Shingles Procedure
(IPC Policy Manual)
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1. **INTRODUCTION**

Following primary infection of chickenpox, also known as varicella (VZV), the virus stays in the body in a dormant state in the nervous system and reactivation of the virus causes shingles (Herpes Zoster). People with shingles are also contagious and contact with the virus from the shingles lesions can result in chickenpox infection in non-immune people e.g. people who have never had chickenpox. It is not possible to develop shingles from exposure to a person with chickenpox.

The first signs of shingles are pain at the affected nerve site usually on one side of the body, especially the chest followed by a rash of fluid filled blisters which can take from as little as a few days to several weeks to crust over. Individuals may also experience fever, headache and malaise for several days prior to the rash developing. Reactivation of the virus is usually associated with immunosuppressant therapy, old age or HIV infection although approximately 20% of the population may experience shingles in their lifetime.

A national shingles immunisation programme has been implemented to lower the incidence and severity of shingles in older people. The shingles vaccine is routinely offered to all people aged 70 years with a catch up programme in those aged 70-79 years.

2. **PROCEDURE**

2.1 **Patient Management**

If shingles is suspected or confirmed in a patient within a clinical area contact tracing for both patients and staff must be undertaken to identify any susceptible individuals, especially pregnant staff members. Appendix 21 and Appendix 22 must be completed by the clinical area staff as a priority and the guidance in the following flow chart followed.

Appendices can be accessed via this link and completed copies of these forms must be submitted to the Infection Prevention and Control team (IPCT) or Occupational Health provider (OHP) as directed in the flowcharts, as soon as possible to ensure serology testing is carried out in a timely manner.

Flowchart 1:
Management of Patient with Suspected or Confirmed Shingles

Part 1

Shingles confirmed/suspected

Isolate immediately (refer to Isolation Procedure)

Inform IPCT 01302 796237

Inform patient’s physician

Send copy (appendix 21) to IPCT

Complete Appendix 21 & 22

Are patients (listed on appendix 21) immune?

Yes – no further action

No

Obtain blood sample for VZ IgG within 7 days of exposure

Positive VZV result

No further action

Negative VZV result

1. Isolate from day 7-21 after exposure
2. If high risk, discuss with Consultant Microbiologist

Send copy (appendix 22) to the OHP
Symptomatic patients must be isolated in single rooms with the door closed until all spots/vesicles are dry/crusted. Patients who are immunocompromised may require a longer period of isolation and the IPCT will advise.

Staff must adhere to and follow the guidance in the Trust’s Isolation Procedure.

Only staff members (including domestics) who have had VZV vaccination or previous history of chickenpox must be allocated to the care of symptomatic patients. Non-immune staff must be made aware that they may be at risk of acquiring chickenpox.

Once isolation precautions have been discontinued terminal cleaning must be undertaken and appendix 10 completed - access is via this link:


Patients can be discharged to their own home if medically fit but should be advised to avoid contact with non-immune people until their spots/vesicles are dried and crusted.

If a symptomatic patient requires admission/transfer to another healthcare facility or needs to attend an appointment that cannot be deferred, then the receiving unit and transportation staff must be informed prior to the transfer so that the required precautions can be implemented. Patients must not attend social day care facilities until all the the spots/vesicles have dried and crusted.

### 2.2 Staff Management

The OHP will assess all new staff who have contact with patients for history of chickenpox exposure and update records. Varicella vaccine is recommended for non-immune healthcare workers who have direct patient contact to protect vulnerable patients from acquiring chickenpox from an infected member of staff (DoH, 2003).

