journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

Title: Infectious Diseases

Ref: IPC-0001-007-v3.4

Status: Approved
Document type: Procedure
Overarching policy: Infection Prevention and Control Policy

Contents

1 Introduction

This procedure is critical to the delivery of OJTC and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism. It helps us deliver our three strategic goals as follows:

This procedure supports the trust to co- create a great experience for all patients, carers and families from its diverse population by ensuring access to the care that is right for you through controlling and managing any incidence of infection/infectious disease.

This procedure supports the trust to co-create a great experience for our colleagues by providing advice and support to clinical teams when caring for a patient with an infection/infectious disease.

This policy supports the trust to be a great partner by working across all disciplines of the trust and external organisations.

To co-create a great experience for our patients, carers and families, so you will experience:
- **Outstanding** and compassionate care, all of the time.
- **Access** to the care that is right for you.
- **Support** to achieve your goals.
- **Choice** and control.

To co-create a great experience for our colleagues, so you will be:
- **Proud**, because your work is meaningful.
- **Involved** in decisions that affect you.
- **Well led** and managed.
- That your workplace is **fit for purpose**.

To be a great partner, so we will:
- Have a **shared understanding** of the needs and the strengths of our communities
- Be **working innovatively** across organisational boundaries to improve services.
- Be **widely recognised** for what we have achieved together.

2 Purpose

Following this procedure will help the Trust to:-

- Ensure all patients with an infection/infectious disease are managed safely and appropriately.
- Ensure all patients with an infection/infectious disease receive appropriate information.
- The potential spread of infection is minimised.
- Ensure all relevant staff know the standard precautions for the management of infectious diseases.

- Ensure all Registered Medical Practitioners (RMPs) understand they have a statutory duty to notify the 'proper officer' at their local Health Protection Team (HPT) of suspected cases of certain infectious diseases.

3 Who this procedure applies to

This procedure applies to any patient who is confirmed or suspected of having an infection / infectious disease.

Respect

- Listening
- Inclusive
- Working in partnership

Compassion

- Kind
- Supportive
- Recognising and Celebrating

Responsibility

- Honest
- Learning
- Ambitious

4 Related documents

The Standard (Universal) Precautions for Infection Prevention and Control defines the universal standards for Infection, Prevention and Control (IPC) which you **must** read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to the following procedures and policies:-

- Hand hygiene
- Laundering and safe handling of linen and clothing
- Decontamination of equipment
- Accidental inoculation
- Waste management policy

5 Notifiable diseases

Doctors in England and Wales have a statutory duty to notify the proper officers of the local Health Protection Team, cases of certain infectious disease. Cases must be reported using the Notification of Communicable Disease form.

NB: This table is only for guidance and each case should be considered individually. The table below lists infectious diseases and conditions that require notification to UKHSA.

Notifiable diseases	Definition / comment	Likely to be urgent?
Acute encephalitis		No
Acute infectious hepatitis	Close contacts of acute hepatitis A and hepatitis B cases need rapid prophylaxis. Urgent notification will facilitate prompt laboratory testing. Hepatitis C cases known to be acute need to be followed up rapidly as this may signify recent transmission from a source that could be controlled.	Yes
Acute meningitis	Viral and bacterial.	Yes, if suspected bacterial infection.
Acute poliomyelitis		Yes
Anthrax		Yes
Botulism		Yes
Brucellosis		No – unless thought to be UK-acquired
Cholera		Yes
COVID-19		Yes
Diphtheria		Yes
Enteric fever (typhoid or paratyphoid fever)	Clinical diagnosis of a case before microbiological confirmation (e.g. case with fever, constipation, rose spots and travel history) would be an appropriate trigger for initial public health measures, such as exclusion of cases and contacts in high risk groups (e.g. food handlers).	Yes
Food poisoning	Any disease of infectious or toxic nature caused by or thought to be caused by consumption of food or water (definition of	Clusters and outbreaks, yes. For specific organisms see Table 2.

