

Isolation Procedure

ICPr012

| Version No. | Date Ratified/ Amended | Date of Implementation | Next Review Date | Reason for Change (eg. full rewrite, amendment to reflect new legislation, updated flowchart, minor amendments, etc.) |
|-------------|------------------------|------------------------|------------------|---|
| 1 | 01/03/16 | | 01/03/2018 | Changed from policy to procedure |
| 2 | June 18 | 29/06/2018 | 30/06/2020 | review |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

*This document is uncontrolled once printed. Please refer to the Trust intranet for the current version.
ICPr012 review June 20*

Table of Contents

| | | |
|----|---|------------------------------|
| 1 | INTRODUCTION | 4 |
| 2 | MODES OF TRANSMISSION..... | 5 |
| 3 | RISK ASSESSMENT | 5 |
| 4 | TYPES OF ISOLATION | 5 |
| 5 | STANDARD PRECAUTIONS | 6 |
| 6 | PRINCIPALS OF ISOLATION NURSING | 7 |
| 7 | ENTERING THE ISOLATION AREA..... | 7 |
| 8 | PRECAUTIONS FOR VISITORS | 8 |
| 9 | DISPOSAL OF FAECES/URINE..... | 8 |
| 10 | DISPOSAL OF CLINICAL WASTE..... | 9 |
| 11 | CROCKERY AND CUTLERY..... | 9 |
| 12 | CLEANING | 9 |
| 13 | LINEN | 10 |
| 14 | PROTECTIVE ISOLATION..... | 10 |
| 15 | TRANSPORT/TRANSFER TO OTHER DEPARMENTS/HOSPITALS..... | 10 |
| 16 | IN THE CASE OF DEATH | 10 |
| 17 | WHEN CAN ISOLATION PRECAUSTIONS BE STOPPED? | 11 |
| 18 | REFERENCES AND FURTHER READING | 11 |
| 19 | APPENDIX 1 - EQUALITY CONSIDERATIONS | ERROR! BOOKMARK NOT DEFINED. |
| 20 | APPENDIX 2 - INTER HEALTH CARE INFECTION PREVENTIONS AND CONTROL TRANSFER FORM..... | 12 |
| | APPENDIX 3 - A-Z OF INFECTIOUS DISEASE..... | 14 |

1 INTRODUCTION

The terms 'isolation' and 'isolation nursing' are used in preference to 'barrier nursing'. There are two reasons for isolating patients for control of infection purposes:

- to protect the patient 'Protective Isolation'
- to protect others 'Source Isolation'.

This procedure will deal with the isolation of the patient to protect others '**Source Isolation**'. Source isolation is used to minimise the risks of micro-organisms being transferred from the affected person to other patients and staff. It is important to recognise that it is the **micro-organism**, which is being isolated (e.g. Source) rather than the patient. Advice should be sought from the Infection Prevention and Control Nurse (IPCN) on the appropriateness of isolating patients/residents. Before deciding to isolate a patient, careful consideration must be given to the following:

- patient/resident's clinical condition, e.g. mental health
- mode of transmission of the infection, e.g. air-borne, faecal-oral route
- the availability of facilities
- the environment
- the susceptibility of others to the infection
- evidence-based practice.

The decision to isolate a patient/resident in any setting must not be taken lightly and should always be taken after assessing the risk to the individual, other patients/residents and staff. To isolate a confused or distressed patient may be detrimental to their well-being. When isolation precautions are required they should be tailored to meet the needs of the patient/resident rather than the application of a ritual. Whilst additional precautions may need to be taken with some communicable diseases, e.g. the wearing of masks for Pulmonary TB, the application of **Standard Precautions** is all that is required for the majority of infections.

2 MODES OF TRANSMISSION

Infection can spread by a number of methods: airborne, droplet, contact and blood borne spread

- Airborne transmission occurs by dissemination of droplet nuclei or dust particles containing the infectious agent; microorganisms can be dispersed widely and over long distances.
- Droplet transmission: droplets are generated from the source person primarily during coughing, sneezing and talking and are propelled a short distance only.
- Contact transmission is the most important and frequent mode of transmission and involves either direct person-to-person contact or indirect contact via a contaminated intermediate object.
- Blood-borne infection via inoculation is prevented by standard precautions which must be applied to all patients at all times

3 RISK ASSESSMENT

Risk assessment is the assessment of the factors that influence the transmission of a pathogen and its impact. It enables staff to prioritize the use of isolation facilities **and must** be done in conjunction with the Infection Prevention and Control Team.

