1. Introduction

Much of the work carried out in controlling infections in hospital is devoted to preventing the spread of infection between patients or to the protection of hospital staff. The risk that infected staff pose to patients or other staff members is often poorly recognised. If the risk posed by infection in health care workers is not recognised and addressed, there is the potential for large outbreaks of infection among staff and/or patients. For this reason, any staff member who may be suffering from one of the conditions listed in this document MUST be referred to Occupational Health Department immediately.

2. Policy Scope

Although intended principally for nursing and medical staff employed by The Newcastle upon Tyne Hospitals Foundation Trust, this policy is also applicable to other areas where staff members have direct contact with patients. It is intended to supplement, but not replace, guidelines which may already exist in other departments (e.g. catering).

3. Aim of Policy

This policy summarises existing Trust policies on how staff with infections should be dealt with. The policy aims to prevent or minimise the risk that infected healthcare workers pose to patients and other employees of the Trust. It gives guidance to staff and managers on the risks of certain infectious diseases, and to which professionals within the Trust these suspected infections should be reported.

More detailed information can be found in the following trust policies available on the Trust intranet site.

- Control of MRSA in the Newcastle Hospitals
- Guidelines for the Management of Infestation with Scabies, Lice and Fleas in Newcastle Hospitals
- Hepatitis B, Hepatitis C and HIV policy for Healthcare Workers
- Immunisation for Trust Staff and Protection against Infectious Disease Policy
- Needlestick Injuries and Blood Borne Viruses Exposure: Code of Practice
- Standard Precautions
- Tuberculosis: Prevention and Control in Newcastle Hospitals.
4. **Duties (Roles and Responsibilities)**

4.1 The Chief Executive has overall responsibility for the implementation monitoring and review of this policy on behalf of the Board of Directors of the Trust. Furthermore, this responsibility is delegated to the Director of Infection Prevention Control (DIPC). All healthcare workers have a professional duty to ensure that they take reasonable steps to avoid putting the health of others at risk.

4.2 To reduce the risk of occupational exposure to infectious diseases, managers in conjunction with the Occupational Health Department (OHD) have a responsibility to ensure that all staff have access to and have read the Trust's Infection Prevention and Control Policies.

4.3 **Role of Occupational Health**

The role of the OHD in managing infectious disease in staff is to expedite diagnosis of the condition and facilitate its treatment. In cases where the diagnosis is in doubt, the Occupational Health Physician may call upon existing expertise within the Trust. With regard to treatment, although in some cases the function of the OHD will be to direct staff members to their own general practitioners when treatment is required, there are certain conditions in which it is more appropriate that treatment is given on-site by the OHD. This would include conditions where there were important implications for the spread of infection within the Trust such that it would not be desirable to wait for treatment to be obtained elsewhere. The need for on-site treatment will depend on the condition concerned and will be decided by the OHD in conjunction with the IPCT.

5. **Definitions**

- Occupational Health Department (OHD)
- Infection Prevention and Control Team (IPCT)
- Infection Prevention and Control Nurse (IPCN)
- Methicillin Resistant Staphylococcus Aureus (MRSA)
- Varicella Zoster Virus (VSZ)

6. **General principles**

6.1 **Relationships between the Occupational Health and the Microbiology & Virology Departments**

Infected or potentially infected staff who have not sought advice from their general practitioner should be referred in the first instance to the OHD, who will liaise with the Infection Prevention and Control Team (IPCT) when necessary. Infection Prevention and Control Nurses (IPCNs) provide a seven day cover to all acute hospital sites in the Trust. In addition, an on-call medical microbiologist and
an on-call medical virologist are always available out-of-hours. They should be consulted if a potential infection control problem arises.

6.2 Specimen collection

Where specimens are required for diagnosis of a condition this should be discussed with the OHD who will then arrange for the submission of the specimen. Specimens must **ONLY** be submitted by the Occupational Health Department. There have been instances where microbiology specimens have been taken from staff members by ward nursing or medical staff. These are often sent with inadequate clinical details and can delay the recognition of a potential cross infection hazard. This practice should be strongly discouraged. If it is essential that specimens are collected outside the normal working hours of the Occupational Health Department then this should be discussed with the on-call Microbiologist or virologist. All results should however be directed to the OHD.