Notifiable diseases	Definition / comment	Likely to be urgent?
	the Advisory Committee on the Microbiological Safety of Food).	
Haemolytic uraemic syndrome (HUS)		Yes
Infectious bloody diarrhoea	See also HUS in Schedule 1 and VTEC in Schedule 2.	Yes
Invasive group A streptococcal disease and scarlet fever		Yes, if IGAS. No, if scarlet fever
Legionnaires' Disease		Yes,
Leprosy		No
Malaria		No, unless thought to be UK-acquired
Measles		Yes
Meningococcal septicaemia		Yes
Monkey pox		Yes
Mumps	Post-exposure immunization (MMR or HNIG) does not provide protection for contacts.	No
Plague		Yes
Rabies	A person bitten by a suspected rabid animal should be reported and managed urgently, but if a patient is diagnosed with symptoms of rabies, they will not pose a risk to human health.	Yes
Rubella	Post-exposure immunisation (MMR or HNIG) does not provide protection for contacts.	No
Severe Acute Respiratory Syndrome (SARS)		Yes
Scarlet fever		Yes
Smallpox		Yes
Tetanus		No, unless associated with injecting drug use
Tuberculosis		No, unless healthcare worker or

Notifiable diseases	Definition / comment	Likely to be urgent?
		suspected cluster or multi drug resistance
Typhus		No
Viral haemorrhagic fever (VHF)		Yes
Whooping cough		Yes, if diagnosed during acute phase
Yellow fever		No, unless thought to be UK-acquired

A full list of notifiable organisms' causative agents is available on Gov.uk website

In addition this procedure contains a list of infections and communicable diseases which may affect clients / patients within TEWV. It is not an exhaustive list and the advice of your local Health Protection Team (HPT) should be sought for conditions not listed.

5.1 Contact details for notifying Health Protection Team

The notifiable disease should be referred to the Proper Officer within 3 days or notify them verbally within 24 hours. Please refer to Gov.uk website

Locality	In hours contact number	Out of hours for health professionals only
Durham or Teesside Newcastle HPT	0300 303 8596	0191 269 7714
Yorkshire and Humber HPT	0113 386 0300	0151 9091219

6 Staff responsibilities

The nurse in charge **must** ensure that:

- ✓ Contact Infection, Prevention and Control Team (IPC Team) for advice regarding isolation
- ✓ Single room accommodation is available if required/necessary
- ✓ All items such as aprons, gloves, patient charts, laundry bags, adequate linen etc are available.
- ✓ Ensure access to hand hygiene facilities

6.1 Role of the community staff

- ✓ Contact IPC Team to discuss for advice
- ✓ Nurses visiting infectious patients in their own homes must select the appropriate precautions, determined by the route in which the infection can be transmitted.

7 How to manage infectious patients

7.1 Accommodation.

Please refer to **appendix 3** for isolation requirements for known infectious diseases.

- ✓ A single room with hand wash-basin and en-suite toilet are necessary in most circumstances. If en-suite facilities are not available please allocate a commode or toilet for this patient use.
- ✓ Avoid selecting rooms with carpets for patients suspected of infection/infectious disease.
- ✓ If patient has leave planned or appointments booked please discuss with IPC Team.

The decision to isolate a patient should be based on the infection risk, symptoms and risk of transmission in accordance with the relevant infection prevention and control policy or following discussion with the infection prevention and control team.

The Isolation of patients is undertaken for two main reasons:

- ✓ Source Isolation: to prevent transfer of infection from the patient to others.
- ✓ Protective Isolation: to prevent transfer of infection to a particularly susceptible patient.

The decision to isolate a patient should not be taken lightly and should always be taken after assessing the risk to the individual, other service users, staff and the decision documented.

Advice should be sought from the IPC Team and the following should be taken into consideration:

- ✓ How the infection is spread, e.g. faecal-oral route
- ✓ The environment
- ✓ Susceptibility of others

To understand the risks of cross infection posed by microorganisms the varying routes of transmission must be acknowledge and are defined as:

