York Teaching Hospital NHS
NHS Foundation Trust

Viral Haemorrhagic Fever

(VHF)

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Target audience:	All Trust Staff
Relevant Regulations and Standards	

Executive Summary

This policy outlines the management of patients with VHF and the infection control measures needed to minimise the spread of these organisms that are in addition to standard precautions.

Version History Log

Version	Date Approved	Version Author	Status & location	Details of significant changes

Contents

1 Introduction & Scope

Viral haemorrhagic fevers (VHF) are severe and life-threatening diseases caused by a range of viruses. Most are endemic in a number of parts of the world, most notably Africa, parts of South America and some rural parts of the Middle East and Eastern Europe.
Environmental conditions in the UK do not support the natural reservoirs or vectors of any of these diseases and although cases of VHF are occasionally imported into the UK the risk of epidemic spread in the general population is negligible.
There is however a risk of acquiring these diseases by inoculation injury particularly among hospital and laboratory staff. Accidental inoculation may result from needlestick injury or by contamination of broken skin and/or mucous membranes by infected blood or body fluids. Strict infection control precautions are required to protect those who may be exposed.
This policy is aimed at all medical staff, nursing staff and allied health care professionals.

2 Definitions

RNA – Ribonucleic acid - is one of the three major macromolecules (along with DNA and proteins) that are essential for all known forms of life.

Zoonotic **-** an infectious disease that can be transmitted (in some instances, by a vector) from non-human animals, both wild and domestic, to humans or from humans to non-human animals.

HSIDU – High Security Infectious Diseases Unit

HPA – Health Protection Agency

CCDC – Consultant in Communicable Disease Control

Vector - an organism such as a mosquito or tick that transmits disease-causing microorganisms from an infected person or animal to another

3 Policy Statement

VHF's are caused by viruses from four distinct families: arenaviruses, filoviruses, bunyaviruses, and flaviviruses.

Four agents of VHF are of particular concern in the UK because of possible person-to-person spread - ***Lassa, Ebola, Marburg and Crimean/Congo Haemorrhagic Fevers.***

For guidance on incubation periods and initial symptoms follow Appendix (i)

For guidance on categorisation follow Appendix (ii)

For initial management of patients follow Appendix (iii)
For additional information on PPE follow Appendix (iv)
For additional/supporting information follow Appendix (v)
Useful contacts see Appendix (vi)

4 Equality Impact Assessment

The Trust statement on Equality is available in the Policy for Development and Management of Policies at Section 3.3.4.

A copy of the Equality Impact Assessment for this policy is at appendix A.

5 Accountability

Corporate accountabilities are detailed in the **Policy for Development and Management of Policies** at section 5.

All healthcare professionals and volunteers are responsible and accountable to the Chief Executive for the correct implementation of this policy.

Professional staff are accountable according to their professional code of conduct. Medical staff are professionally accountable through the General Medical Council, and nurses are professionally accountable to the Nursing and Midwifery Council.

6 Consultation, Assurance and Approval Process

Consultation, assurance and approval process is detailed in section 6 of the **Policy for the Development and Management of Policies.**

The Stakeholder is the Hospital Infection Prevention Committee.

7 Review and Revision Arrangements

The date of review is given on the front coversheet.

Persons or group responsible for review is the Hospital Infection Prevention Committee

The Compliance Unit will notify the author of the policy of the need for its review six months before the date of expiry.

On reviewing this policy, all stakeholders identified in section 6 will be consulted as per the Trust's Stakeholder policy. Subsequent changes to this policy will be detailed on the version control sheet at the front of the policy and a new version number will be applied.

Subsequent reviews of this policy will continue to require the approval of the appropriate committee as determined by the **Policy for Development and Management of Policies.**

8 Dissemination and Implementation

8.1 Dissemination

Once approved, this policy will be brought to the attention of relevant staff as per the **Policy for Development and Management of Policies**, section 8 and Appendix C Plan for Dissemination.

This policy is available in alternative formats, such as Braille or large font, on request to the author of the policy.

8.2 Implementation of Policies

The Policy will be disseminated through the Consultants; Clinical Directors; Directorate Manager; Matrons; and Ward Managers via emails and meetings.

9 Document Control including Archiving

The register and archiving arrangements for policies will be managed by the Compliance Unit. To retrieve a former version of this policy the Compliance Unit should be contacted.

10 Monitoring Compliance and Effectiveness

This policy will be monitored for compliance with the minimum requirements outlined below.

