

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Management Plan for Severe Acute Respiratory Syndrome (SARS)

Effective Date: May 2009

Review Date: May 2012

1. Introduction

SARS is a severe respiratory disease caused by SARS coronavirus (SARS CoV). It was first recognised in Guangdong Province in China in November 2002, and spread worldwide before being contained by 5 July 2003. During this period over 8000 individuals were affected in over 30 countries. Subsequently between July 2003 and May 2004, four small and rapidly contained outbreaks of SARS have been reported, three of which appear to have been linked to laboratory releases of SARS-CoV.

Close contact with an infected person is believed to pose the highest risk of the infective agent spreading from one person to another. SARS appears to be less infectious than influenza and the incubation period is thought to be around two to seven days (maximum ten days). Cases are not considered infectious 10 days after fever resolution.

The possibility of SARS re-emergence remains and there is a need for continuing vigilance. Heightened awareness of staff involved with acute adult and paediatric patients both in A&E and admission units across the Trust should help to ensure the best clinical outcome and reduce risks to staff.

2. Case Definitions

The current UK case definitions focus on the identification of persons with severe unexplained pneumonia either returning from a country with previous documented transmission of SARS or who are part of a cluster within a health care facility in the UK.

2.1 Possible Case:

2.1.1 Individual Case

A person fulfilling the clinical case definition of SARS (see below)

and

Within the ten days prior to illness onset, a history of travel to an area classified by WHO as a potential zone of reemergence of SARS (This currently includes all provinces of China, including Hong Kong SAR).

Or

Within the ten days prior to illness onset, a history of exposure to laboratories or institutes which have retained SARS virus isolates and/or diagnostic specimens from SARS patients.

2.1.2 Health Care Worker Cluster

Two or more health care workers in the same health care facility fulfilling the clinical definition of SARS (see below) and with onset of illness within the same ten day period.

2.1.3 Other Hospital Cluster

Other Hospital Cluster - Hospital acquired illness in three or more persons (health care workers and/or other hospital staff and/or patients and/or visitors) in (or linked to) the same health care facility fulfilling the clinical case definition of SARS (see below) and with onset of illness within the same 10 day period.

Clinical Case Definition

An update of the clinical description of SARS is available from the WHO website at <<http://www.who.int/csr/sars/en>>. The following clinical case definition of SARS is consistent with the WHO clinical case definition and has been developed for public health purposes.

The respiratory illness should be severe enough to warrant hospitalisation and include a history of:

Fever of $\geq 38^{\circ}\text{C}$ (documented or reported)

and

One or more symptoms of lower respiratory tract illness (cough, difficulty breathing, shortness of breath)

and

Radiographic evidence of lung infiltrates consistent with pneumonia or Respiratory Distress Syndrome (RDS)

or

Autopsy findings consistent with the pathology of pneumonia or RDS without an identifiable cause

and

No alternative diagnosis to fully explain the illness

It is important that a detailed travel history is obtained from patients with symptoms and signs consistent with clinical SARS and that it is ascertained whether other family members and/or close contacts (particularly within the hospital setting) have had a similar illness within the 10 days prior to the patient's onset of illness.

2.2 Probable Case:

An individual with symptoms and signs consistent with clinical SARS (Possible case) and with preliminary laboratory evidence of SARS CoV infection based on the following:

Either

Single positive antibody test for SARS CoV

Or

Positive PCR for SARS-CoV on a single clinical specimen and assay

2.3 Confirmed Case:

An individual with symptoms and signs consistent with clinical SARS (Possible case) and with laboratory evidence of SARS-CoV infection based on one or more of the following currently performed at Centre for Infection, Colindale:

2.3.1 PCR positive for SARS-CoV using a validated method from:

At least two different clinical specimens (e.g. nasopharyngeal and stool)

or

The same clinical specimen collected on two or more occasions during the course of the illness (e.g. sequential nasopharyngeal aspirates)

or

Two different assays or repeat PCR using a new RNA extract from the original clinical sample on each occasion of testing.

2.3.2 Seroconversion by ELISA or IFA

Negative antibody test on acute serum followed by positive antibody test on convalescent phase serum tested in parallel

or

Four-fold or greater rise in antibody titre between the acute and convalescent phase sera tested in parallel.