- ✓ Direct Contact - organisms can be transmitted directly to susceptible people via contaminated equipment or by the hands of healthcare workers. It is therefore essential that hands are decontaminated before and after every episode of direct patient care.
- ✓ Fomites – organisms can be transmitted from one person to the environment and from that environment to another person. Therefore, equipment must be kept clean and dry and must be decontaminated between each use.
- ✓ Respiratory droplets – this is transmission of large particles from the oropharyngeal mucosa of an infected patient. These droplets can travel up to 6 feet horizontally. They rapidly fall to the floor and do not remain suspended in the air.
- ✓ Airborne – organisms can be transmitted in dust (usually tiny skin scales) or in tiny respiratory droplets which can be suspended in the air. This can be cause by procedures which produce aerosols (e.g. intubation, bronchoscopy, tracheal suction) or by procedures which have the potential to re-suspend dust (e.g. bed making). Airborne transmission can cause infection between patients at distances much greater than 6 feet.
- ✓ Food-borne/ water-borne – this occurs when contaminated foods are ingested.

- ✓ Blood-borne – blood or blood-stained material is potentially hazardous and infection is transmitted via inoculation incidents, existing breaks in the skin, gross contamination of mucous membranes, sexual activity or across the placenta from mother to baby / pregnant person.

Vector-borne – disease which is spread via biting insects is currently not a major problem in the UK, however insects such as cockroaches can carry pathogenic organisms on their bodies and in their digestive tracts. This may infect the hospital environment, including food and sterile supplies; therefore, storage of supplies in clean well-ventilated areas is essential

7.2 Hand hygiene

After removing protective clothing and after dealing with infectious patients wash your hands with:

Liquid soap and water fully dry with disposable paper towels
or
Decontaminate them with alcohol gel (if available)

Alcohol gel is not recommended for hand decontamination when nursing patients with Clostridium Difficile (C-diff) or during an outbreak of any gastroenteritis. Use liquid soap and water.

7.3 Plastic aprons/Long sleeve gowns

Are necessary to prevent clothes/uniform becoming contaminated during patient contact.

- ✓ **Must** be put on prior to patient contact.
- ✓ **Must** be removed immediately before washing hands and leaving the room.
- ✓ **Must** be removed in a way that prevents contamination of the uniform/clothing.

7.4 Gloves

- ✓ Wash hands prior to putting on gloves

- ✓ Gloves must be put on before patient contact and discarded into the clinical waste bag immediately before washing hands.
- ✓ Take care **not** to touch the outside of the gloves as they are removed.
- ✓ Wash hands after leaving the room

Gloves are only required when handling the patient or body fluids.

7.5 Eye and face protection

- Level of eye and face protection will depend on the overall risk assessment of the patient.
- Approved for use in NHS Goggles/visors and face masks are recommended for all procedures where there is a risk of aerosol or splashing of blood/body fluids which could create a possible risk of infection through the eyes and mouth

Further advice is available from the Infection Prevention Control department

7.6 Waste management

Waste and sharps **must** be disposed of according to the Trust waste management policy and procedure.

7.7 Laundry

- ✓ You **must** place re-usable linen items e.g., bed sheets etc. into a water-soluble bag, then into an outer red laundry bag secure and label 'Infected Linen'.
- ✓ Water soluble bags are available from Cardea.
- ✓ Patient clothing needs to be washed separately in an industrial washing machine

For further information see Decontamination of Equipment and Laundering and safe handling of linen and clothing

7.8 Equipment / instruments

All multiple use patient equipment needs to be decontaminated between use.

For further information see Decontamination of Equipment

7.9 Food and drink

- ✓ Routine crockery and cutlery are adequate for most patients.
- ✓ All crockery and cutlery used by infectious patients must be adequately disinfected, preferably in dishwasher/sanitiser, which achieves a hot wash cycle with a minimum temperature in 60oC and a final rinse cycle of 82oC.

If in doubt contact an Infection, Prevention and Control Nurse (IPCN).