If staff working in a care environment develop a rash that is suspected to be shingles their manager must inform the OHP on the next working day. Depending on where the lesions are on the body and whether they work with high risk patients, exclusion from work may not be necessary. OH will risk assess and advise the individual. If exclusion is advised the individual must refrain from work until all spots/vesicles have dried/crusted. Out of hours advice may also be sought from the consultant microbiologist

Contact tracing for both patients and staff must be undertaken to identify any susceptible individuals, especially pregnant staff members. Appendix 21 and Appendix 22 must be completed by the care environment area staff as a priority and the guidance in the following flow chart followed.
Flowchart 2:
Management of Staff Member in a Care Environment
with Suspected or Confirmed Shingles

Confirmed Shingles (diagnosed by medical practitioner)

Refrain from work and inform Line Manager

Line Manager to inform IPCT and OHP

Complete Appendix 21 & 22

Send copy (appendix 21) to IPCT

Send copy (appendix 22) to the OHP

Continue assessment using Part 2 of Patient Flowchart

OHP to undertake risk assessment and manage staff contacts

Send copy (appendix 22) to the OHP
Non-immune care staff with significant exposure will need to be restricted from duties during the infectious phase of the incubation period (7-21 days after exposure) and the OHP will advise further on this.

Non immune pregnant staff will also be advised by the OHP about potential risks on an individual basis.

### General Information (Criteria)

| Diagnosis                  | • Diagnosis of shingles must be confirmed by a medical practitioner.  
|                           | • Swabs are not usually required. |
| Infectious Period          | • From when the rash appears until the blisters are dry and have crusted over. |
| Mode of Transmission       | • Direct contact with vesicle fluid from an infected person which is then transferred via the mucous membranes of a non-immune individual. |
| Susceptible People         | • Individuals who have had chickenpox may develop shingles at any time in their lives although older people and those with conditions affecting the immune system are more at risk.  
|                           | • People who are not immune to chickenpox may contract chickenpox from a person with shingles. |
| People at Increased Risk of Severe Disease | • Pregnant women and their baby when the woman has no immunity to chickenpox (a pregnant woman who has shingles does not present a risk to her baby)  
|                           | • Neonates born to non-immune mothers who have had direct contact with a person with shingles may develop chickenpox  
|                           | • Immunocompromised individuals may suffer more severe and prolonged symptoms |
| Complications              | • Chronic severe pain  
|                           | • Occasionally permanent neurological damage and/or visual impairment |
| Immunity                   | • Shingles may occur more than once in a lifetime |
| Vaccination                | • Yes - individuals over 70 years of age |
| Treatment                  | • Systemic antiviral treatment can reduce the severity and duration of pain, reduce complications and reduce viral shedding  
|                           | • Treatment should be started within 72 hours of the onset of rash usually for 7-10 days  
|                           | • People at high risk of developing serious complications can be given immunoglobulin |
2.4 Visitor Contacts

Non-immune visitors should be advised about the risks of visiting clinical areas and discouraged from visiting if possible. They should refrain from visiting if they develop flu-like symptoms and a rash.

3. Definitions/Explanation of Terms Used

Varicella – chickenpox

Vesicles – small blisters containing clear fluid

Varicella Zoster Virus (VZV) – a herpes virus that causes chickenpox and shingles

Herpes Zoster – shingles

Varicella Zoster Immunoglobulin (VZIG) – medication containing varicella zoster antibodies used to protect against infection

Prophylaxis – treatment given to prevent disease

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

Refer to the home page, section 4, of the Infection Prevention and Control Policy


4.1 Occupational Health Provider

The Occupational Health Provider is responsible for:

- Assessing all new staff who have contact with patients to determine a history of chickenpox, positive varicella serology or history of two doses of VZV
- Immunisation history record keeping
- Testing for immunity to varicella and vaccinating non-immune staff unless contra-indicated
- Offering evidence based advice to manage staff with shingles in the workplace

5. LINKS TO ASSOCIATED POLICIES/DOCUMENTS

Infection Prevention and Control Manual

6. REFERENCES/FURTHING READING


Department of Health (2003) Chickenpox (Varicella) Immunisation for Health Care Workers

7. APPENDICES

To access the following Appendices please see IPC Manual homepage https://www.rdash.nhs.uk/46192/infection-prevention-and-control-manual/

Appendix 21 – Chickenpox/shingles Patient Contact List
Appendix 22 – Chickenpox/shingles Staff Contact List
Appendix 10 – Terminal Clean Procedure