2.4 Discarded Case

A case is discarded when an alternative laboratory diagnosis is made which can fully explain the illness **or** the patient has a negative convalescent serology result (NB a negative PCR result does not result in the declassification of a possible case)

3. Case Reporting

For suspected cases please contact:

- The Consultant on call for Infectious Diseases (Adult or Paediatric as appropriate), or out of hours contact the relevant on-call ID physician [via NGH switchboard]
- The Infection Prevention and Control Team/Microbiology: [FRH–Dr Gould (ext. 31248), NGH–Dr Raza (ext. 48878) RVI–Dr Nayanan (ext. 29436) or their deputies. Out of hours, contact the on-call Microbiologist via switchboard]
- The Duty Doctor at the HPA laboratory, NGH [0191 226 1074, or via NGH switchboard]
- The relevant ICU – NGH, RVI, FRH [Consultant Intensivist on call]
- Communicable Disease Control [Consultant on call via NGH switchboard] – statutory requirement

4. Major Outbreak Policy / Major Incident Plan

The following Trust policies may be instituted, including convening of the Major Outbreak Control Group as defined in the 'Major outbreaks of infection' policy.

[Major outbreaks of infection: Investigation and control policy](#)
[Trust Major Incident Plan](#)

The UK approach to SARS provides for an escalating response based on Alert levels, similar to those used for pandemic influenza:

- Alert level 0 (no cases internationally)
- Alert level 1 (cases internationally, but no cases in the UK)
- Alert level 2 (sporadic cases imported into the UK)
- Alert level 3 (One or more hospital or community outbreaks in the UK)
- Alert level 4 (Outbreaks in the UK with extensive community transmission)
- Alert level 5 (post outbreak, de-escalation)

At alert level 1-3 SARS guidance and plans should be reviewed.

At alert level 4 trusts will be asked to prepare to initiate plans to reduce elective admissions and to review plans for the cohorting of infected patients. These will be done in line with the plans agreed as part of the trust's influenza pandemic plan. Some hospitals may be asked to become SARS-only receiving hospitals, this will be coordinated by the Local and Regional Services (LARS) of the Health Protection Agency.

5. Infection Control

5.1 Patient Isolation Precautions

- Patients should be admitted directly to single rooms; admission via Accident and Emergency, the Medical Admissions Unit or Emergency Admissions Suite (FH) should be avoided wherever possible.
- Patients who present at the Accident and Emergency Department should be placed in a single room whilst awaiting assessment. Staff should wear protective clothing as detailed below. Rooms to be appropriately decontaminated before being used again (see 4.7 below).
- Isolate patient in a negative pressure isolation room or if this is unavailable a single room with own bathroom facilities, separate from other patients.
- Suitable information must be placed on the isolation room door indicating the need for isolation, although there will be a need to respect patient confidentiality.
- Only essential staff should enter the isolation room.
- A record of all staff caring for the patient must be maintained. The record sheet should be placed at the door and all staff entering must complete this. This record should be sent to the Occupational Health Department each day.
- Should numbers of affected patients be such that single room isolation is not possible, patients may be cohorted together in a bayed area. The above

recommendations should still apply. A risk assessment must first be carried out with a member of the Infection Prevention and Control Team.

- Rooms/areas with air conditioning systems should have them turned off and not restarted until the patient has been discharged and decontamination performed.
- Patients should wear a surgical facemask, if able to do so, when in close contact with uninfected persons. As a guide, the mask should be changed after eight hours, or sooner if it becomes saturated or breathing is difficult. Where possible, they should be advised to cough/sneeze into a paper tissue, which should be disposed of carefully as infected clinical waste. Hands of suspected cases should be frequently washed, particularly after contact with body fluids.
- Disposable crockery/cutlery may be used when caring for SARS cases.

5.2 Personal Protective Equipment for Contacts

Use an EN149: FFP3 respirator mask for all persons coming into contact with suspected or probable cases e.g., entering the patient's room. If one is not immediately available, a surgical facemask should be worn until a suitable mask is obtained. Please read user instructions supplied with the respirator mask carefully and ensure that the respirator seals tightly to the face when in use (i.e. perform a 'fit check'). Fit is critically important. The respirator mask should fit snugly over the face with the coloured side out and the metal strip at the top. Position the strings to keep the mask firmly in place over the nose, mouth and chin. Mould the metallic strip to the bridge of the nose. Beards, long moustaches and stubble may cause leaks around the respirator. Do not touch the mask again until it is removed, when the wearer is in a safe area, outside the patient's room. It should then be discarded as infected clinical waste. Powered air-purifying respirators (PAPR) are not currently recommended due to concerns over potential contamination during removal and cleaning. If PAPRs are used staff must be fully trained in their safe use.