When undertaking a risk assessment with the Infection Prevention and Control Team the following factors will be considered:

- The type of pathogen
- The route of transmission and any evidence of transmission
- Susceptibility of the other patients near to the infected patient in the same bay
- Whether the organism is antibiotic resistant.
- Possible detrimental effects of isolation to the patient i.e. risk of falls, confusion or depression weighed against severity of the risk of transmission to other patients.
- Control methods and their rationale

Northamptonshire Healthcare foundation Trust Community Infection Prevention Tool must be used to identify patients at risk of infection, to identify further actions required

4 TYPES OF ISOLATION

There are two types of isolation nursing:

Source isolation is to segregate the infected patient/resident in a single room to prevent the spread of infection to other patients

Protective isolation is used to segregate the susceptible patient/resident to prevent them from acquiring an infection from other patients.

Cohort nursing may be undertaken if there are several patients/residents with the same infection/symptoms and there are insufficient facilities available to isolate each patient in a single room. In this situation, a number of patients may share the same room/area. These areas should have doors that can be closed to provide physical separation from other patients. Cohorted patients should be cared for by **designated staff**. (*DH Saving Lives 2007*). Patients with *Clostridium difficile* infection must only be cohorted with other patients with confirmed *Clostridium difficile*.

Requirements

Isolation nursing will normally be carried out in a single room. The room should ideally have its own toilet and hand basin. If en-suite facilities are not available, a designated toilet/commode must be identified for the infected person's use.

Should the patient develop a condition which requires isolation and a single room is not available, standard precautions should be strictly adhered to. The IPCN should be contacted for further advice.

5 STANDARD PRECAUTIONS

Please read in conjunction with the Standard Precautions/Hand Hygiene Procedure.

In association with Standard Precautions, it is important that staff wear protective clothing **only** when it is appropriate:

- disposable gloves should be worn when in contact with body fluids, e.g. blood, urine, faeces
- disposable aprons should be worn when in contact with body fluids, or to protect the healthcare worker's clothing/uniform from direct contact with the patient's clothing or bedding.

It is important to dispel the belief/tradition that because a patient is in isolation, healthcare workers need to put on protective clothing even if they are undertaking tasks that do not have direct contact with the patient, e.g. giving a patient a cup of tea. A risk assessment should be used for all patients whether isolated or not.

However, for patients with confirmed or suspected ***Clostridium difficile*** infection, all healthcare workers must use gloves and aprons for any contact with such patients, as well as their immediate environment and body fluids, in line with the **sight** protocol. Protective clothing should be changed between procedures as per standard precautions. See *Clostridium Difficile Procedure*.

EQUIPMENT THAT MAY BE REQUIRED (Care should be taken not to over stock the isolation area.)

- Charts.
- Disposable aprons.
- Latex gloves or equivalent.
- Clinical waste bag – refer to Waste Management Policy.

*This document is uncontrolled once printed. Please refer to the Trust intranet for the current version.
ICPr012 review June 20*

- Notice for the door (if applicable) with advice to see nurse in charge before entering.
- Alcohol hand gel.
- Masks (only if appropriate for the patients condition, e.g. TB).
- Eye protection – only if there is a possibility of splashing of body fluids to the eyes/face.
- A red soluble laundry bag for foul/infected linen.
- A red linen or plastic laundry bag for transportation to the laundry room.
- Pedal operated bin lined with orange bag for clinical waste.
- Sharps bin.
- Wash bowl.
- Bed (a plastic cover should be on the mattress and pillowcases underneath the bed linen).
- Liquid soap (preferably wall mounted).
- Paper towels (preferably in a dispenser and wall mounted).
- Designated commode (if en-suite facilities are not available).
- Bedpan/commode pan cover.

6 PRINCIPALS OF ISOLATION NURSING

Standard principles should be followed and implemented following a **risk assessment**.

Standard principles include:

- the appropriate use of protective clothing – gloves, aprons/gowns, eyewear and masks
- long sleeved gowns may be indicated if extensive contamination is likely
- hand hygiene
- cleaning, disinfection and sterilization
- disposal of waste
- disposal of sharps and procedures following a blood/splash injury
- correct management of linen
- spillage management
- mucous membrane protection.

