Public – To be published on the Trust external website

Title: Chickenpox (varicella zoster) and Shingles (herpes zoster) procedure

Ref: IPC-0001-026-v1.1

Status: Approved
Document type: Procedure

Contents

1 Introduction

Chickenpox is a common childhood illness in the UK. It is caused by a virus called varicella-zoster. Approximately 90% of adults in the UK are immune to chickenpox because they have been exposed to the virus and had chickenpox as a child. Those who have not had chickenpox during childhood are still at risk, as chickenpox is spread quickly and easily from infected people to others who are susceptible and to those who do not have immunity.

Following initial chickenpox infection, the body produces antibodies that protect the person from further infection. The chickenpox virus remains within the nervous system, where it lies dormant and inactive. However, as people get older or if they become immunosuppressed immunity to chickenpox, can wane and varicella zoster virus present in their nerve cells from previous infection can become reactivated and cause shingles (also known as herpes zoster). Stress can also cause immunity to wane resulting in shingles.

Shingles occurs when the dormant virus (varicella) reactivates and spreads down the sensory nerve roots. This produces a localised rash. Shingles can only occur in people who have previously had chickenpox and therefore have dormant virus. Some people may not recall having chickenpox, as they may have had an asymptomatic or very mild illness with little or no spots.

Chickenpox is highly infectious and is mainly transmitted via the respiratory route. While shingles is less infectious and is mainly transmitted via direct contact with the fluid produced in the rash (vesicles).

You cannot catch shingles from someone who has chickenpox or shingles.

You can catch chickenpox from someone who has shingles if you have not had chickenpox before and therefore do not have any immunity.

This procedure aligns with our journey for change as set out in the overarching Infection Prevention and Control Policy

2 Purpose

Following this procedure will help the Trust to: -

- Ensure patients with chickenpox and shingles are cared for appropriately and actions are taken to minimise risk of cross infection and severe infection.
- Ensure the safety of all patients in our care by implementing infection prevention and control controls and measures promptly.
- Ensure any member of staff with chickenpox or shingles are excluded from work until deemed non infectious

3 Who this procedure applies to

- All trust staff.
- This procedure aligns with Trust values as we listen to staff and respect their views. We ensure any staff member who has difficulties with the measures detailed in this procedure can discuss their needs so that standards are maintained while individual differences are recognised and supported.

4 Related documents

Standard precautions for Infection Prevention and Control Policy which you must read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to: -

- Standard IPC Precautions
- Hand Hygiene
- Decontamination of equipment
- Infectious diseases
- Laundering and safe handling of linen and clothing procedure
- Human, Rights, Equality Diversity and Inclusion Policy

5 Chickenpox - background

Most people in the UK develop chickenpox during childhood. However, some adults (up to 5-8% of the population) have never been infected with varicella zoster virus. People who do not have a definite history of previous chickenpox (or shingles) and who have not been vaccinated are regarded as non-immune. These individuals are vulnerable to varicella zoster infection.

People from Tropical countries are less likely to have had chickenpox as a child than UK-born individuals. Therefore, a relatively high proportion of adults from tropical countries are susceptible to infection with varicella zoster virus.

Chickenpox and shingles can both result in shedding of varicella zoster virus. Therefore, both chickenpox and shingles can lead to chickenpox in susceptible contacts. Exposure to

varicella zoster cannot always be prevented, but steps can be taken to reduce the risk of severe complications in those who are most at risk through post exposure prophylactic treatment.

5.1 Symptoms of chickenpox

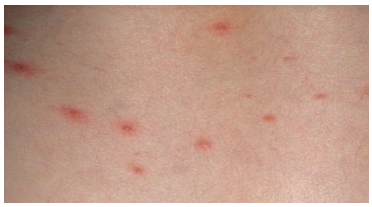
Chickenpox virus initially causes an acute systemic illness. 1-2 days before the rash appears, most people develop some mild flu-like symptoms, including:

- feeling sick
- a high temperature (fever) of 38C or over
- aching, painful muscles
- headache
- generally feeling unwell
- loss of appetite

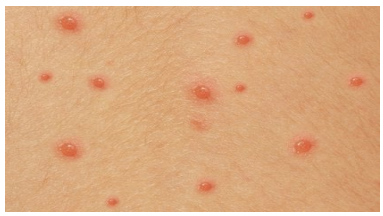
Symptoms, especially fever tend to be more common and worse in adults than in children.