Contact Precautions include:

- Long-sleeved fluid repellent disposable gown for all persons entering the room
- Gloves made of latex or suitable alternative with similar antiviral properties, with tight-fitting cuffs for contact with the patient or their environment
- Disposable eye protection comprising tight-fitting goggles or face-shield for all patient contact (glasses provide inadequate protection against droplets, sprays and splashes).
- On leaving the isolation cubicle, dispose of gown and gloves as infected clinical waste inside the room immediately before you leave it. Remove mask and goggles/visor outside the room and dispose as infected clinical waste. Then wash hands before re-entering the main ward. See hand hygiene section below.

5.3 Hand Hygiene

Essential before and after all patient contact, removal of protective clothing and cleaning of the environment. Use antibacterial handwash or alcohol-containing hand rub if hands are socially clean. Rings, wrist watches and wrist jewellery must not be worn by staff, in line with Trust policy.

5.4 Equipment

- Where possible, use dedicated equipment in the isolation room
- Dispose of single use equipment as clinical waste inside the room.
- Reusable equipment should be avoided. If used, disinfect with a freshly prepared solution of 1000ppm available chlorine. It should be noted that hypochlorite may corrode some metals. Another suitable disinfectant may be used if this could be a problem.
- Closed system suction should be used
- Use of equipment that re-circulates air (e.g. fans, hot air warming blankets) should be avoided. If used, they should be decontaminated in accordance with manufacturers' instructions and any filters changed. Fans, however, cause less air movement than opening windows in the re-aerosolisation of settled particles. Staff changing filters must be instructed in safe working practices.

5.5 Cleaning and Decontamination

- Domestic staff must be made aware of the need for additional precautions.
- Daily cleaning should be carried out with 1000ppm available chlorine.
- Domestic staff must wear protective clothing as indicated above.
- The isolation area should be cleaned after the rest of the ward area.
- Dedicated or disposable equipment must be used for cleaning.
- Dedicated cleaning equipment must be decontaminated with a 1000ppm available chlorine solution following use
- Blood and body fluid spills should be decontaminated using a solution containing 10,000 ppm available chlorine.
- SARS coronavirus is an enveloped RNA virus and is therefore susceptible to disinfection methods. It is, however, possible that it can survive in the environment for up to 24hrs, so a good standard of environmental decontamination is vital. See Trust [Terminal Cleaning of Isolation Rooms Policy](#)

5.6 Linen and waste

- Clinical waste must be disposed of as infected clinical waste (see Trust Waste Management Policy)
- Laundry should be managed as infected laundry and bagged securely inside the isolation room (see [Trust Hospital Laundry Policy](#))

5.7 Aerosol-Producing Procedures

If possible, aerosol-producing procedures such as the administration of nebulised medication, diagnostic sputum induction, bronchoscopy, airway suctioning and intubation should be avoided. If such procedures are unavoidable, they should take place in a negative pressure single room if available (or in a single room) with the minimum staff possible present.

Entry and exit from the room should be minimised during the procedure.

All staff present must wear appropriate personal protective equipment as outlined above. Powered air-purifying respirators (PAPR) are not currently recommended due to concerns over potential contamination during removal and cleaning. If PAPRs are used staff must be fully trained in their safe use.

5.8 Critical Care

A separate policy for the management of SARS patients in critical care facilities will be available in those areas.

- SARS patients should be transferred to intensive care if their condition is deteriorating to allow early planned intubation by an experienced operator.
- All respiratory equipment must be protected with a filter that has viral efficacy to 99.99%.
- Disposable respiratory equipment should be used where possible.
- The ventilatory circuit should not be broken unless absolutely necessary.
- In-line filters and nebulisers should be used with especial reference to the expiratory circuit.
- The use of non-invasive positive pressure ventilation equipment should be avoided.
- Water humidification should be avoided where possible.