7 ENTERING THE ISOLATION AREA

Protective clothing is **not** required (**except for patients with Clostridium difficile**) if there is **no** physical contact, e.g. talking to the patient/resident, help with feeding or taking a drink into the room).

For direct patient care, the following protective clothing should be applied before entering the room:

- **disposable plastic apron:** for contact with body fluids, or the patient's clothing or bedding
- **disposable latex gloves:** for contact with body fluids, e.g. blood, urine, faeces
- **goggles/visor:** if there is a possibility of splashing to the eyes with body fluids

The healthcare worker should then enter the room.

This document is uncontrolled once printed. Please refer to the Trust intranet for the current version.

ICPr012 review June 20

All staff should wash their hands and change their gloves after **each** significant 'hands on' contact with the patient. On completion of the episode of care, whilst still in the room, protective clothing, e.g. gloves and apron, should be removed and disposed of as clinical waste, remove protective eye wear/visor or mask if applicable (if protective eye wear/visor are not disposable they should be placed in a bag for removal to the dirty utility room for decontamination).

Hands should be washed with liquid soap and dried with a paper towel.

On exiting the room, wash hands **again** immediately, by using either the alcohol gel on the trolley outside the isolation area, or at the nearest wash basin before touching anything.

Staff/carers with moist lesions on hands, e.g. eczema, should seek advice from IPCN on what procedures they can perform. The lesions must be covered with an impermeable dressing and disposable gloves worn.

Disposable gloves are not an alternative to effective hand washing. Hands should always be washed after removal of gloves.

The door to the room should only be kept closed for airborne infections e.g. Influenza, Pulmonary TB, and Norovirus. In certain other circumstances door closure may be advised by the IPCN.

Visitors suffering from an infection should only visit following a risk assessment by nursing/medical staff.

A notice should be placed on the entrance to the isolation room/area requesting visitors to seek advice from nursing staff before entering.

Wherever possible, disposable equipment should be used inside the room.

8 PRECAUTIONS FOR VISITORS

With the exception of Pulmonary TB, (see TB Policy) visitors, including children, do not need to take additional measures other than to wash their hands (or use alcohol gel) before leaving an isolation room.

Protective clothing, i.e. aprons and gloves are **not** required.

Consideration should be given to the appropriateness of children visiting and advice on a case-by-case basis can be sought from the IPCN.

9 DISPOSAL OF FAECES/URINE

Standard Precautions should be used when disposing of faeces and urine (see Standard Precautions Policy).

Where bedpans and urine are to be taken to the dirty utility room the following procedure should be followed:

- put on disposable gloves and a disposable plastic apron and cover the bed/commode pan or urinal with paper immediately prior to leaving the room
- on entering the sluice, dispose of the contents carefully in order to avoid splashing in either a macerator or washer/disinfector
- place the paper cover into a **foot operated** clinical waste bin
- remove protective clothing and discard as clinical waste
- wash hands immediately with soap and water.

Commodes should be left in the patient's room for their use only, and should be cleaned after each use with warm water and detergent. Refer to Decontamination, Cleaning and Disinfection Procedure A-Z for infected/grossly soiled equipment. At the end of isolation, these items should be thoroughly cleaned (see terminal cleaning).

10 DISPOSAL OF CLINICAL WASTE

Clinical waste, e.g. soiled dressings, used gloves and aprons, from **all** patients in isolation should be placed in a clinical waste bag inside the room. When 2/3 full (or if offensive odour remove immediately) the neck of the bag should be securely tied and the bag labelled and removed to the designated storage area. Clinical waste bags do not require 'double bagging' unless the outside of the bag is torn or visibly contaminated. (See Waste Management Policy for further details).

11 CROCKERY AND CUTLERY

There are no specific precautions for crockery and cutlery. Used crockery and cutlery should be washed as usual in the dishwasher (there is no need to wash separately from other patients' items). Water jugs and drinking glasses should also be machine washed. Disposable crockery and cutlery are not required.

12 CLEANING

The Infection Prevention and Control Team will advise on the frequency of cleaning the isolation rooms and solutions to be used.

Isolation rooms will be cleaned daily with a second check clean.

The nurse in charge must inform the locality supervisor of the need for isolation cleaning.

Make sure that separate cleaning equipment is being used to clean the isolation rooms. This equipment must be kept clean and dry within the room. The mop head must be removed and sent to the laundry after each use.