6.3 Antimicrobial treatment

Infected staff members have on occasion received antibiotics prescribed by hospital medical staff. This is not permissible. Not only are antibiotics inappropriate for certain conditions, but inadequate or erroneous treatment may put patients at risk of being infected by staff.

6.4 Specific Infections

Infections in hospital staff which may be spread to other staff or to patients include:

- upper respiratory infections (viral and bacterial)
- skin infections
- gastrointestinal infections
- infestation by fleas, lice, and scabies mites
- methicillin resistant *Staphylococcus aureus* (MRSA) colonisation or infection
- bloodborne viral infections
- tuberculosis
- communicable diseases such as Varicella, Measles, Rubella

These infections are discussed in more detail below.

6.4.1 Viral respiratory infections

Infections such as the common cold spread rapidly in institutions such as hospitals. Other infections (for example, influenza) may be particularly serious in elderly or debilitated patients. Staff with mild acute viral infections should avoid working with immunosuppressed patients and should refrain from work or be re-deployed in low risk areas if their clinical
condition permits. Decisions with regard to refraining from work or redeployment will be made by OHD following liaison with the IPCT on an individual basis. Staff with clinical influenza (i.e. fever, headache, prostration, muscle pains etc) should not be at work. Influenza vaccination is offered to all staff annually to reduce the risk of infection to patients and to themselves. Vaccination is highly recommended, and this is especially important for staff working in high risk areas, vaccinations are free and can be accessed throughout the Trust.

Where there is a suspected outbreak of Influenza A prophylactic treatment may be considered for staff with direct patient contact following discussion with OHD, IPCT, Microbial Pharmacist and Consultant Virologist.

6.4.2 Bacterial respiratory infections

The most important of these is a sore throat due to group A streptococcus, an organism capable of causing outbreaks of potentially fatal infection in hospitalised patients. Members of staff with sore throats, who work in high risk areas, e.g. Intensive care, obstetrics, surgery, should notify Occupational Health during office hours for appropriate assessment and screening. When the Occupational Health department is closed, staff should contact the Infection Control team in the first instance, or the microbiologist on call for advice. Throat swabs should be taken if this diagnosis is suspected. If specific treatment is required this will be discussed between the Medical staff in Microbiology and the OHD.

6.4.3 Bacterial skin infections

The usual cause of infected cuts, boils and other minor skin infections is Staphylococcus aureus and more rarely MRSA. Large outbreaks of infection have been known to occur in patients as a result of spread of staphylococci from infected staff. A member of staff suffering from such infections should be referred to OHD for assessment of the possible risk to patients. Cellulitis is often due to group ‘A’ streptococcal infection. Staff with cellulitic lesions should not work in high risk areas and should report to the OHD for advice.

6.4.4 Herpes Simplex infections (including cold sores)

Healthcare workers with herpetic whitlow (herpetic lesion on finger) or extensive (usually primary) oral herpes are at highest risk of transmitting HSV, and should be excluded from all direct patient contact until the lesions are fully crusted. Healthcare workers with oral HSV reactivations (cold sores) who follow strict standard precautions are unlikely to infect a patient; however as a precautionary measure staff with active lesions should be excluded from
**direct** contact with the following high-risk patient groups until lesions are fully crusted:

- Women during delivery (to avoid infection of the newborn)
- Neonates
- Immunocompromised Patients
- Patients with extensive burns or skin conditions which compromise the skin barrier.

There is no need to exclude healthcare workers from contact with other patients, including pregnant women (other than at delivery).

6.4.5 Varicella Zoster virus (VZV, chickenpox/shingles)

Staff with chickenpox or exposed areas of shingles should not be in work until lesions have crusted (usually about 5 days). Those with active shingles which can be covered may work but should avoid contact with susceptible individuals.