5.9 Operating Theatres

Theatres must be informed in advance.

- The patient should be transported directly to the operating theatre and should wear a surgical mask.
- The patient should be anaesthetised and recovered in the theatre.
- Staff should wear protective clothing as detailed above.
- Disposable anaesthetic equipment should be used wherever possible.
- Re-usable anaesthetic equipment should be decontaminated in line with Trust policy.
- The anaesthetic machine must be protected by a filter with viral efficiency to 99.99%.
- Instruments and devices should be decontaminated in the normal manner. Instruments must be transported safely to the sterile services department.
- The theatre should be cleaned using a 1000ppm available chlorine solution (see below)
- Theatres should not be used for 15 minutes after the patient leaves in conventionally ventilated theatres or 5 minutes in ultraclean ventilation theatres.

5.10 Patient Transfer

Where possible, all procedures and investigations should be carried out in the isolation room. Only a minimal number of staff should be present in room during any procedures.

Only if clinical need dictates should patients be transferred to other departments and the following procedures then apply:

The department must be informed in advance

- The patient must be taken straight to, and return from the investigation/treatment room, and must not wait in a communal area
- Ideally patients should be seen at the end of a list to allow appropriate decontamination after any procedure
- The patient should wear a 'surgical ' mask - this will prevent large droplets being expelled into the environment by the wearer
- Porter and escort staff need not wear masks during transit if the patient is able to wear a mask
- Gloves and gowns should be worn for direct contact with the patient
- The trolley/chair should be wiped with a 1000ppm available chlorine solution after use
- Staff carrying out procedures must wear the protective clothing indicated above
- The treatment/procedure room and all equipment should be cleaned with a 1000ppm available chlorine solution
- Transfer of SARS cases to another hospital should be avoided unless absolutely necessary
- SARS patients should not be transferred solely for the purpose of accommodation in a negative pressure room. If transfer is essential, the Infection Control Team at the receiving hospital must be advised in advance
- Transfer of other patients who may have been exposed to SARS and could be incubating disease should also be avoided. If transfer is essential, the Infection Control Team at the receiving hospital must be advised in advance of the transfer.
- If ambulance transfer is required, they must be informed in advance and will transport the patient using category 3 containment measures.

5.11 Visitors

- The number of visitors should be restricted and in some circumstances it may be preferable to exclude all except essential visitors.
- Previously exposed household contacts of SARS cases should wear masks when visiting SARS cases.
- Visitors of SARS patients should be assessed to determine whether they fall into the category of close contacts. If they do, they should be screened for the presence of fever or respiratory symptoms by the senior nurse in charge of the ward or their deputy. Close contacts with either fever or respiratory symptoms should not be allowed to enter the hospital as visitors and should be educated about this policy.

- Visitors must be informed about the use of infection control precautions when visiting SARS patients and their responsibility for adherence to them.
- A list of all visitors should be kept by the ward.

6. Microbiological and other Pathological Samples

- The medical staff in Microbiology or Virology must be consulted prior to microbiological sampling, who will liaise with the reference laboratory on the need for specific SARS testing and appropriate samples. It is particularly important to exclude influenza as a cause early in the investigation.
- All samples from potential SARS cases should be clearly marked as **possible SARS**, labeled with Biohazard stickers and double bagged. They can be sent to the laboratory by normal transport systems, but **not** via the air tube system (see Trust [Transport of Clinical Specimens policy](#))
- Microbiological samples from suspected SARS cases should be handled at Containment level 3.
- Blood samples should be treated as 'high risk' specimens and handled in the laboratories with precautions appropriate for HIV/hepatitis and other blood-borne viruses.

7. Patient Management

Suspected cases should be admitted directly into an isolation cubicle (see section 4) for assessment. Early transfer to intensive care should be considered. If required, empirical antibacterial therapy should include cover for organisms associated with a community-acquired pneumonia of uncertain aetiology. During the previous outbreaks several antiviral strategies were used; there is some evidence for the effectiveness of interferons, ribavirin and proteases such as lopinavir, however there is no consensus on the most effective strategy. Other causes of respiratory illnesses must be actively excluded.