7.10 Laboratory specimens

Follow the Royal Marsden Manual online procedure for specific specimen taking guidelines:

Faecal sampling - Royal Marsden Manual (rmmonline.co.uk)
Swab sampling: wound - Royal Marsden Manual (rmmonline.co.uk)
Sputum sampling - Royal Marsden Manual (rmmonline.co.uk)
Swab sampling: nose - Royal Marsden Manual (rmmonline.co.uk)
Swab sampling: rectum - Royal Marsden Manual (rmmonline.co.uk)
Urine sampling: midstream specimen of urine: male - Royal Marsden Manual (rmmonline.co.uk)
Urine sampling: midstream specimen of urine: female - Royal Marsden Manual (rmmonline.co.uk)
Urine sampling: catheter specimen of urine - Royal Marsden Manual (rmmonline.co.uk)

Safe labelling of specimens

- ✓ Ensure each specimen is clearly labelled with the patient's name, date of birth, NHS number and location eg. ward name.
- ✓ The pathology request form must also identify the patients details as well as relevant clinical details, reason for the specimen request and any current antibiotic treatment.

- ✓ Ensure the laboratory request form is also signed by the clinician who has requested the specimen.
- ✓ The specimen must be secured in the specimen container and placed into a leak proof sealed specimen bag along with the request form.
- ✓ Any specimens deemed as high risk of infection (e.g. from patients with blood borne viruses or diseases such as Creutzfeldt-Jacob Disease) must be placed into a mini grip plastic bag before being placed into the bag with the pathology request form, they should also be labelled as 'high risk' (high risk stickers can be ordered via cardea).
- ✓ Unlabelled or incorrectly labelled specimens will be discarded by the receiving laboratory department.

Transportation of laboratory specimens

- ✓ All pathology specimens must be transported in a leak proof, washable container. The container must be secure and must comply with UN 3373 standards.
- ✓ Specimen transport containers must not be left unattended in a patient access area.
- ✓ Specimen transport containers must be cleaned at least weekly, or immediately if they become contaminated.
- ✓ Where specimens are transported to the laboratory by vehicle, the transport specimen container must be placed into a cardboard transport box labelled with both the destination and senders name and address.
- ✓ Each specimen container must be in a separate plastic bag with sufficient material to fully absorb any leakage of the specimen
- ✓ Vehicles used for specimen transportation must be equipped with personal protective equipment and a spill kit. Any spillages must be cleaned immediately, and the specimen requester informed as a further specimen will need to be obtained.

7.11 Transfer of patients

- ✓ If patients require transfer to another ward, staff must ensure that the receiving ward is aware of the infection prevention and control precautions required.
- ✓ If a patient is to be transferred to another hospital or healthcare establishment, ensure the receiving ward/unit/ambulance is given information regarding the infection current treatment and any IPC precautions required
- ✓ Inform the Trust IPCNs if patient transferred to another hospital/health care premises or discharge home.

7.12 Visitors

- ✓ The nurse in charge **must** inform visitors of the precautions required to minimise the risk of transmission of the infection, e.g., the need to wash their hands before leaving the room.
- ✓ Relatives, unless involved in close patient care, **do not** need to wear protective clothing.
- ✓ If requested, the IPCN will visit and speak to patient and/or relatives.
- ✓ Where appropriate, children and elderly visitors who may be more susceptible to the infection should be advised of the risks prior to visit

7.13 Disposal of urine and faeces

- ✓ Patient with en-suite - Clean daily check regularly and increase cleaning as required
- ✓ When handling bedpans, urinals, etc, wear disposable gloves and aprons. The bedpan or urinal **must** be covered during transfer to disposal area.
- ✓ For units **without** macerators or washer disinfectors, dispose of body fluids into a designated toilet, close lid, flush and clean toilet. Dispose of the empty bedpan or urinal into a clinical waste bag.
- ✓ If the patient is unable to maintain their own hygiene needs or they need assistance, staff **must** be aware of the need to ensure toilet/bathroom areas are monitored to ensure standards of cleanliness are maintained.
- ✓ Patient with commode / designated toilet – clean before and after each use

8 Communication

- ✓ Communication with staff, patients and relatives is essential.
- ✓ Information leaflets are available – please contact IPC Team.
- ✓ Patients' confidentiality, privacy and dignity **must** be always maintained
- ✓ IPC Team will advise on management of individual patients.

9 Environmental Cleaning

The nurse in charge **must** ensure that hotel services and nursing staff are aware of the importance of daily thorough cleaning of the room used for infectious patients. Specific agreed cleaning schedules are available from the Hotel Services Supervisor.