The classical sign of chickenpox is the appearance of crops of spots/blisters (vesicles) that initially start on the face and scalp before spreading to the trunk and limbs. The rash typically develops in 3 stages:

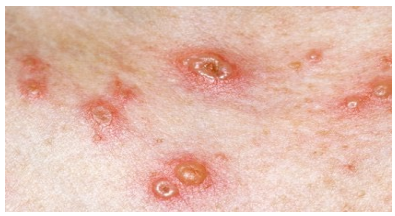
- In **stage 1**, the spots occur in successive crops and can be anywhere on the body, including in the mouth or around the genitals where the spots maybe quite painful. Several stages of spot development are present on the body at the same time, with new spots occurring whilst older spots are forming blisters and scabs.
- In **stage 2** the spots turn into fluid filled blisters that can be very itchy and can easily burst.
- Eventually in **stage 3** the lesions dry to form scabs that eventually drop off. Some of the scabs will become flaky whilst others will leak fluid.



Stage 1



Stage 2



Stage 3

Taken from NHS Chickenpox 2023 Chickenpox - NHS (www.nhs.uk)

The chickenpox spots look the same on children and adults. But adults usually have a high temperature for longer and more spots than children.

It is possible to get chickenpox more than once, but this is very unusual.

Chickenpox is usually a relatively mild illness that doesn't require any specific treatment. However, in adults or people who are immunosuppressed chickenpox can be more severe and can result in secondary complications such as pneumonia, encephalitis, and hepatitis.

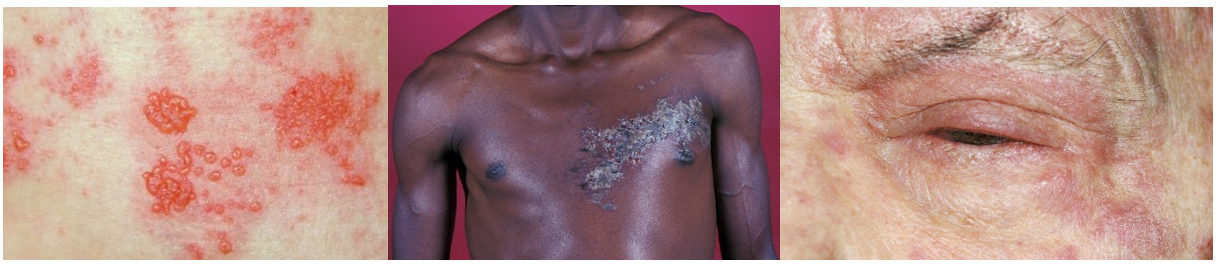
- Primary viral pneumonia is the most common complication in adults.
- People who smoke are particularly at risk of fulminating varicella pneumonia.

5.2 Symptoms of shingles

The first signs of shingles are usually:

- a tingling or painful feeling in an area of skin
- a headache or feeling generally unwell

This is usually followed by a rash (lesions) that appears a few days later. Most commonly the rash appears on the chest and abdomen, but it can appear anywhere on the body including, the face, eyes and genitals. Shingles rash appears as blotches on the skin, and usually only affects one side of the body.



Shingles rash pictures taken from NHS (2023) Shingles - NHS (www.nhs.uk)

Shingles rash becomes itchy blisters that ooze fluid before eventually drying out and forming scabs. The rash can be in and around the eye, making the eyes red and sore it can also affect sight and hearing and make it hard to move the side of the face. It can take up to 4 weeks for the shingles rash to heal, and the skin can remain painful for several weeks after the rash has gone.

6 Mode of transmission

Chicken pox is spread from person-to-person via the following modes of transmission:

- inhalation of virus by the respiratory route. Respiratory infection can be caused by inhalation of large droplet particles or smaller airborne particles. Airborne particles can be suspended in the air for several minutes and may travel several metres from the patient.
- person to person via direct contact with vesicle fluid
- contact with articles (e.g. clothes and bedding) soiled by vesicle fluid or infected respiratory secretions

Shingles cannot be caught from shingles, however if an individual is not immune to chicken pox (i.e. they have never had chicken pox) they are at risk of developing chicken pox from contact with shingles lesion. This would be via the following:

- person to person via direct contact with vesicle fluid
- contact with articles (e.g. clothes and bedding) soiled by vesicle fluid

7 Period of infectivity

Chickenpox can be transmitted to other people from 2 days before the spots appear until the spots have all dried and formed scabs this typically takes 4-7 days from the appearance of the first spots.