Isolation rooms, cohort areas should be cleaned last, after other rooms, bays and general areas on the ward.

Single use gloves and aprons must be worn when cleaning the isolation rooms and hands washed before leaving the room.

Special attention must be given to all horizontal surfaces and frequently touched surfaces, such as door handles/door push plates, nurse call system, toilet areas and sink taps.

Following discharge or transfer of the patient from the isolation room, the room must be thoroughly cleaned. Curtains should be sent for laundering as infected linen. Walls need only be washed if visibly soiled.

The vacated bed, mattress and bed area on the ward must be appropriately decontaminated before it can be reoccupied.

Fresh flowers are not permissible in isolation rooms.

13 LINEN

Linen should be treated as infected. (See Laundry Procedure.)

14 PROTECTIVE ISOLATION

Patients who are particularly susceptible to infection such as those with neutropenia, leukaemia or on immunosuppressive drugs, etc, may require isolation nursing to prevent acquisition of infection from other patients, staff or the environment.

It is unlikely that a patient nursed in the community setting would have a level of susceptibility that would require protective isolation. Further advice on protective isolation can be obtained from the IPCN.

15 TRANSPORT/TRANSFER TO OTHER DEPARTMENTS/HOSPITALS

This should be avoided or kept to a minimum. Ideally, investigations should be performed in the isolation room. If visits to other departments/wards are unavoidable, please contact the Infection Prevention and Control Team. Clinical need and the patient's welfare take priority over the infection problem; e.g. if the patient is required to be transferred to an acute unit. Please complete the form in appendix 2 when transferring patients.

16 IN THE CASE OF DEATH

In order to protect the mortuary staff; follow Northamptonshire Healthcare foundation Trust Care of the deceased patient guidelines.

17 WHEN CAN ISOLATION PRECAUTIONS BE STOPPED?

Source or protective isolation precautions can be discontinued when the patient is no longer at risk of spreading infection to others. Inform the Infection Prevention and Control team when precautions have been discontinued or discuss with the team if in doubt as to whether precautions can be discontinued.

Frequent assessment and evaluation of the patient's situation is therefore important.

Some specific disease policies give criteria on when isolation precautions can be stopped. If in doubt, discuss with the Infection Prevention and Control Team.

18 EQUALITY CONSIDERATIONS

The author has considered the needs of the protected characteristics in relation to the operation of this policy and protocol to align with the outcomes with IP&C Assurance Framework. We have identified that ensuring that communication reaches all vulnerable groups. The service has been designed to ensure communication relevant to any outbreaks or other healthcare associated infections reaches all sections of the community. This includes taking into consideration communication barriers relating to language or specific needs to reach the whole population. IP&C work closely with multi agency groups and community partners where appropriate we will undertake engagement and outreach activity. We targeted action to relevant groups follow public health England's communication framework. Some groups are particularly vulnerable in relation to their protected characteristics, e.g. age, ethnic minority communities and disability and where we identify that, the expectation is that staff will meet the needs appropriately.

19 REFERENCES AND FURTHER READING

Department of Health (2015) The Health and Social Care Act 2008. Code of Practice on the prevention and control of infections and related guidance

Department of Health (2007) Essential Steps to Safe, Clean Care Interhealthcare service user infection risk assessment form

Department of Health (2007) Saving Lives: reducing infection, delivering clean and safe care. Isolating service users with healthcare-associated infection

APPENDIX 1 - INTER HEALTH CARE INFECTION PREVENTIONS AND CONTROL TRANSFER FORM

| | |
|--|--|
| <p>Patient/Client details: (insert label if available) Name: Address</p> <p>NHS Number: Date of Birth:</p> | <p>Consultant:</p> <p>GP:</p> <p>Current patient/client location:</p> |
| <p>Receiving facility – hospital, ward, care home, district nurse:</p> <p>Contact No:</p> <p>Is the ICT/Ambulance service aware of transfer? Yes/No</p> | <p>Transferring facility – hospital, ward, care home, other:</p> <p>Telephone No:</p> <p>Is this patient/client an infection risk? <i>Please tick the most appropriate box and give confirmed or suspected organism.</i></p> <p><input type="checkbox"/> Confirmed risk Organism <input type="checkbox"/> Confirmed risk Organism <input type="checkbox"/> Suspected risk Organism <input type="checkbox"/> No known risk</p> |
| <p>If the patient/client has diarrhoeal illness, please indicate bowel history for last week: (based on Bristol Stool Chart)</p> <p>Is the diarrhoea thought to be of an infectious nature? Yes/No</p> | |