Community staff may be asked for advice from relatives. Thorough household cleaning using detergents and water is often all that is necessary.

10 Death of patients with suspected or known infectious disease

Infection, Prevention and Control precautions continue to apply when handling any deceased patient; some infections remain capable of being transmitted after death of the patient. The undertaker must be informed if the patient has one of the following infections:

- Hepatitis B or C
- Human Immunodeficiency Virus (HIV / AIDS)
- Typhoid Fever
- Paratyphoid Fever
- Diphtheria
- Meningococcal Septicaemia
- Tuberculosis
- Creutzfeldt Jakob Disease (CJD)
- Invasive Group A Streptococcal Infection

11 Definitions

Term	Definition
HPT	• Health Protection Team
IPC	• Infection, Prevention and Control
IPCC	• Infection, Prevention and Control Committee
IPCN	• Infection, Prevention and Control Nurse
IPC Team	• Infection, Prevention and Control Team
RMP	• Registered Medical Practitioner
UKHSA	• UK Health and Security Agency

12 How this procedure will be implemented

- This procedure will be published on the Trust's intranet and external website.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.

12.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All staff	Online IPC training	1hr	Yearly

13 How the implementation of this procedure will be monitored

Auditable Standard/Key Performance Indicators		Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	IPC Audit	Yearly environment and IPC audit undertaken by IPCN or Modern Matron	IPCC

14 References

DoH (2001) The Epic project: Developing National evidence- based guidelines for preventing healthcare associated infections.

Lawrence J & May D (2003). Infection Control in the Community. Churchill Livingstone. London

Ayliffe G A J et al. (2000) Control of Hospital Infection (4th edition). Arnold. London

Wilson J (2001). Infection Control in Clinical Practice. Bailliere Tindall. London

National Institute for Clinical Excellence (NICE) 2012. Infection control: Prevention of healthcare-associated infection in primary and community care.

DoH (2015) The Health Act 2008 Code of Practice for the Prevention and Control of Health Care Associated Infection London DH 2015.

DoH (2006) Essential steps to safe, clean care. Reducing healthcare-associated infections in Primary Care Trusts; Mental health trusts; Learning disability organisations; Independent healthcare; Care Homes; Hospices: GP practices and Ambulance Services.

Notifiable Diseases

Home - Royal Marsden Manual (rmmonline.co.uk) accessed 19 January 2023

15 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval:	09 June 2022 v3.3 19 January 2023 v3.4	
Next review date:	13 April 2025	
This document replaces:	Infectious Diseases IPC-0001-007-v3.3	
This document was approved by:	Name of committee/group	Date
	IPCC (v3.2) Head of IPC (pending retrospective recording in IPCC minutes) (v3.3) IPCC (v3.3) IPCC v3.4 (changes in principle)	13 April 2022 (v3.2) 09 June 2022 (v3.3) (Pending) 19 January 2023
This document was ratified by:	Name of committee/group	Date
	IPCC (actual amended document to be retrospectively approved)	20 April 2023 (pending formal retrospective approval)
An equality analysis was completed on this document on:	09 March 2022	
Document type	Public	
FOI Clause (Private documents only)	N/A	

Change record

Version	Date	Amendment details	Status
v3.2	13 April 2022	Full review with transfer to new template. Minor changes:- Change 1 Updated contact telephone numbers for health protection team,	Approved

		Change 2 Covid-19 added to notifiable diseases list.	
v3.3	9 June 2022	Minor change only:- Added 'Monkey Pox' and 'Scarlet fever' to section 5 Notifiable Diseases and to Appendix 3 – Infectious Diseases	Approved by Head of IPC Pending retrospective recording in IPCC minutes
v3.4	19 Jan 2023	Minor change only: Information regarding safe labelling and transportation of specimens added to section 7.10, due to withdrawal of procedure Ref IPC-0001-015 v3 for specimen collection Minor change only: Links to specimen collection procedures within the Royal Marsden Online Manual added into section 7.10 Royal Marsden online added to references	Agreed in principle at IPCC 19 January 2023, pending retrospective final approval at IPCC 20 April 2023

