>Dec 2013</td>
<td>Lead Nurse</td>
<td>Routine revision</td>
</tr>
<tr>
<td>8.0</td>
<td>Nov 2016</td>
<td>Lead Nurse</td>
<td>Routine revision</td>
</tr>
<tr>
<td>9.0</td>
<td>Oct 2018</td>
<td>Lead Nurse</td>
<td>Routine revision resulting in changed format to comply with the Policy for the Development, Ratification and Management of Procedural Documents; minor wording change to subsection 9.4 to include community requirements and addition of subsection 9.5 to advise on precautions in patients own homes.</td>
</tr>
</tbody>
</table>

### Associated Trust Policies/Procedural documents:
- Employee screening and immunisation policy
- Standard infection control procedures
- Torridge ward operational guidance
- Infection prevention and control policy

### Key Words
- Chicken pox
- Varicella Zoster
- Shingles
- Herpes Zoster

### In consultation with and date:
- Infection Prevention & Control Team: 22/11/2017
- Consultant Microbiologists: 22/11/2017
- Governance Managers, Corporate Managers, Department Managers, Service Managers, Senior Operational Managers, Lead Nurses, Senior Nurses, Matrons, Community DD and ADN, Equality Team: 22/11/2017
- Policy Expert Panel: 31st January 2018
- Infection Control and Decontamination Assurance Group: 29th January 2018

### Contact for Review:
- Lead Nurse, Infection Prevention and control

### Executive Lead Signature:
(Applicable only to Trust Strategies & Policies)
- Medical Director
# CONTENTS

1. INTRODUCTION ............................................................................................................. 4
2. DEFINITIONS ................................................................................................................ 4
3. DUTIES AND RESPONSIBILITIES OF STAFF ............................................................ 4
4. CLINICAL FEATURES .................................................................................................. 5
5. TRANSMISSION ............................................................................................................. 6
6. INFECTIOUS PERIOD .................................................................................................. 6
7. DIAGNOSIS .................................................................................................................. 7
8. INFECTION CONTROL MEASURES ........................................................................... 7
9. ISOLATION .................................................................................................................... 7
10. RELATIVES/Visitors .................................................................................................... 8
11. CONTACTS .................................................................................................................. 8
12. STAFF CONTACTS ..................................................................................................... 8
13. IMMUNOCOMPROMISED CONTACTS ..................................................................... 9
14. PREGNANT CONTACTS ........................................................................................... 9
15. MATERNITY UNIT/NEONATAL UNIT/ PAEDIATRIC UNIT ...................................... 9
16. NOTIFICATION .......................................................................................................... 10
17. ARCHIVING ARRANGEMENTS .............................................................................. 10
18. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY ........................................................................................................... 10
19. REFERENCES ............................................................................................................ 11

APPENDIX 1: COMMUNICATION PLAN .......................................................................... 12
APPENDIX 2: EQUALITY IMPACT ASSESSMENT TOOL ............................................. 13
1. INTRODUCTION

1.1 Chickenpox is an acute, highly infectious disease caused by the varicella zoster (VZ) virus. The incubation period is between 7-21 days. Chickenpox is infectious for 1-2 days before the rash appears until the vesicles are dry or have crusted over. Chickenpox usually confers lifelong immunity, although the virus persists in a latent form in the sensory nerve ganglia of the dorsal root. Reactivation of the latent VZ virus in later life results in Shingles (Herpes zoster). It is not known what causes the virus to reactivate and reactivation can be spontaneous or follow a period of physical illness or stress. It is possible to develop chickenpox from exposure to a person with shingles, but not possible to develop shingles from exposure to a person with chickenpox.

1.2 Immunisation against VZ virus is available. It is Trust policy to offer varicella vaccine to all non-immune employees working in clinical areas. Please refer to the employee screening and immunisation policy.

1.3 Chickenpox does not require PHE notification in England and Wales.

1.4 Failure to comply with this policy could result in disciplinary action.

2. PURPOSE

2.1 The purpose of this document is to provide guidance for staff on how to manage patients with chickenpox and shingles.

3. DEFINITIONS

3.1 Incubation period – the time it takes for the symptoms to appear.

3.2 Infectious period – the period during which an infected person can transmit a pathogen to a susceptible host.

3.3 Index case – the patient diagnosed with chickenpox or shingles.

3.4 Chickenpox ‘contact’ – any patient or member of staff who is non-immune to the VZ virus and who has had contact with a case of chickenpox at any time from 48 hours before the onset of the rash until all the lesions are crusted.