Cases of chickenpox or shingles in staff should be reported to the IPCT. Both chickenpox and shingles can cause serious problems in hospitals, and staff who may be suffering from VZV infection, or who have been in contact with it and who are not aware of their immune status MUST be referred to the OHD for assessment. Where staff are found to be not immune and have had contact with Varicella they will be excluded from work until they no longer pose a risk of infection.

Varicella vaccine is now available for staff and those who are not immune to Varicella will be offered vaccination by the OHD.

6.4.6 Other viral rashes

Measles and rubella although uncommon now, may also cause serious problems in hospitals and staff who are thought to be suffering from these conditions or who have been in contact with it, MUST be referred to the OHD for assessment. Staff who have not had two vaccinations containing Measles and Rubella will be vaccinated with MMR. Where vaccination is not appropriate or possible, blood screening will be performed.

Other viruses – a number of other viruses including Coxsackie A and B may cause specific rashes e.g. Hand, foot and mouth disease. Staff with any rash should contact OHD for advice.
6.4.7 Gastrointestinal infections

“Loose stools" can be caused by a variety of mechanisms of which infectious agents (bacteria, viruses and protozoa) provide only one. Diarrhoea and vomiting can spread rapidly among both staff and patients with some of the latter being very vulnerable.

In the case of viral infections excretion in faeces may be brief and easily missed. If infection is suspected (from clinical details, or evidence of linked cases) the members of staff involved should be referred urgently to the OHD for appropriate investigations, both bacteriological and virological.

Staff must not return to work until they have been asymptomatic for 48 hours.

Where there is evidence of a salmonella or campylobacter infection staff must discuss all stool specimen results with OHD prior to returning to work.

If cases of diarrhoea and vomiting occur in staff or where a possible outbreak is suspected the IPCT should also be informed without delay.

6.4.8 Infestation with insects or mites

Three types of infestation, fleas, lice, and scabies mites may cause problems for hospital staff. Of these, by far the most important is scabies, since this has the greatest potential to cause very large outbreaks of disease. See the additional Trust policy– Guidelines for the management of infestations of lice, fleas, and scabies mites.

The IPCN MUST be informed about any cases of hospital acquired louse infestation of staff or patients, or if a problem with flea bites occurs on a ward.

If one or more cases of scabies occurs on a ward in either staff or patients (other than a patient newly admitted with the disease) the IPCN, or in her/his absence the Infection Prevention and Control Doctor, MUST be informed immediately. IPC will liaise with OHD regarding the need for treatment of staff.

Staff members who may be infested with scabies, or who have an itchy skin rash the cause of which is unknown, MUST attend OHD as soon as possible. Such staff should be referred to an Occupational Health Physician, who will make the diagnosis, taking advice if required from a Dermatologist. If the diagnosis of scabies is confirmed, the OHD will inform the IPCT, who will in turn visit the ward to assess the extent of the
problem and arrange for any necessary treatment of patients. If it is necessary to give treatment to staff following a ward outbreak appropriate advice and a prescription will be issued by the OHD. All other intimate contacts (including family) of established cases of scabies should receive appropriate treatment through their general practitioner.

6.4.9 MRSA

Staff member(s) will be screened for MRSA where indicated at the request of the IPCT. This will consist of nose and throat swabs, and swabs from any skin lesions. Additional swabs may be requested in certain situations on the advice of the IPCT. Staff who have been requested to screen should do so prior to clinical contact.

Staff who are screen positive may be excluded from working in certain high risk areas until their swabs prove to be negative. For further information please refer to the Control of Methicillin Resistant Staphylococcus Aureus (MRSA) policy.

6.4.10 Tuberculosis

Staff who have had close contact with patients with active pulmonary tuberculosis must contact the OHD for advice. Staff who themselves suffer from the infection must ensure that the OHD and the IPCD/IPCN are informed so appropriate action may be taken. Specific advice is available in the policy Tuberculosis: Prevention and Control in Newcastle Hospitals.