10.1 Process for Monitoring Compliance and Effectiveness

Evidence	Monitoring /Who by	Frequency
a. Hand hygiene	Hand hygiene audits completed by ward/ department staff	Monthly
b. Antimicrobial prescribing	Antimicrobial policy audits by Antimicrobial Stewardship Team	As required dependent on issues raised
c. Use of Personal Protective Equipment	Saving Lives High Impact Intervention 8 – cleaning clinical equipment completed by ward/ department staff	Monthly
d. Decontamination equipment	Saving Lives High Impact Intervention 8 – cleaning clinical equipment completed by ward/ department staff	Monthly

	Matron Environment Audits completed by matrons	
e. Decontamination environment	Monit audits completed by domestic teams PEAT inspections completed by PEAT teams	According to risk category for each ward/ department
f. Isolation	IPT documentation records. CPD whiteboard records.	For individual patient cases
g. Data	CPD data, laboratory database surveillance by IPT	Monthly

10.2 Standards/Key Performance Indicators

Saving Lives High Impact Intervention 8 – Cleaning clinical equipment

Hand Hygiene compliance data

IPT performance dashboards

11 Training

See section 11 of the **Policy for Development and Management of Policies** for details of the statutory and mandatory training arrangements.

12 Trust Associated Documentation

YHFT [CORP.RL10] Policy for the Development and Management of Policies

YHFT [GL.CLIN.CLIN3] Antimicrobial Formularies

YHFT [CLIN.IC19] Infection Prevention Policy for the Decontamination of Reusable Medical Devices and the Environment

YHFT [CLIN.IC12] Infection Prevention Policy for Effective Hand Hygiene

YHFT [CLIN.IC6] Infection Control Standard Precautions Policy

YHFT [CLIN.IC8] Infection Prevention Isolation Policy

YHFT [CLIN.IC9] Laundry Policy

13 External References

P. Aleksandrowicz, K. Wolf, D. Falzarano, H. Feldmann, J. Seebach, H. Schnittler (2008) *Viral haemorrhagic fever and vascular alterati.* Institute of Physiology, Technical University, Dresden, Germany, Special Pathogens Program, National Microbiology Laboratory, Public Health Agency of Canada, and Department of medical microbiology, University of Manitoba, Canada

http://www.cdc.gov/ncidod/diseases/virlfvr/virlfvr.htm

http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ViralHaemorrhagicFever/

http://www.hse.gov.uk/aboutus/meetings/committees/acdp/141008/acdp90p9.pdf **Advisory Committee on Dangerous Pathogens Management and control of serious viral infections**

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@ab/documents/digitalasset/dh_087496.pdf (Biological agents: Managing the risks in laboratories and healthcare premises)

http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1194947321070 (Cardinal signs and tips for key biological agents)

http://library.nhsgg.org.uk/mediaAssets/Manuals/nhsgg_icp_manual_39_ods_vhf.pdf (for advice on transport)

http://www.hse.gov.uk/pubns/priced/hsg53.pdf

http://www.hse.gov.uk/aboutus/meetings/committees/acdp/070612/acdp97P5-annex-1.pdf

14 Appendices –

Appendix (i) - Guidance on incubation periods and initial symptoms
Appendix (ii) - Guidance on categorisation

Appendix (iii) - Initial management of patients

Appendix (iv) - Additional information on PPE
Appendix (v) - Additional/supporting information
Appendix (vi) - Useful contacts

Appendix A	Equality Impact Assessment Tool
Appendix B	Checklist for the Review and Approval
Appendix C	Plan for the Dissemination of the Policy

Appendix (i) - Incubation periods and initial symptoms

Patient assessment

A VHF infection should be considered in any patient presenting with an unexplained fever with a history of recent foreign travel. Most cases can be dismissed on epidemiological/geographical grounds alone.

VHF endemic areas: List of countries by disease -

Lassa fever: Burkina Faso, Cote d'Ivoire, Ghana, Guinea, Liberia, Mali, Nigeria, Sierra Leone

Crimean-Congo Haemorrhagic Fever: Afghanistan, Albania, Armenia, Bulgaria, Congo, Greece, Iran, Kazakhstan, Kosovo , Mauritania, Pakistan, Russian Federation, Senegal, Serbia, South Africa, Tajikistan, Turkey, Turkmenistan, Ukraine, Uzbekistan, Zimbabwe

Marburg: Angola, Democratic Republic of the Congo, Kenya, Uganda, Zimbabwe

Ebola: Democratic Republic of the Congo, Cote d'Ivoire, Gabon, Kenya, Sudan, Uganda

Argentinian Haemorrhagic Fever: limited agricultural region in the pampas of Argentina

Bolivian Haemorrhagic Fever: Benin province (Machupo virus) and Cochabamba province (Chapare virus), Bolivia

Kyasanur forest disease: Kamataka State, India

Alkhurma Haemorrhagic Fever: Makkah & Najran provinces, Saudi Arabia

http://www.hpsc.ie/hpsc/A-Z/Vectorborne/ViralHaemorrhagicFever/EndemicAreasandRecentOutbreaks/EndemicAreasListofcountriesbydisease

Last updated: 23 March 2012

Clinicians should seek the help and advice of a consultant microbiologist the CCDC or a specialist in infectious diseases or tropical medicine if VHF is suspected.

- HSIDU (Royal Free Hospital London Tel. No. 020 7794 0500 or Newcastle General Hospital Tel. No. 0191 233 6161). Ask for Infectious Diseases doctor on call.