The incubation period following exposure to chickenpox is 2 – 3 weeks. In chickenpox, varicella zoster virus is shed from the nasopharynx (upper part of the throat behind the nose) up to 5 days but usually 1 – 2 days before the rash appears.

In chickenpox and shingles, virus is shed from the skin lesions until the vesicles have dried to form scabs.

Patients with chickenpox are generally regarded as infectious from 2 days before the appearance of the rash until all the skin lesions have dried.

Patients with shingles are infectious from the time of onset of the rash until all the skin lesions have dried.

Patients who are immunosuppressed (e.g. those on high doses of corticosteroids, ≥20mg daily for ≥2 weeks) have increased risk of severity and frequency of shingles and are more likely to be infectious for longer and to develop more severe complications of chickenpox.

Pregnant women / people who have no history of chickenpox are also at increased risk of developing severe disease.

Varicella zoster virus is therefore a highly transmissible agent, and Chickenpox is much more infectious than Shingles.

A susceptible person should be regarded as having had a significant contact with an infectious person with chickenpox, if present in the same room for 15 minutes or longer. Any direct face-to-face contact, within six feet, should also be regarded as potentially infectious, regardless of how brief the period of exposure. Significant contact with shingles refers to direct physical contact (not necessarily limited to contact with the skin lesions themselves).

8 Management of patients with suspected or confirmed chickenpox or shingles

8.1 Chicken pox

Admission of patients with chickenpox should be avoided wherever possible, if admission cannot be deferred or avoided, the patient with suspected or confirmed chickenpox must be isolated on admission, into an ensuite room with the door closed, and the IPC team must be informed. If chickenpox develops whilst the patient is an inpatient, isolate the patient in their bedroom with the door closed immediately on symptoms and inform IPC. The patient's privacy and dignity will be maintained throughout their stay.

⚠ Chicken pox is a notifiable disease. Registered medical practitioners must therefore notify the UK Health Security Agency (UKHSA, previously Public Health England) of any suspected or confirmed cases.

Notifiable diseases are certain infections that may present a risk to human health. Check the list of notifiable diseases. Notifiable diseases

Please ensure patients are informed of the notification to UKHSA.

8.1.1 Treatment

Treatment for chickenpox is not routinely prescribed; however, the following actions are advised to assist patient comfort:

- Ensure the patient is provided with plenty of drinks to maintain hydration.
- Analgesic medication such as paracetamol prescribed to help with nerve pain. Discuss with pharmacy re the use of anti-inflammatory medication as these may result in serious skin infections.
- Ensure the patient has short clean nails and discourage scratching, as scratching can cause scarring.

- Cooling creams / antihistamines may be prescribed if appropriate to reduce itching.
- Encourage the patient to wear cool loose clothing.
- Please refer to NICE guidelines for additional support and treatment guidance. https://cks.nice.org.uk/topics/chickenpox/

8.1.2 Isolation

All patients with chickenpox must be isolated in their bedroom preferably with its own ensuite facilities and the door must be closed. In rooms that are not ensuite, a commode must be provided for that patient's personal use only and a bathroom identified for their use only for the duration of their isolation.

During isolation period staff must be mindful of the patient's wellbeing and will make adjustments to ensure wellbeing is maintained.

Patients must be isolated until all the skin lesions are dry and crusted, which is usually about 4 - 7 days after the appearance of the rash.

8.1.3 Personal protective equipment (PPE)

During the period of isolation of a patient with chicken pox anyone entering the patient's room must wear the following PPE:

- Single use disposable gloves
- Single use disposable apron (or long-sleeved gown if extensive splashing or undertaking aerosol generating procedure (AGP's))
- Single use FFP3 mask – please note staff must be fit tested every 2 years as per HSE (2023) guidance and must perform a fit check each time they wear a new FFP3 mask.
- Hands must be washed or decontaminated with alcohol hand sanitiser before donning and after removal of PPE.
- See following NHS England guidance for donning and doffing PPE- Putting on and Removing PPE v3 (england.nhs.uk)

Please consult the National Infection Prevention and Control Manual (NICPM) for England for further information on appropriate use of PPE.

8.2 Shingles

For patients with suspected or confirmed shingles a risk assessment is required. If the shingles lesions (rash) are in a place on the body that can be covered with absorbent waterproof dressings, then the patient may not require isolation. However, the risk assessment must consider the vulnerability and immune status of the other ward patients

and if high risk patients are identified the affected patient will be required to isolate. Examples of high-risk patients are those who individuals who have never had chicken pox, pregnant people and immunosuppressed individuals.