6.4.11 Blood borne viral infection

Blood-borne viruses (BBVs) include HIV or hepatitis B or hepatitis C viruses. Staff who have any reason to believe that they may have been exposed to infections must promptly contact the Occupational Health Department. Staff sustaining a sharps injury or body fluid splash must follow the Trust policy, Needlestick Injuries and Blood Borne Viruses Exposure: Code of Practice.

Staff who have good reason to believe (having taken steps to confirm the facts as far as practicable) that a worker who has a BBV infection is practising in a way which places patients at risk, or has done so in the past, must inform the Consultant Occupational Health Physician.

6.4.12 Other infections

Although the majority of common problems have been covered above, there exist other potential infective hazards which have not been
mentioned. If in doubt, the Occupational Health Department, IPCT (or out-of-hours the duty medical Microbiologist) should be contacted for advice.

6.4.13 Cytomegalovirus (CMV)

CMV is a common virus and a member of the Herpes virus group. The mode of transmission is usually by intimate exposure from mucosal contact with infectious tissues, secretions or excretions. Congenital infection may also occur by trans-placental spread. It is a common infection and in Western Europe 40-60% of adults will be immune by the age of 40. Infection acquired later in life, in otherwise healthy individuals, is usually asymptomatic or may cause a glandular fever like illness. However primary infection during pregnancy results in transmission to the foetus in 40% of cases with serious consequences in 5-10%. There is no available vaccine against CMV at present.

There is controversy in the literature about the risk of infection to susceptible paediatric staff. Some papers suggest that there is evidence of an increased occupational risk of infection for staff working with children, or nursing patients with a high risk of infection, compared to other people of similar ages. However there are also studies which indicate that CMV is not an occupational hazard for paediatric staff as sero-conversion to CMV positive does not occur more frequently than in the general population. The consensus is that there is no reason why pregnant staff should be excluded from contact with known excretors of CMV provided standard precautions are taken to prevent exposure to contaminated secretions.

Viral excretion may continue for months after a primary infection especially in children. There will be many healthy children who are in hospital for other reasons e.g. routine surgery, who will be actively excreting virus at any one time, hence the importance of standard precautions. As with any transmissible infection in adults or children, it would be good practice to inform a receiving ward or department of the patient’s infectious state, prior to transfer, to highlight the importance of adhering to standard precautions. In addition, pregnant staff who are particularly concerned about caring for patients excreting CMV should contact Occupational Health.

Routine serological screening of female staff nursing children or adults who may be excreting CMV is not indicated. The most important means of preventing CMV in health care workers is education of all staff especially those handling young children. CMV is excreted in many body fluids including urine, saliva, blood, tears, semen and breast milk. Standard precautions should be used for handling all body fluids. Good hand hygiene should also be practised routinely and the importance of avoiding close physical contact with young children emphasised.
7. Training

There are currently no training requirements/elements related to this policy. However it is important to emphasize that all staff must adhere to all relevant trust policies and procedures related to infection prevention and control.

8. Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed

9. Monitoring Compliance with the Policy

<table>
<thead>
<tr>
<th>Standard / Process / Issue</th>
<th>Monitoring and Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Method</td>
</tr>
<tr>
<td>Reporting of infections or potential infections as outlined in this policy</td>
<td>Review of DATIX Incident reports</td>
</tr>
<tr>
<td></td>
<td>By</td>
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<tr>
<td></td>
<td>IPCT</td>
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<td></td>
<td>Committee</td>
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<td></td>
<td>Infection Control Committee</td>
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<td></td>
<td>Frequency</td>
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<tr>
<td></td>
<td>Monthly</td>
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</tbody>
</table>

10 Consultation and Review

This policy has been circulated to:
- IPCT
- OHD
- Consultant Virologist

The policy will be reviewed annually by the Infection Control Committee.

11 Implementation

The policy will be placed on the Intranet and listed as ‘New’. It will be circulated to Directorate Managers and Matrons, to be disseminated to staff.