| Relevant specimen results and treatment information, including antimicrobial therapy | | | | |
|--|--|--|-------|--------|
| Specimen | | | | |
| Date | | | | |
| Result | | | | |
| Treatment information | | | | |
| Other Information: | | | | |
| Is the patient/client aware of their diagnosis/risk of infection? | | | | Yes/No |
| Does the patient/client require isolation? | | | | Yes/No |
| Signature of staff member completing form | | | | |
| Print name | | | | |
| Telephone No: | | | Date: | |

For further advice please contact your Infection Prevention and Control Team

APPENDIX 2 - A-Z OF INFECTIOUS DISEASE

| DISEASE (* = Incubation Period) | ROUTE OF TRANSMISSION | PERIOD OF INFECTIVITY | MANAGEMENT OF CONTACT | COMMENTS |
|--|--|---|---|--|
| HIV/AIDS (Acquired Immune Deficiency Syndrome/Human Immunodeficiency virus *Can be up to 10 years | - Innoculation of infected blood/body fluids - Unprotected sex - From infected mother to baby in utero and breast milk | - Vary according to the stage of infection. - Infectivity will be greatest when viral load is highest. | Main risk to healthcare staff is from contaminated sharps. Contact Occupational Health immediately for sharps injuries advice. | Routine Isolation of patients is not required. But protective isolation required for AIDS sufferers |
| Bronchiolitis | Direct contact with airborne respiratory droplets and contact with secretions. | May be up to three weeks even once asymptomatic. | None | Isolation required |
| Chickenpox * 10 - 21 days | Droplet inhalation/direct contact with vesicular fluid or respiratory secretions. | 2 days before rash and 5-7 days after onset of rash and until all lesions are crusted. | If contact is a pregnant woman, seek advice from Doctor/Midwife. | Isolation required Exclude non-immune staff and visitors. |
| Clostridium Difficile | Faecal oral route following direct/indirect contact with faeces. | Until 48 hours without diarrhoea. | No special precautions unless symptomatic. | Isolation required Encourage good personal hygiene, especially hand washing. Environmental cleaning especially toilet areas. |

| DISEASE (* = Incubation Period) | ROUTE OF TRANSMISSION | PERIOD OF INFECTIVITY | MANAGEMENT OF CONTACT | COMMENTS |
|---|--|--|---|--|
| Cytomegalovirus | In the saliva, urine and blood of infected person | Duration of illness. Immuno-suppressed and infants may excrete virus for long periods. | None unless symptomatic. If pregnant speak to GP/Midwife. | Good personal hygiene and hand washing after handling nappies and before preparing or eating food. Keep all cuts covered. |
| Diarrhoea of unknown origin - suspected infectious. Includes:- <ul style="list-style-type: none"> • Campylobacter • Dysentery • E.coli 0157 • Cryptosporidiosis • Food poisoning • Giardiasis • Salmonellosis * A few hours to a few days | Contaminated food Contaminated water Direct/indirect Faecal oral | While having symptoms of diarrhoea and or vomiting (usually not infectious after 48 hours with normal stools) For some of these infections, the organism may be excreted in stools for a prolonged period even when asymptomatic. | None unless symptomatic. Food handlers particularly, should be excluded from work until 48 hours symptom free. In some cases Environmental Health clearance may be required and this will be advised accordingly. | Notifiable for food poisoning. Isolation required if symptomatic, until 48 hours of normal stools. Encourage good personal hygiene. Ensure good environmental cleaning, especially toilet areas. |
| Glandular Fever * From 4 - 6 weeks | - Contact with saliva. - Can also spread by airborne droplets | While virus present in saliva which may persist for months | None | Hand washing essential especially if hands contaminated with saliva. |