3.5 Shingles ‘contact’ – any patient or member of staff who is non-immune to the VZ virus and who has had contact with a case of disseminated, exposed shingles from the day of the rash until crusting of the exposed rash.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 The Chief Executive and Board of Directors are responsible for ensuring the provision of suitable and sufficient resources and facilities to enable effective management of a patient with chickenpox or shingles.

4.2 The Directors of Infection Prevention and Control (DsIPC) are responsible for providing expert guidance and advice to the Infection Prevention and Control Team, clinical and managerial staff about measures needed to protect staff, patients and members of the public from infection.
4.3 **The nursing staff** in the clinical area/ward or the patients home in which a patient who may have chickenpox or shingles is recognised, are responsible for ensuring that appropriate infection control interventions are implemented and that other care providers involved in the care of the patient are informed of any necessary precautions.

4.4 **Medical staff** are responsible for diagnosing and treating the patient with chickenpox or shingles, if required.

4.5 The **Infection Prevention & Control Team** are responsible for advising on infection control measures appropriate to the care setting, relating to chickenpox or shingles.

4.6 The **Infection Control Doctor and Consultant Microbiologists** are responsible for providing advice on the diagnosis of chickenpox or shingles.

4.7 The **Occupational Health Physician** is responsible for ensuring that processes are in place to screen new employees who may be required to have contact with patients with chickenpox or shingles in accordance with the Immunisation and screening policy and to advise any staff contacts who are non-immune or unsure of their immune status.

4.8 **Patient Flow Manager and Site Management Team** are responsible for organising patient movements to isolation rooms.

4.9 **Isolation Ward (Torridge Ward) staff** are responsible for ensuring that adult patients admitted to the acute hospital are managed in an appropriate isolation room.

4.10 **All staff** required to have contact with patients are responsible for ensuring that they are compliant with the Staff Screening and Immunisation policy.

5. **CLINICAL FEATURES**

5.1 **Chickenpox**

5.1.1 Chickenpox is characterised by red, itchy spots that turn into fluid filled blisters. It usually appears initially on the face, ears, scalp and trunk, but can spread over the entire body. Other symptoms which may precede the rash by 48 hours include general malaise, fever and headache.

5.1.2 Complications include:

- Bacterial skin infection, most common in young children
- Lung involvement, more common in adults
- In pregnancy severe maternal chickenpox, intrauterine infection and foetal varicella syndrome. In later pregnancy, varicella can result in premature delivery or neonatal chickenpox

5.1.3 Whilst the possibility is **highly unlikely**, if the rash or blisters are more prominent on the face and extremities (including palms of the hands and soles of the feet) than on the trunk and are at the same stage of development so all very nearly the same size, smallpox should be considered as a possibility and the Infection Prevention and Control Team notified immediately. Smallpox no longer exists as a naturally acquired infection and its re-emergence would be as a result of an accidental or deliberate release of the virus.
5.2 **Shingles**

5.2.1 Shingles is an infection of a sensory nerve and the skin around it.

5.2.2 The infection has three phases:

- **Prodrome** (1-4 days before rash): burning, tingling, numbness or pruritus in affected skin
- **Acute** (painful rash, lasting 7–10 days): macules and papules developing into blister-like lesions, occurring at the site of the affected sensory nerve, typically causing a strip-like pattern on one side of the body.
- **Healing** (2–4 weeks): crusting of lesions

5.2.3 Complications include:

- Post–herpetic neuralgia (common in adults)
- Skin changes: secondary infection, scarring, changes in pigmentation
- Ocular complications
- Ramsay Hunt syndrome: lesions in ear, facial paralysis, associated hearing and vestibular symptoms

6. **TRANSMISSION**

6.1 **Chickenpox**

6.1.1 Chickenpox is transmitted by direct person to person contact, via airborne spread of respiratory droplet nuclei and vesicle fluid, or through contact with infected items such as clothing and bedding.

6.2 **Shingles**

6.2.1 Shingles is much less infectious than chickenpox, although spread may occur from patients who have extensive lesions (disseminated shingles), and susceptible contacts can develop chickenpox. Transmission can occur through direct contact with exudate from wet lesions, or airborne via vesicle fluid in disseminated shingles.

7. **INFECTIOUS PERIOD**

7.1 **Chickenpox**

7.1.1 The infectious period is from 48 hours before onset of the rash and continues until all lesions are dry and have crusted, usually 5-6 days after onset. Immunosuppressed patients may be infective for longer.