8. Last Offices

- Carry out last offices using the protective clothing and medical procedures identified above.
- A body bag should be used.
- Mortuary staff and funeral directors must be advised of the biohazard risk.
- Viewing and touching of the cadaver by relatives should be discouraged.
- Embalming is not recommended by the Health Protection Agency.
- If a post-mortem examination is made on a patient who dies meeting the case definition of a probable case, precautions should be taken against the risk of infection from aerosols created during the examination.
- In addition to the standard precautions, for autopsies and post-mortem assessment of SARS cases, personal protective equipment (PPE) should be worn including:
 - Protective garments: surgical scrub suit, surgical cap, impervious gown or apron with full sleeve coverage, eye protection (e.g. goggles or face

shield), shoe covers and double surgical gloves with an interposed layer of cut-proof synthetic mesh gloves.

- Respiratory protection: EN149: FFP3. Powered air-purifying respirators (PAPR) are not currently recommended due to concerns over potential contamination during removal and cleaning. If PAPRs are used staff must be fully trained in their safe use.

9. Contacts of Cases

- Close contacts are considered to be family, friends or health care workers who lived with, or who had direct contact with respiratory secretions, body fluids and/or excretions (e.g. faeces) of a symptomatic case.
- Close contacts remain at risk until ten days after their last contact with a symptomatic case.
- Any person who develops symptoms of SARS within 10 days of being a close contact of a suspected case should be advised to seek medical advice and inform medical staff of their contact with a suspected SARS case
- The management of contacts will vary depending on whether the case is a possible, probable or confirmed SARS case and whether they are health care workers or not (see below)
- Contacts may continue with usual activities unless they become unwell, except in special circumstances where voluntary home isolation may be advised (see sections 8.3 and 8.5)
- Each clinical area should keep a list of staff who have attended a patient with probable or suspect SARS, and their date of last contact should be recorded.
- Enhanced hospital based surveillance for 'atypical pneumonia' should be instigated.
- Consideration should be given to introducing twice daily temperature monitoring of all in-patients.

Contacts other than Health Care Workers

9.1 Management of contacts of a possible case

Contacts of a possible case should be given information on SARS, available at <http://www.hpa.org.uk/> No specific follow-up is needed. Contacts are free to continue with usual activities unless they become unwell. A close contact who develops symptoms of SARS within ten days of contact with a possible case should phone their GP and seek medical advice. They should inform medical staff of their contact with a possible case.

9.2 Management of Contacts of a Probable Case

A list of close contacts should be generated, recording the date on which they last had contact with the case. Clinicians should liaise with the local CCDC/Health Protection team on follow-up responsibilities, but locally it has been agreed that the CCDC/Health Protection team are responsible for the follow-up of close contacts of suspected cases of SARS other than occupational contacts in the healthcare setting.

On day one, the local Health Protection Team will telephone the contact to assess their health and provide them with information on SARS <http://www.hpa.org.uk/>
On day ten following last contact with the case the local Health Protection Team will telephone the contact to assess their health. Contacts who develop symptoms of SARS should initially be assessed at home by their GP rather than in the practice setting. If the patient meets the clinical case definition for SARS, they should be referred to hospital. If the contact is mildly unwell, they should be managed at home by their GP. While at home, the patient should keep contact with others to a minimum until their symptoms have resolved and they have been afebrile for 48 hours. GPs should contact the patient regularly during the course of the patient's illness.

9.3 Management of Contacts of Confirmed Cases

Voluntary home isolation is recommended for a close contact of a confirmed case of SARS. Such close contact should stay indoors and keep contact with other people to a minimum for a period of ten days from the time of last contact with the case. They should monitor their health for SARS symptoms over this ten-day period, and phone their GP if they develop any symptoms. In addition, the GP or local Health Protection team should telephone the contact daily during the ten-day incubation period to assess their health.

10. Health Care Workers

10.1 Healthcare workers who have contacted a patient in the UK with suspected SARS

These staff, and those who have been in contact with respiratory secretions and/or body fluids of a person with SARS, will be regarded as a close contact and instructed to monitor their health during on-going contact and for ten days after their last potential exposure.