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Nursing and Governance / IPC and Physical Healthcare
Title	Infectious Diseases
Type	Procedure/guidance
Geographical area covered	Trust wide
Aims and objectives	To set standards in practice to ensure the delivery of patient care is carried out safely and effectively by trust staff. To comply with the Health and Social Care Act 2008.
Start date of Equality Analysis Screening	25/02/2022
End date of Equality Analysis Screening	09/03/2022

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Trust staff and patients
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **- NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **- NO** • **Sex** (Men, women and gender neutral etc.) **- NO** • **Gender reassignment** (Transgender and gender identity) **- NO**

	• **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **- NO** • **Age** (includes, young people, older people – people of all ages) **- NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **- NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **- NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **- NO** • **Veterans** (includes serving armed forces personnel, reservists, veterans and their families **- NO**
Describe any negative impacts	None
Describe any positive impacts	None

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	National guidance and legislation on reportable disease
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	No
If you answered Yes above, describe the engagement and involvement that has taken place	N/A

If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	Training needs
As part of this equality analysis have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	Annual mandatory infection prevention and control training
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	Infection control update prior to attending Trust site

Check the information you have provided and ensure additional evidence can be provided if asked

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet
You must contact the EDHR team if you identify a negative impact - email tewv.eandd@nhs.net

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	N/A	
	Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	Are training needs included in the document?	Yes	
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
10.	**Publication**		
	Has the document been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	

Appendix 3 – Infectious Diseases

Infection or disease	Transmission route	Incubation period	Infectious period / length of isolation	Isolation required	Notifiable to HPT	PPE	Method of cleaning, on discharge or deemed no longer infectious
Bordetella Pertussis (Whooping cough)	Respiratory secretions	7-20 days	3 weeks after onset of cough or 5-7 days after commencing appropriate treatment	Yes	Yes	Gloves and apron	Routine clean
Campylobacter enteritis (Campylobacter jejuni)	Ingestion of the organism in contaminated / undercooked food or water and contact with infected pets / farm animals	2-5 days	Can be excreted in faeces for several weeks	Yes, if possible	Yes	Gloves and apron	Routine clean
Chicken Pox (Varicella Zoster)	Person to person through respiratory secretions / direct contact with vesicle fluid	2-3 weeks	1-2 days before lesions appears and 5 days after	Yes	No	Gloves and apron	Terminal clean

Infection or disease	Transmission route	Incubation period	Infectious period / length of isolation	Isolation required	Notifiable to HPT	PPE	Method of cleaning, on discharge or deemed no longer infectious cleaning
Clostridium difficile (Toxin positive / toxin negative and relapse)	Patient to patient by faecal oral route, indirectly by health workers hands and environmental contamination	Variable	48hrs from last episode of diarrhoea and must have passed a formed stool	Yes	No	Gloves and apron / full length fluid repellent gown	Terminal clean
Conjunctivitis	Direct contact	24-72 hours	Duration of symptoms	No	No	Gloves for contact with eyes	Routine clean
Cryptosporidiosis (Cryptosporium parvum)	Faecal oral, person to person, animal to person, waterborne and foodborne	1-12 days, average 7 days	Can be excreted in stool for several weeks. 48hrs following last episode of diarrhoea.	Yes	No	Gloves and apron	Terminal clean

Infection or disease	Transmission route	Incubation period	Infectious period / length of isolation	Isolation required	Notifiable to HPT	PPE	Method of cleaning, on discharge or deemed no longer infectious
Cytomegalovirus (CMV)	Contact with mucous membranes, urine and respiratory secretions, pregnant person / mother to baby	Mother to baby 3-12 weeks after delivery	Excreted in saliva and urine for months	No	No	Gloves and apron for contact with secretions and urine	Routine clean
COVID-19 – See separate guidance / contact IPCT	Respiratory secretions						
Giardiasis (Giardia Lamblia)	Direct contact with faeces and water borne	3-25 days	Until 48hrs symptom free	Yes	Yes	Gloves and apron	Routine clean
Glandular fever (Epstein-Barr virus)	Person to Person oropharyngeal route via saliva / close personal contact	4-6 weeks	Pro-longed	No	No	Standard precautions	Routine clean
Group A Streptococcal infections / Strep pyogenes (Beta-Haemolytic strep)	Respiratory secretions and direct contact with lesions	1-3 days	Until completion of 48hrs of appropriate treatment	Yes	Only in invasive disease (iGAS)	Gloves and apron	Terminal clean