7.2 **Shingles**

7.2.1 A person with shingles is infectious until their lesions have dried (usually 5-7 days after onset). The blisters that form contain the live virus. If a person, who has never had chickenpox, makes direct contact with an open blister they can contract the virus and develop chickenpox. The period of infectivity may be slightly reduced by acyclovir.
8. **DIAGNOSIS**

8.1 Adults suspected of having chickenpox may require a viral swab to be taken from a wet vesicle. However, often the diagnosis will be made based on clinical signs and symptoms.

8.2 In children, any lesions that look secondarily infected should also be swabbed for microscopy, culture and sensitivity (MC&S) and necrotising fasciitis considered. Discuss antibiotic treatment with a microbiologist.

8.3 Patients should be reviewed for any possible underlying immunosuppression risk factors.

9. **INFECTION CONTROL MEASURES**

9.1 Regardless of the care setting, patients with chickenpox or shingles must only be cared for by staff known to be immune and not immunocompromised or pregnant (refer to employee screening and immunisation policy).

9.2 Standard infection control precautions must be used for all patients regardless of perceived or known infection risk factors (refer to standard infection control procedures and policy).

9.3 In addition to standard infection control precautions the use of gloves and aprons are also required for direct patient contact (and cleaning in hospital) to protect hands and uniforms/clothing.

9.4 In addition to routine hand hygiene at the point of care, hands should be washed with soap and water after removing personal protective equipment prior to leaving the isolation room or the patient’s home. In hospital, once outside the isolation room, clean hands with alcohol gel. In the patient’s own home, clean hands with alcohol hand rub when ready to leave the house.

9.5 When providing health care in patients’ own homes, the above precautions are adequate. There is no requirement to postpone visits as long as visits are undertaken by staff known to be immune. There is no need to see patients at the end of the working day.

9.5 If a hospitalised patient with chicken pox or disseminated shingles needs to visit a clinical department for investigations or procedures, the department must be informed in advance to ensure appropriate precautions can be taken and to avoid the patient being placed in communal areas where they will have contact with other patients.

10. **ISOLATION OF HOSPITAL IN-PATIENTS**

10.1 **Chickenpox**

10.1.2 Admission of patients with chickenpox should be avoided where possible. In hospital settings, patients with suspected or confirmed chickenpox must be isolated immediately in a single room. If symptoms develop during an in-patient stay, transfer to a single room should occur promptly. Ideally, isolation rooms require en-suite facilities, preferably negative pressure ventilation, and doors must be kept closed. If capacity permits, admission/transfer of adult patients to Torridge ward is preferable.
(refer to Torridge ward operational guidance). If a patient is admitted to a community hospital with suspected chickenpox, they must be isolated in a single en suite room and the door must be kept closed.

10.2 Shingles

10.2.1 Patients with shingles will usually be cared for in a single room, during their infectious period. Negative pressure ventilation is not required. Patients admitted to a hospital with shingles will usually be isolated until the vesicles are dry.

10.2.2 If isolation is inappropriate for the patient please seek advice from the Infection Prevention and Control Team. If shingles lesions are not extensive and can be covered with a dressing, isolation may not be necessary.

11. RELATIVES/VISITORS

11.1 Non immune visitors should be advised not to visit hospitalised patients during the infective period. In the patient’s own home, this is entirely the decision of the patient, other members of their household and the visitors themselves.

12. CONTACTS – OTHER PATIENTS

12.1 Refer section 3.4 and 3.5 for definitions of contacts.

12.2 Contacts should be considered immune if there is a good history of chickenpox or episode of zoster in the past or antibody test confirms specific antibodies or varicella immunisation complete.

12.4 The likelihood of infection in the index case must be assessed by a doctor, and infectious chickenpox or shingles must be the likely diagnosis.

12.5 Significant contact with chickenpox is defined as:
  - Contact in the same room or within 10 metres on an open ward/department for 15 minutes or more
  - Direct face to face contact for three minutes
  - Contact with clothing and bedding soiled by discharge from the blisters
  - Maternal – neonatal transmission
  - Continuous household

12.6 Significant contacts that are believed to be non-immune are at risk of developing chickenpox and should be advised of this possibility.