8.2.1 Treatment

Treatment is not routinely required for patients with shingles. However, antiviral medication can be prescribed for patients who are immunosuppressed or are at higher risk of complications. If antiviral treatment is required, it must be started within 3 days of the appearance of the shingles rash. The following actions will also assist patient comfort:

- Analgesic medication such as paracetamol prescribed to help with nerve pain.
- Ensure the affected area is kept clean and dry to reduce the risk of infection.
- Encourage the patient to wear loose fitting clothes.
- If dressings are required to cover the rash, ensure they do not stick directly onto the affected area.

8.2.2 Isolation

All patients with shingles in an exposed area of their body must be isolated in their bedroom preferably with its own ensuite facilities and the door must be closed. If the shingles lesions (rash) are in a place on the body that can be covered with absorbent waterproof dressings, then the patient may not require isolation.

In rooms that are not ensuite, a commode must be provided for that patient's personal use only and a bathroom identified for their use only for the duration of their isolation.

Isolation and period of infectivity will continue until all the lesions (rash) have dried and scabbed over, typically 7-10 days. Although this may take up to 4 weeks to fully heal and the affected skin can be painful even after the rash has gone.

8.2.3 Personal Protective Equipment (PPE)

During the infectious period for patients with shingles staff must wear the following when coming into direct contact with the lesion and or soiled clothing and bedding.

- Single use disposable gloves
- Single use disposable apron
- Hands must be washed or decontaminated with alcohol hand sanitiser before donning and after removal of PPE

8.3 Disposal of clinical waste

All clinical waste, from cases of chicken pox and or shingles is potentially infectious and should be disposed of in the infectious waste stream (orange bags). This includes all gloves, aprons and any disposable articles which may have been in contact with the patient for the duration of isolation including tissues. Once waste bags are 2/3 full the neck should be tied securely, and the bag removed to the disposal area.

8.4 Hand Hygiene

Hand hygiene must be undertaken following removal of PPE/when leaving the patients room. Patients should also be encouraged to wash their hands regularly especially after contact with respiratory secretions or items containing respiratory secretions such as tissues.

8.5 Cutlery/Crockery

Normal ward issue can be used, follow these items must be sanitised in the ward kitchen sanitising unit or dishwasher after each use.

8.6 Linen/ Laundry

Hospital Linen should be treated as 'infected linen' (red soluble plastic bag inside the linen bag) as per the Laundering and safe handling of linen and clothing procedure. Bed linen and towels must be changed daily. Patients should be encouraged to change and launder clothing daily.

8.7 Nursing and medical equipment

Wherever possible all equipment used with patients whilst they are deemed infectious must be either disposable or be able to withstand cleaning/disinfection with 1000ppm million chlorine releasing agent (such as Chlorclean). It is best practice to dedicate medical equipment to the isolated patient. All non-disposable equipment including toys and games must be cleaned after each use with universal Clinell wipes.

8.8 Routine environment / room cleaning

The patient's room must be cleaned daily with 1000ppm chlorine releasing agent (Chlorclean) including all equipment and horizontal surfaces.

8.9 Terminal Cleaning

The patient's bedroom and ensuite must be terminally cleaned as soon as the patient is deemed no longer infectious and isolation discontinued, or on discharge/transfer of the patient. New patients must not be admitted to the affected area until terminal cleaning has been performed. If the patient is transferred to an alternative healthcare provider, the

receiving area and transport team must be informed of the patient's infection status in advance.

8.10 Visitors

Only visitors with known immunity (definite history of vaccination or history of having chickenpox or shingles) are advised to enter the patient's room. Non-immune visitors must be advised and excluded from visiting during the period of infectivity and visiting should be restricted to close contacts only with known immunity.

8.11 Laboratory testing

Laboratory confirmation of chicken pox and shingles is not routinely required as diagnosis can reliably be made from clinical signs and symptoms. Further advice on diagnosis is provided by NICE (2023) Chickenpox | Health topics A to Z | CKS | NICE.

9 Infection Prevention & Control

The infection prevention and control team must be informed of all patients, who have chickenpox or shingles.

The occupational health department and the infection prevention and control team must be informed of any staff member who develops chickenpox, especially if the staff member has been on duty in the 48hours prior to their spots appearing.