Infection or disease	Transmission route	Incubation period	Infectious period / length of isolation	Isolation required	Notifiable to HPT	PPE	Method of cleaning, on discharge or deemed no longer infectious
Group C and G Streptococcal infections (Beta Haemolytic strep)	Respiratory secretions and direct contact with lesions		Until completion of 48hrs of appropriate treatment	Yes - only in respiratory / throat / blood cultures	No	Gloves and apron	Terminal clean - only when isolation is required
Hand foot and mouth	Direct contact with nose and throat	3-5 days	During the acute stages	Whilst in the acute stages when feeling unwell	No	Gloves and apron	Terminal clean
Head lice / pubic lice	Head to head contact. Close personal direct contact	7-10 days depending upon temperature	N/A	No	No	Refer to policy	Routine clean
Hepatitis A	Contact with faeces	15-50 days, average 28-30 days	Immediately before until 7 days after the onset of jaundice	Yes	Yes	Gloves and apron	Terminal clean

Infection or disease	Transmission route	Incubation period	Infectious period / length of isolation	Isolation required	Notifiable to HPT	PPE	Method of cleaning, on discharge or deemed no longer infectious
Hepatitis B	Contact with blood and body fluids through inoculation from sharps / splashes / bites, unprotected sexual intercourse and pregnant person / mother to baby. The degree of risk is influenced by the injury type - Penetrating wounds with large volumes of blood, and hollow bore needles carry greater risk than superficial injuries and splashes	45-180 days average 60 - 90 days.	Prolonged	No - single room maybe required if bleeding, incontinent or other clinical indication	Yes	Standard precautions	Routine clean

Infection or disease	Transmission route	Incubation period	Infectious period / length of isolation	Isolation required	Notifiable to HPT	PPE	Method of cleaning, on discharge or deemed no longer infectious
Hepatitis C	The greatest risk is through infected blood and spread by the sharing of blood-contaminated needles and injecting equipment among injecting drug users	2 weeks - 6 months average 6-9 weeks.	Prolonged	No - single room maybe required if bleeding, incontinent or other clinical indication	Yes	Standard precautions	Routine clean
Herpes simplex virus (HSV types 1 & 2)	Contact with saliva HSV 1 Sexual contact HSV 2	2-12 days	Until lesions are dry	No	No	Standard precautions	Routine clean
Herpes Zoster (Shingles)	Contact with vesicle fluid	2-3 weeks	Until lesions are dry	Yes – depending where lesions are. Seek IPC advice.	No	Gloves and apron - exclude non immune staff	Terminal clean

Infection or disease	Transmission route	Incubation period	Infectious period / length of isolation	Isolation required	Notifiable to HPT	PPE	Method of cleaning, on discharge or deemed no longer infectious
HIV (Human immunodeficiency virus)	Sexual contact / sharing contaminated needles / transfusion of infected blood / transplantation of infected tissue	Variable (HIV 1- 3 months /	Unknown	No	Yes	Standard precautions	Routine clean - caution if a large blood spillage has occurred
Impetigo	Direct contact with skin lesions	Variable	Duration of lesions or until at least 48hrs of appropriate therapy is completed	Yes	No	Gloves and aprons	Routine clean
Infectious diarrhoea - Norovirus / Rotavirus	Direct contact with faeces and aerosol from vomit	2- 3 days	Until at least 48hrs symptom free	Yes	No	Gloves and apron	Terminal clean