13. STAFF CONTACTS

13.1 Refer section 3.4 and 3.5 for definitions of contacts.

13.2 Contact Occupational Health if non-immune or unsure of immune status.
14. IMMUNOCOMPROMISED CONTACTS

14.1 Following known or possible exposure to chickenpox and shingles, immunocompromised patients with no known history of chickenpox should have their immune status checked by serology and a Microbiologist should be contacted. Varicella Zoster immunoglobulin (VZIG) should be given to susceptible contacts and is available from Pharmacy if recommended/authorised by a medical microbiologist.

14.2 Certain groups of patients, especially bone marrow transplant patients, may not be immune, even if they have had previous chickenpox or VZIG. For advice contact Microbiology.

15. PREGNANT CONTACTS

Following known or possible exposure to VZ virus, pregnant patients and staff should have their immune status checked. If susceptibility is confirmed by antibody testing the women should be offered VZIG within 10 days of contact. Due to the potential risks to the unborn child, pregnant staff should not care for infectious patients unless their immunity has been confirmed by antibody testing. If unsure, staff should check their immune status with Occupational Health.

16. MATERNITY UNIT/NEONATAL UNIT/ PAEDIATRIC UNIT

16.1 Maternity Unit

16.1.1 The immune status of mothers who have been exposed to a suspected or confirmed case of either chickenpox or shingles should be assessed prior to admission to the maternity unit. Pregnant contacts with a positive history of chickenpox do not require VZIG. Those with a negative history must be tested for VZ antibody before VZIG is given. The outcome in pregnant women is not adversely affected if administration is delayed up to 10 days after initial contact while a VZ antibody test is undertaken.

16.1.2 In addition to the infection control measures above, if a mother has or develops chickenpox whilst on the maternity unit the following measures are required:

- Isolate from other mothers, babies, neonates and those known to be susceptible
- If mother develops chickenpox less than 7 days before delivery or up to 7 days after, her baby must be given VZIG – Pharmacy hold the stocks and will release them if authorised to do so by a medical Microbiologist.
- VZIG is also indicated for babies of exposed susceptible mothers

16.2 Paediatrics and Neonatal Unit

16.2.1 Paediatric patients with a history of significant contact (as defined in section 12) must be isolated in a single cubicle on Bramble.

16.2.2 Babies requiring neonatal unit care with a history of significant contact (as defined in section 12) must be isolated in a single room on the neonatal unit.

16.2.3 Babies who are exposed to chickenpox after discharge from the neonatal unit who require hospital admission must be admitted to Bramble Ward and NOT the NNU.

16.2.4 If Bramble Ward is unable to isolate the patient due to ward pressures a risk assessment of patient groups will determine whether non-immune asymptomatic contacts can be placed with other children in a bay.

Varicella Zoster Virus, Chickenpox & Shingles Policy
Ratified by: Infection Control & Decontamination Assurance Group: 29th January 2018
Review date: July 2022
16.2.5 The patients considered suitable to expose to a child who may be incubating chickenpox include:
- Those considered to be immune
- Those most likely to be discharged home within a short period

16.2.6 The patients who should not be exposed to a child who may be incubating chickenpox are:
- Those who are immunocompromised
- Those likely to remain in hospital during the full incubation period
- Those who attend regular day case and outpatient appointments

17. **NOTIFICATION**

17.1 Healthcare staff must report, at the earliest opportunity, patients suspected or infected with chickenpox or shingles to the Infection Control Team (refer to the Infection Prevention and Control Policy) so that appropriate advice can be provided to those providing care.

18. **ARCHIVING ARRANGEMENTS**

18.1 The original of this policy, will remain with the Lead Nurse/ Director for Infection Prevention and Control. An electronic copy will be maintained on the Trust Intranet, (A-Z), P – Policies (Trust-wide) – V – Varicella Zoster Virus, Chickenpox & Shingles. Archived electronic copies will be stored on the Trust's “archived policies” shared drive and will be held indefinitely. A paper copy (where one exists) will be retained for 10 years.

19. **PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY**

19.1 To monitor compliance with this policy/ strategy, the auditable standards will be monitored as follows:

<table>
<thead>
<tr>
<th>No</th>
<th>Minimum Requirements</th>
<th>Evidenced by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Hospitalised patients with chickenpox or extensive shingles will be isolated in a single room</td>
<td>Appropriate isolation of hospitalised patients during the annual patient placement audit</td>
</tr>
</tbody>
</table>

19.2 **Frequency**
On a case by case basis, as part of a routine review of infectious patients. Any concerns will be discussed by the IPCT at routine meetings, and if relevant, reported to Infection Control and Decontamination Assurance Group (ICDAG). Significant incidents will be included in the DIPC annual report.