| DISEASE (* = Incubation Period) | ROUTE OF TRANSMISSION | PERIOD OF INFECTIVITY | MANAGEMENT OF CONTACT | COMMENTS |
|---|---|--|---|--|
| Hand, Foot and Mouth Disease (Coxsackie virus) * 3 - 5 days | Contact with respiratory secretions and faeces. | During acute stage of illness | None | Good personal hygiene. Wash hands after handling soiled tissues. Good environmental cleaning especially of toilets. |
| Hepatitis A * 2 - 6 weeks | Faecal –oral route Food contaminated by infected food handler. Contaminated water | Maximum infectivity immediately prior to and for 7 days after onset of jaundice. | Hepatitis A vaccine/immunoglobulin may be given to protect close family contacts. | Notifiable disease - Isolation not necessary - Encourage good personal hygiene. - Don't share towels - Good environmental cleaning especially toilet area - Hand hygiene before food preparation and eating. |

| DISEASE (* = Incubation Period) | ROUTE OF TRANSMISSION | PERIOD OF INFECTIVITY | MANAGEMENT OF CONTACT | COMMENTS |
|--|--|--|--|--|
| Hepatitis B * 2 - 6 months | Sexually transmitted Innoculation of infected blood (needle-stick injury or via open wound) From mother to baby | Virus carried in blood for years and infectivity of carriers varies. HBeAg positive carriers of hepatitis B virus in their blood are most likely to transmit infection. | Vaccine and or immunoglobulin available for close contacts. Vaccine available and offered to health care workers. | Notifiable disease Isolation not necessary however; Follow standard precautions - Deal with all blood spills promptly and safely. - Careful disposal of sharps - Biohazard labels on specimens - Keep all cuts covered - Encourage not to share personal hygiene items such as a tooth brush and shavers. |
| Hepatitis C * 1 - 6 months | -Sexually transmitted -Innoculation of infected blood -From mother to baby | May persist indefinitely as carrier state | No vaccine available | Notifiable disease As hepatitis B |

| DISEASE (* = Incubation Period) | ROUTE OF TRANSMISSION | PERIOD OF INFECTIVITY | MANAGEMENT OF CONTACT | COMMENTS |
|---|--|---|---|--|
| Herpes simplex (cold sores) * 2 - 12 days | Direct contact with lesions, exudate or saliva (usually during close contact such as kissing). | Once someone has the herpes virus it does not completely disappear but remains dormant and can re-activate. | None | <ul style="list-style-type: none"> - Isolation not necessary - Antivirals now available for treatment - Wash hands after touching sores and before touching eyes. - Those with cold sores should avoid kissing newborn babies - Avoid sharing items such as lipstick. |
| Herpes Zoster (Shingles) *10 - 21 days | Direct contact with lesions | Until lesions have crusted (approximately 7 – 10 days after onset) | Varicella immunoglobulin for non-immune immunocompromised neonatal and pregnant contacts. | Isolation may be required (Depends if those in contact have had chicken pox previously). |
| Impetigo *4 - 10days | Direct contact with lesions | Until lesions have healed | None | <p>Isolation not required</p> <p>Good personal hygiene and hand washing after dealing with infected person.</p> |

| DISEASE (* = Incubation Period) | ROUTE OF TRANSMISSION | PERIOD OF INFECTIVITY | MANAGEMENT OF CONTACT | COMMENTS |
|---|---|---|------------------------------|--|
| Influenza *15 days | Airborne spread from respiratory droplets and can also be transmitted by direct contact on contaminated hands. | Approximately 3 -5 days from clinical onset | None | Isolation required The influenza virus can persist for hours in dried mucus. Dispose of used tissues and wash hands, cover mouth and nose when coughing or sneezing. |
| Legionnaires' Disease *2 - 10 days | Not transmitted from person to person Usually isolation from equipment such as cooling towers associated with air conditioning and industrial processes, and in warm water systems where if the temperature is kept around 43° C the bacteria can breed. | N/A | N/A | Isolation not required The source of the infection should be sought and rectified. |
| Lice (Body Lice) | Clothing or intimate body contact | Until successfully treated | None unless infected | Clothing and bedding should be laundered on a hot wash. |