All staff with patient contact are strongly advised to have immunity to infection with varicella zoster virus. Staff, who have had chickenpox or who have been shown to have antibody to varicella zoster virus, are not at risk of chickenpox. Only staff who are immune to chickenpox can enter the isolated patient's room.

Any staff member who is concerned that they may not be immune to varicella zoster virus must not have contact with a patient with chicken pox or shingles. They should contact the occupational health department immediately for advice and assessment as vaccination may be required.

Any non-immune, pregnant staff member who comes into contact with a patient with varicella infection should seek advice from their Midwife and the occupational health department.

Any non-immune persons who have been exposed to a patient with varicella-zoster infection should be isolated from 7 days following their first exposure until 21 days after their last exposure. Contact the IPC team for further advice as confirmation blood tests may be advised to ascertain immunity status and to assesses if post exposure prophylaxis is required.

Patient information leaflets on both Chickenpox and Shingles can be found on the IPC intranet page and should be offered to patients.

Only staff with known immunity (definite history of vaccination or history of having chickenpox or shingles) can enter the patient's room. Pregnant staff should not care for patients with chicken pox.

10 Managing Contacts of Cases

Significant contact with an infectious person is defined as being present in the same room for 15 minutes or longer or any face-to-face contact (regardless of how brief) with a person with chickenpox.

Significant contact with shingles is usually defined as direct physical contact with the patient (not necessarily limited to contact with the skin lesions themselves).

Managing contacts of patients with chickenpox or shingles involves the following processes:

- Determining who has been exposed to the source patient.
- Deciding if the contact is non-immune and therefore at risk of acquiring chickenpox.
- Preventing non-immune contacts spreading infection to others.

NICE (2023) guidelines provide further advice if required Chickenpox | Health topics A to Z | CKS | NICE

10.1 Deciding if the Contact is non-immune

All patients and staff who have been exposed to someone with chickenpox or shingles should be asked if they have ever had chickenpox or shingles previously. People who cannot give a definite history of having had a varicella infection are potentially non-immune. Staff must contact Occupational health for further advice. Patients should have their blood tested for varicella zoster IgG antibody. If they are found to be antibody negative or there is an equivocal result, then the patient is regarded as non-immune and at risk of developing chickenpox.

10.2 Preventing Non-Immune Patients Infecting Others

Non-immune persons who have been exposed to a patient with varicella-zoster infection should be isolated from 7 days following their first exposure until 21 days after their last exposure.

Patients who give a definite history of previous chickenpox or shingles or who are shown to have varicella zoster IgG antibodies do not require isolation as they are not at risk of infection.

10.3 Pregnant women / people

Chickenpox in early pregnancy (i.e. during the first 20 weeks) is associated with congenital malformations in around 2% of cases. Infection during pregnancy also carries an increased risk of severe chickenpox pneumonia in the pregnant women/person.

Post exposure prophylaxis is recommended for pregnant women/person who fulfil all the following 3 criteria:

- significant exposure to chickenpox (varicella) or shingles (zoster) during the infectious period
- at increased risk of severe chickenpox such as immunosuppressed individuals or women / people pregnant
- no antibodies to varicella-zoster virus (VZV) – urgent VZV antibody testing can be performed within 24 hours

UKHSA (2023) provide further guidance to aid risk assessment post exposure prophylaxis for varicella or shingles in pregnancy.

Shingles in pregnancy is mostly mild with little, or no risk associated to the baby.

10.4 Varicella Zoster Vaccine

Vaccination with varicella zoster vaccine is used to protect non-immune staff from acquiring chickenpox. When new staff members commence employment, they should be screened for a history of previous chickenpox by the occupational health department. Staff members who cannot recall having had a definite episode of chickenpox will be tested for antibodies to varicella zoster virus. Staff members, who are found to have negative or equivocal antibodies to varicella zoster virus, will be offered vaccination against the infection.

10.5 Shingles Vaccine

The pharmacy team must be consulted to discuss shingles vaccination for individual patients. Shingles vaccination is recommended for the following groups of people:

- people who turned 65 on or after 1 September 2023
- people aged 70 to 79 who have not yet been vaccinated
- people aged 50 and over with a severely weakened immune system

Shingles vaccine helps to protect individuals against shingles by reducing the risk of getting shingles and reducing the chances of getting serious complications of shingles. People can have shingles more than once and you can still get shingles following vaccination, however symptoms can be much milder.