Infection or disease	Transmission route	Incubation period	Infectious period / length of isolation	Isolation required	Notifiable to HPT	PPE	Method of cleaning, on discharge or deemed no longer infectious
Influenza	Respiratory secretions	24-72 hrs.	7 days after onset of symptoms	Yes	Yes	Gloves and apron. Surgical face mask if in close contact of a patient -2 metres, eye protection if a risk of excessive coughing / sneezing into eyes.	Routine clean
Legionellosis (Legionnaires disease, Legionnaires pneumonia)	Airborne (not person to person)	2-10 days	N/A	No	Yes	Standard precautions	Routine clean
Measles	Airborne via respiratory droplets or direct contact with secretions	10 days	From before rash appears until 4 days after	Yes	Yes	Gloves and apron	Routine clean
Infection or disease	Transmission route	Incubation period	Infectious period /	Isolation required	Notifiable to HPT	PPE	Method of cleaning, on discharge or

			length of isolation				deemed no longer infectious
Monkey Pox	Direct contact and indirect contact	5-21 days	Until lesions have dried and intact skin underneath – seek advice from IPCT	Yes	Yes	FFP3 mask (staff must be fit tested) Gloves Long sleeved gown Eye protection	Terminal clean
MRSA	Direct and indirect contact	Variable	Ideally until 3 negative sets of swabs	Refer to policy	No	Gloves and apron	Terminal clean
Multi Resistant Gram Negative Bacteria. Including ESBL / Amp C / CPE	Direct and indirect contact	Variable	See notes	Yes – refer to policy / IPCT	No	Gloves and apron	Terminal clean
Mumps	Respiratory droplet and direct contact with saliva and urine	15-18 days	7 days prior to appearance of symptoms and up until 5 days after	Yes	Yes	Gloves and apron	Routine clean
Parvovirus	Respiratory secretions /pregnant person / Mother to foetus	Variable 4-20 days	7 days after onset of rash	Yes	No	Gloves and aprons	Terminal clean

Infection or disease	Transmission route	Incubation period	Infectious period / length of isolation	Isolation required	Notifiable to HPT	PPE	Method of cleaning, on discharge or deemed no longer infectious
Ringworm	Direct skin to skin contact or indirect contact from backs of chairs, barber clippers, combs, hairbrushes	10-14 days	Until clinically cured	only children	No	Gloves and aprons when dealing with lesions	Routine clean
Rubella (German measles)	Direct contact with respiratory secretions and urine	14-21days	7 days prior to onset of rash and at least 4 days after	Yes	Yes	Gloves and apron	Terminal clean
Salmonella	Food borne and direct contact with faeces	6-72 hours usually 12-36 hours	Until 48hrs after commencing normal stools	Yes	Yes	Gloves and apron	Terminal clean
Scabies	Prolonged skin to skin contact	2-6 weeks	Until mite destroyed by treatment	No - unless Norwegian scabies	No	Gloves and aprons for direct patient contact	Routine clean
Scarlet fever - refer to Group A Strep							

Infection or disease	Transmission route	Incubation period	Infectious period / length of isolation	Isolation required	Notifiable to HPT	PPE	Method of cleaning, on discharge or deemed no longer infectious
Syphilis	Direct contact with infectious exudate from obvious or concealed moist lesions of the skin and mucosal membranes. Sexual contact, pregnant person / mother to baby	10 days to 3 months usually 3 weeks	Until 48 hrs of appropriate therapy	No	No	Gloves and aprons for contact with bodily fluids	Routine clean
Threadworm (Pinworm)	See comments	2-6 weeks	On completion of appropriate treatment. However the eggs can survive for 2 weeks outside the body	No	No	Gloves and apron when dealing with bodily excretions, faecally contaminated bed linen and clothes	Routine clean

Infection or disease	Transmission route	Incubation period	Infectious period / length of isolation	Isolation required	Notifiable to HPT	PPE	Method of cleaning, on discharge or deemed no longer infectious
Tuberculosis (Mycobacteria Tuberculosis)	Respiratory secretions / airborne	2-10 weeks	Patients who are positive, are normally considered to be non-infectious after 14 consecutive days of continuous treatment with anti-tuberculosis therapy (antibiotics).	Yes - smear positive pulmonary TB	Yes	Gloves and aprons. Face masks are not generally required for staff. A patient who is smear positive and has a productive cough should be asked to wear a surgical mask if they leave their room.	Terminal clean
Vancomycin resistant enterococci (VRE) also known as Glycopeptide resistant enterococci (GRE)	Direct / indirect contact		Completion of treatment and faecally continent.	Refer to IPC	No	Gloves and apron	Terminal clean