| DISEASE (* = Incubation Period) | ROUTE OF TRANSMISSION | PERIOD OF INFECTIVITY | MANAGEMENT OF CONTACT | COMMENTS |
|--|---|---|---|---|
| Lice (Head Lice) | Direct contact | Until successfully treated | All close contacts should be checked and treated if necessary | Avoid close head contact until treated |
| Lice (Pubic Lice) | Direct contact with public hair and less commonly axillae, beards and eyebrows. | Until successfully treated | Sexual and recent close contacts should be treated | Avoid close contact until treated |
| Malaria *12 - 30 days but wide variable | Transmitted to humans by bite of infected female anopheles mosquitos. Cases have occurred by injection or transfusion of blood from infected person or by use of contaminated needles and syringes. | N/A | N/A | Notifiable disease Isolation not required |
| Measles *7 - 14 days | Airborne by respiratory droplet and direct contact with nasal and throat secretions of infected persons | From just before rash appears until 7 days after appearance | Immunoglobulin may be considered in adults and children who are immuno-compromised and have no antibodies to measles. | Notifiable disease Isolation required Combined measles, mumps and rubella (MMR) vaccine available. |

| DISEASE (* = Incubation Period) | ROUTE OF TRANSMISSION | PERIOD OF INFECTIVITY | MANAGEMENT OF CONTACT | COMMENTS |
|--|--|---|---|---|
| Meningococcal Meningitis (bacterial) *2 - 10 days | Close person to person contact where respiratory secretions from the mouth and from the mouth and throat are inhaled or by direct contact (kissing). | Until 24 hours after start of treatment | Close contacts will receive antibiotics as directed by Consultant in Communicable Disease Control (CCDC). | Notifiable disease Isolation required (CCDC) must be notified urgently. |
| Meningitis (Viral) | Faeces and respiratory secretions (kissing, coughing & sneezing). | Until virus no longer present in stools. | None | Notifiable disease Isolation not required |
| Mumps * 12 - 25 days | Respiratory droplets and direct contact with saliva of infected person. | 6 – 7 days before and up to 6 days after onset of swelling. | Non- immune staff should avoid contact if possible. | Notifiable disease Isolation required MMR vaccine available. |
| Ringworm on body (Tinea Corporis) (Not a worm but a fungal skin infection, ring shape in appearance) * 4 -10 days | Direct or indirect contact with infected areas of skin. Also from infection animals and from contaminated floors and shower stalls. | As long as rash is present | Check for signs of ringworm and treat if necessary. | Isolation not necessary but avoid sharing personal items linen or walking about with bare feet. Avoid swimming pools and gyms until treatment completed . |

| DISEASE (* = Incubation Period) | ROUTE OF TRANSMISSION | PERIOD OF INFECTIVITY | MANAGEMENT OF CONTACT | COMMENTS |
|--|--|---|--|---|
| Rubella (German Measles) * 14 - 23 days | Direct contact with respiratory secretions or droplets. | 7 days before and at least 5 days after rash appears. | Pregnant women offer blood test for antibodies within 10 days of earliest contact. | Notifiable disease - Isolation required - MMR vaccine available - Pregnant women who have had contact and are unsure of their immunity status, should speak to their Doctor or Midwife immediately. |
| Scabies *1 days - 6 weeks depending on previous exposure | Close skin to skin contact | Until mites destroyed by treatment | Family members and contacts should be checked and treated accordingly. | Isolation not required. Avoid close contact until 24 hours following treatment. |
| Scarlet Fever (Group A Streptococci) *1 - 5 days | Airborne droplets from coughs and sneezes | Day sore throat starts until 24 hours after antibiotics started. | None | Notifiable disease |
| Shingles (Herpes zoster) Occurs in those who have previously had chickenpox and is a re-activation of the virus. | Shingles cannot be transmitted but direct contact with lesions by those who have not had chickenpox could lead to development of chickenpox. | Until lesions have crusted (approximately 7-10 days after onset). | Varicella immunoglobulin for non-immune, immuno-compromised neonatal & pregnant contacts who are non-immune. | Isolation may be required (depends if those in contact have had chicken pox previously). |

| DISEASE (*= Incubation Period) | ROUTE OF TRANSMISSION | PERIOD OF INFECTIVITY | MANAGEMENT OF CONTACT | COMMENTS |
|--|---|---|---|--|
| Tuberculosis (Pulmonary) *4 - 12 weeks before signs of disease found by skin testing. | Inhalation of droplets containing the bacteria, for example, when an infected person coughs or sneezes. | Infectious if smear positive and remains so until 14 days after starting and adhering to treatment and clinical improvement has occurred. | By TB Team | Notifiable disease Isolation may be required |
| Worms (round worms, tape worms and thread worms) | Faecal oral route | Until successfully treated | All family in the same household should receive treatment at the same time. | Isolation not required |

Click [here](#) to return to the table of contents