All staff should have chickenpox immunity – check with the Occupational Health Team if you are unsure

11 Terms and definitions

Term	Definition
VZV	• Varicella Zoster Virus
VZIg	• Varicella immunoglobulin
Herpes zoster	• Shingles
Varicella	• Chickenpox
Chickenpox	• Is a highly infectious disease caused by Varicella zoster virus
Shingles	• Caused by VZV and is secondary to chicken pox
Immunoglobulin	• A specialised preparation of antibodies taken from the plasma of blood doners
Incubation period	• Time from becoming infected to when symptoms first appear
Pneumonia	• inflammation of the lungs, usually caused by an infection
Encephalitis	• swelling of the brain
Vesicles	• blisters on the skin
Lesions	• spots / blisters / rash

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 trust staff	E learning IPC mandatory training	Approx. 1 hour	Yearly clinical staff 3 yearly nonclinical staff

13 How the implementation of this procedure will be monitored

Number	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	Reviewing infections reported by nursing staff	IPC quarterly report to the IPC committee members	IPC committee

14 References

Department of Health (2029) The Green book Varicella - Chapter 34 (publishing.service.gov.uk)
Last accessed 27/02/24

NHS England (2021) Chickenpox - NHS (www.nhs.uk) last accessed 27/02/24

NHS Scotland (2023) Chickenpox | NHS inform

NHS England (2023) Shingles - NHS (www.nhs.uk) last accessed 13/03/24

NHS England (2023) Shingles vaccine - NHS (www.nhs.uk)

Department of Health (2014) Chickenpox: public health management and guidance - GOV.UK (www.gov.uk) last accessed 13/03/24

Public Health England (2017) - Guidance on infection control for chickenpox and shingles in prisons, immigration removal centres and places of detention (publishing.service.gov.uk) last accessed 27/02/24

National Institute for Health and Care Guidance (2023) Chickenpox | Health topics A to Z | CKS | NICE last accessed 13/03/24

UKHSA (2023) Guidelines on post exposure prophylaxis for varicella or shingles (publishing.service.gov.uk) last accessed 13/03/24

NHS England » National infection prevention and control manual for England – appendices last accessed 3/04/24

15 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	14 January 2026
Next review date	16 April 2027
This document replaces	IPC-0001-026-v1
This document was approved by	IPCC
This document was approved	14 January 2026
This document was ratified by	n/a
This document was ratified	n/a
An equality analysis was completed on this policy on	24 November 2025
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
1	16 Apr 2024	New document	Withdrawn
1.1	14 Jan 2026	Added to section “Management of patients with suspected or confirmed Chickenpox or Shingles” yellow important box information with text “Chicken pox is a notifiable disease…” * Clarified PPE requirements for chicken pox and shingles. Separated management guidance for chicken pox and shingles - see section 8. *note this change was discussed at IPCC October 2025 but publication paused until further discussions held.	Approved

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	Infection Prevention Control Team
Title	Chickenpox and Shingles procedure
Type	Procedure
Geographical area covered	Trust wide
Aims and objectives	Prevention and management of cases of chickenpox and shingles
Start date of Equality Analysis Screening	24 November 2025
End date of Equality Analysis Screening	24 November 2025

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Patients, families, carers, staff and visitors
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	Patients who have shingles or chickenpox will be required to isolate for a period of time. Consideration will be made to the patient's wellbeing and adjustments will be made to ensure wellbeing, privacy and dignity is maintained. Adjustments will also be made to ensure communication with a patient's family and friends is maintained if they are unable to visit'
Describe any positive impacts	The procedure aims to safeguard and protect people with certain protected characteristics e.g. Pregnancy & Maternity', 'Disability' such as immunocompromised.

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.)	UKHSA guidelines NICE guidelines NHS guidelines
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes

If you answered Yes above, describe the engagement and involvement that has taken place	IPC team IPC Committee will review and approve this document, IPCC includes patient representatives. The draft procedure will also be submitted for trust wide consultation.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	N/A

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	n/a
Describe any training needs for patients	n/a
Describe any training needs for contractors or other outside agencies	n/a

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

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?	Yes	
	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	
	Are training needs included in the document?	Yes	

	Title of document being reviewed:	Yes / No / Not applicable	Comments
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	03/12/2025
9.	**Approval**		
	Does the document identify which committee/group will approve it?	yes	IPC
10.	**Publication**		
	Has the policy been reviewed for harm?	yes	
	Does the document identify whether it is private or public?	Yes	public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	