Authors: Infection Prevention and Control
Occupational Health
Consultant Virologist
Appendix A

Useful Contacts

**Occupational Health Department** NGH Ext 21188  
**Occupational Health Consultant** Dr Hamish Paterson - Ext 21188  
**Occupational Health Clinical Nurse Lead Manager** Ray Fagg – Ext 21188  
**Deputy Lead Nurse** Barbara Goodfellow – Ext 21188  
Out of hours contact switchboard for on-call staff.

**Infection Prevention and Control Doctors**  
Dr M Narayanan for RVI Ext 29436  
Dr Julie Samuel for Freeman Ext 48867  
Out of hours contact switchboard for on-call Medical staff.

**Infection Prevention and Control Nurses**  
Matron Infection Prevention and Control Dect 20584 – Louise Hall  
RVI Infection Prevention and Control Nurses Dect 21801/21622  
Freeman Infection Prevention and Control Nurses Dect 26411

**Health Protection Agency**  
**Health Protection Unit**  
Dr Meng Khaw, Consultant in Health Protection 0191 273 3584  
Anne Halewood, Health Protection Nurse 0191 516 3333

**Clinical Virologists**  
Via Ext 21104 during working hours and via switchboard out of hours.
### IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th>Policy Title: Control Of Infection in Healthcare Workers</th>
<th>Yes/No?</th>
<th>You must provide evidence to support your response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (* denotes protected characteristics under the Equality Act 2010)</td>
<td>No</td>
<td>Applies to all staff, characteristics not relevant</td>
</tr>
<tr>
<td>• Race *</td>
<td>No</td>
<td>Applies to all staff, characteristics not relevant</td>
</tr>
<tr>
<td>• Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td>Applies to all staff, characteristics not relevant</td>
</tr>
<tr>
<td>• Nationality</td>
<td>No</td>
<td>Applies to all staff, characteristics not relevant</td>
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<tr>
<td>• Gender *</td>
<td>No</td>
<td>Applies to all staff, characteristics not relevant</td>
</tr>
<tr>
<td>• Culture</td>
<td>No</td>
<td>Applies to all staff, characteristics not relevant</td>
</tr>
<tr>
<td>• Religion or belief *</td>
<td>No</td>
<td>Applies to all staff, characteristics not relevant</td>
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<tr>
<td>• Sexual orientation including lesbian, gay and bisexual people *</td>
<td>No</td>
<td>Applies to all staff, characteristics not relevant</td>
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<tr>
<td>• Age *</td>
<td>No</td>
<td>Applies to all staff, characteristics not relevant</td>
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<tr>
<td>• Disability – learning difficulties, physical disability, sensory impairment and mental health problems *</td>
<td>No</td>
<td>Applies to all staff, characteristics not relevant</td>
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<tr>
<td>• Gender reassignment *</td>
<td>No</td>
<td>Applies to all staff, characteristics not relevant</td>
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<tr>
<td>• Marriage and civil partnership *</td>
<td>No</td>
<td>Applies to all staff, characteristics not relevant</td>
</tr>
<tr>
<td>2. Is there any evidence that some groups are affected differently?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3. If you have identified potential discrimination which can include associative discrimination i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?</td>
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<td></td>
</tr>
<tr>
<td>4(a). Is the impact of the policy/guidance likely to be negative? (If “yes”, please answer sections 4(b) to 4(d)).</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4(b). If so can the impact be avoided?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4(c). What alternatives are there to achieving the policy/guidance without the impact?</td>
<td></td>
<td></td>
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<tr>
<td>4(d). Can we reduce the impact by taking different action?</td>
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</table>

**Comments:**

**Action Plan due (Or Not Applicable): n/a**

Name and Designation of Person responsible for completion of this form: Hilary Cheyne, OHN. Date: 13.07.2012

Names & Designations of those involved in the impact assessment screening process: ____________________________________________________________

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

For advice on answering the above questions please contact Frances Blackburn, Head of Nursing, Freeman/Walkergate, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.