19.3 **Undertaken by**
Infection Control Nurses
19.4 **Dissemination of Results**
At the Infection Control and Decontamination Assurance Group which is held quarterly and the relevant Divisional Governance Groups if there is failure to comply with the policy.

19.5 **Recommendations/ Action Plans**
Implementation of the recommendations and action plans will be monitored by the Infection Control and Decontamination Assurance Group, which meets quarterly. Any barriers to implementation will be risk-assessed and added to the risk register. Any changes in practice needed will be highlighted to Trust staff via the Governance Managers’ cascade system.

19.6 Any barriers to implementation will be risk-assessed and added to the risk register.

20. **REFERENCES**


### APPENDIX 1: COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

<table>
<thead>
<tr>
<th>Staff groups that need to have knowledge of the policy</th>
<th>All staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>The key changes if a revised policy</td>
<td>Routine revision resulting in changed format to comply with the Policy for the Development, Ratification and Management of Procedural Documents; minor wording change to subsection 9.4 to include community requirements and addition of subsection 9.5 to advise on precautions in patients own homes.</td>
</tr>
<tr>
<td>The key objectives</td>
<td>The purpose of this document is to provide a policy for staff on how to manage patients with Chickenpox and Shingles wherever care is delivered</td>
</tr>
<tr>
<td>How new staff will be made aware of the policy and manager action</td>
<td>Induction process</td>
</tr>
<tr>
<td>Specific Issues to be raised with staff</td>
<td>Compliance with Staff Screening and Immunisation Policy</td>
</tr>
<tr>
<td>Training available to staff</td>
<td>N/A</td>
</tr>
<tr>
<td>Any other requirements</td>
<td>N/A</td>
</tr>
<tr>
<td>Issues following Equality Impact Assessment (if any)</td>
<td>No negative impacts</td>
</tr>
<tr>
<td>Location of hard / electronic copy of the document etc.</td>
<td>Trust intranet ‘Hub’</td>
</tr>
</tbody>
</table>
APPENDIX 2: EQUALITY IMPACT ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>Name of document</th>
<th>Varicella Zoster Virus, Chickenpox &amp; Shingles Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division/Directorate and service area</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>Name, job title and contact details of person completing the assessment</td>
<td>Judy Potter, Lead Nurse/Director Infection Prevention and Control</td>
</tr>
<tr>
<td>Date completed:</td>
<td>23/11/2017</td>
</tr>
</tbody>
</table>

The purpose of this tool is to:
- identify the equality issues related to a policy, procedure or strategy
- summarise the work done during the development of the document to reduce negative impacts or to maximise benefit
- highlight unresolved issues with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. **What is the main purpose of this document?**
   To provide a framework for treatment and management of patients with chickenpox and shingles.

2. **Who does it mainly affect?** *(Please insert an "x" as appropriate:)*
   - Carers ☐
   - Staff ☒
   - Patients ☒
   - Other (please specify)

3. **Who might the policy have a ‘differential’ effect on, considering the “protected characteristics” below?**

<table>
<thead>
<tr>
<th>Protected characteristic</th>
<th>Relevant</th>
<th>Not relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Disability</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Sex - including: Transgender, and Pregnancy / Maternity</td>
<td>☒</td>
<td>☐</td>
</tr>
<tr>
<td>Race</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Religion / belief</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Sexual orientation – including: Marriage / Civil Partnership</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>
4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to?

All patient groups

5. Do you think the document meets our human rights obligations?  ☒

A quick guide to human rights:

- **Fairness** – how have you made sure it treat everyone justly?
- **Respect** – how have you made sure it respects everyone as a person?
- **Equality** – how does it give everyone an equal chance to get whatever it is offering?
- **Dignity** – have you made sure it treats everyone with dignity?
- **Autonomy** – Does it enable people to make decisions for themselves?

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

There were no concerns that may be relevant to equality or human rights identified during the creation of this policy

Infection Control & Decontamination Assurance Group, Occupational Health and the Policy Expert Panel were involved in this review.

7. If you have noted any ‘missed opportunities’, or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

<table>
<thead>
<tr>
<th>“Protected characteristic”:</th>
<th>None.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue:</td>
<td></td>
</tr>
<tr>
<td>How is this going to be monitored/ addressed in the future:</td>
<td></td>
</tr>
<tr>
<td>Group that will be responsible for ensuring this carried out:</td>
<td></td>
</tr>
</tbody>
</table>