- The use of bank or agency staff should be avoided wherever possible.
- Each clinical area should keep a list of these staff and their date of last contact. The record sheet should be placed at the door and all staff entering must complete this. This record should be sent to the Occupational Health Services each day.
- The Occupational Health Services should provide information about SARS and ask staff to report any fever or respiratory symptoms during the ten day period following contact.
- Staff are free to continue with usual activities unless they become unwell or have not followed normal infection control procedures, however wherever possible, they should avoid working in other parts of the hospital or in other hospitals until they are past the incubation period of SARS. (Ten days following last contact with a suspect or probable case).
- If they develop symptoms of SARS within 10 days of being a close contact of a suspect or probable case they should seek medical advice. In these circumstances, if they are at work, they must contact the Occupational Health Services promptly for advice (out of hours, the on-call Infectious Diseases

Physician should be contacted). If the symptoms occur when the member of staff is at home, they should remain there and contact their General Practitioner (or call NHS Direct on 0845 4647) **and** contact the Occupational Health Services (or, out of hours, the Infectious Diseases Physician on-call) for advice. They should not return to work until seven days after the resolution of fever and respiratory symptoms. During this period, possibly infected workers should avoid close contact with people in the general community as well as in healthcare settings. For asymptomatic contacts, a check should be made on day 10 following last contact with the case to ensure that these staff have remained well.

10.2 Healthcare workers returning from an affected area

All staff, students and other healthcare personnel within the Trust who have recently returned from an area of the world where SARS is currently circulating **must** contact their local occupational health department before returning to work. They will be instructed to monitor their health for ten days after leaving these areas. They may return to work as normal, **Unless**:

- They are unwell and develop symptoms consistent with SARS In these circumstances, if they are at work, they must contact the Occupational Health Services promptly for advice (out of hours, the on-call Infectious Diseases Physician should be contacted). If the symptoms occur when the member of staff is at home, they should remain there and contact their General Practitioner (or call NHS Direct on 0845 4647) and contact the Occupational Health Services (or, out of hours, the Infectious Diseases Physician on-call) for advice. They should not return to work until seven days after the resolution of fever and respiratory symptoms. During this period, possibly infected workers should avoid close contact with people in the general community as well as in healthcare settings.
- They are well but have been in close contact with a SARS case, involved in the care of a SARS case or worked in a healthcare setting where cases were being treated. Healthcare staff in this group must contact the Occupational Health Services or, out of hours, the on-call Infectious Diseases Physician. They should avoid contact with patients for 14 days after departure from an affected area, and monitor their own health over this period, seeking medical advice if they become unwell.

11. Monitoring

Compliance with this Policy will be monitored by the Infection Prevention and Control Team in conjunction with the Infectious Disease Consultant who will inform the Health Protection Agency of any cases.

12. References

Groneberg DA et al. treatment and vaccines for severe acute respiratory syndrome. Lancet infect Dis. 2005; 5(3); 147-55

Health Protection Agency. SARS – hospital infection control guidance. www.hpa.org.uk (2005)

Health Protection Agency. Microbiological guidance for taking and handling specimens from suspect SARS patients. <http://www.hpa.org.uk/> (2005)

Health Protection Agency. Information on face masks and respirators. <http://www.hpa.org.uk/> (2005)

Health Protection Agency. Case definition and guidance on reporting, and management of SARS patients in the UK in the inter-epidemic period. <http://www.hpa.org.uk/>. (2005)

Health Protection Agency. Interim contingency plan for severe acute respiratory syndrome. <http://www.hpa.org.uk/> (2003)

Author: Consultant Microbiologist/Virologist

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
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.

Policy Title:	Management Plan for Severe Acute Respiratory Syndrome (SARS)	Policy Author:	Dr S Waugh
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		There is no evidence that SARS affects any one group more than any other.
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4(a).	Is the impact of the policy/guidance likely to be negative? <i>(If “yes”, please answer sections 4(b) to 4(d)).</i>	No	
4(b).	If so can the impact be avoided?		
4(c).	What alternatives are there to achieving the policy/guidance without the impact?		
4(d)	Can we reduce the impact by taking different action?		

Comments:	Action Plan due (or Not Applicable):
	Not Applicable

Name and Designation of Person responsible for completion of this form: **Sheila Waugh. Consultant Virologist** Date: **20/05/09**

Names & Designations of those involved in the impact assessment screening process: Infection Control Committee

(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 Helen Lamont, Deputy Director Nursing & Patient Services, 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.