The incubation period for VHF ranges from 1 - 21 days. Initial symptoms include;

- Fever
- Malaise
- Headache
- Sore throat
- Muscle and joint pains
- Nausea, vomiting and diarrhoea may also occur

Ebola and Marburg often cause a measles-like rash after 4 – 7 days. Obvious bleeding is a later or terminal event. Pyrexia may last as long as 16 days with temperatures reaching 41°C.

Testing for malaria must be undertaken **immediately**, as treatment for malaria will need to be considered in the absence of a firm diagnosis.

- Send FBC sample to haematology requesting malarial film
- Contact the lab before sending the sample and give full clinical details
- If the first sample is negative send 2 subsequent samples to absolutely exclude malaria
- Do not send blood samples for other tests unless discussed and agreed by microbiology.

Other relatively common causes of febrile illness in travellers returning from Africa include typhoid fever, dengue, Rickettsial infections and tropical parasites. Multiple infections are not uncommon in the tropics and the finding of malarial parasites does not absolutely exclude one of the haemorrhagic fevers or other serious infections.

Appendix (ii) - Categorisation

The purpose of risk assessment and patient categorisation in relation to VHF is to provide efficient and timely management of patients, while affording maximum protection for the laboratory and clinical staff involved in the patients care.
For this purpose, patients are assigned to one of three risk groups: **minimum, moderate or high.**

Minimum risk

- This category includes febrile patients who have ***not*** visited known endemic areas before the onset of illness.
- Or have been in endemic areas (or in contact with a known or suspected source of a VHF), but in whom the onset of illness was *definitely* more than 21 days after their last contact with any potential source of infection.

Moderate risk

- This category includes febrile patients who **have** visited an endemic area during the 21 days before the onset of illness, but have none of the additional risk factors which would place him or her in the high risk category.
- Have not been in a known endemic area but who may have been in adjacent areas or countries during the 21 days before the onset of illness, and who have evidence of severe illness with organ failure and/or haemorrhage that could be due to VHF and for which no alternative diagnosis is currently evident.

High risk

- This category includes febrile patients who have been in an endemic area during the three weeks before illness and have lived or stayed in a house for more than 4 hours where there were ill feverish persons known or strongly suspected to have a VHF.
- Those who took part in nursing or caring for ill, feverish patients known or strongly suspected to have a VHF, or had contact with body fluids, tissue or with the dead body of such a patient.

- Laboratory, health or other worker who has or is likely to have been in contact with the body fluids, tissues or the body of a human or animal known or strongly suspected to have a VHF.
- Those previously categorised as "moderate" risk, but who have developed organ failure and/or haemorrhage.
- Have not been in an endemic area but during the three weeks before illness they have cared for a patient or animal known or strongly suspected to have VHF or came into contact with the body fluids, tissues or dead body of such a patient or animal.
- Have handled clinical specimens, tissues or laboratory cultures known or strongly suspected to contain an agent of VHF.

Appendix (iii) - Initial management of patients

Minimum risk

- Minimum risk patients may be admitted to a general hospital managed with standard isolation techniques.
- The Infection Prevention Team must be informed before the patient is admitted, or immediately after admission.
- The Consultant in Communicable Disease Control (CCDC) must be informed of suspected cases. For patients in the minimum risk category statutory notification of suspected VHF is not required.
- Standard procedures for transport of specimens should be used.
- Patients may be transported by ambulance without special precautions.

Moderate risk

- If presenting to ED with no specialist facilities, isolate and arrange transfer to unit as below.
- Moderate risk patients should be admitted either to the Department of Health designated High Security Infectious Disease Units (HSIDU) or to intermediate isolation facilities after consultation with the physician in charge.
- The CCDC must be notified of a suspected case in the moderate category.
- Fluid repellent gown to be worn if risk of exposure to high volumes of body fluids
- Gloves when risk of contact with body fluids
- Goggles for splash risk
- Fluid repellent surgical facemask for potential aerosolization or splash procedures
- In more than 95% of cases malaria will be the alternative diagnosis. Virological tests for VHF are therefore generally not indicated for moderate risk patients unless discussed and agreed with a consultant microbiologist.
- Initial malaria test may be carried out locally, but other patient management specimens should be sent to an HSID laboratory and transported in accordance with the recommendations as below.

- Contacts should be identified by the CCDC, but unless the patient is re-categorised as high risk the contacts will not be placed under surveillance.
- Ambulance Category III will be required to transport the patient.

High risk

- Any patient known or strongly suspected to be suffering from VHF should be admitted to an HSIDU as above.
- A combination of negative pressure isolation room and flexible film isolator (Trexler) is the preferred method of containment.
- Fluid repellent gown to be worn if risk of exposure to high volumes of body fluids
- Gloves when risk of contact with body fluids
- Goggles for splash risk
- Fluid repellent surgical facemask for potential aerosolization or splash procedures
- Ambulance transport of the patient must be Ambulance Category III http://library.nhsgg.org.uk/mediaAssets/Manuals/nhsgg_icp_manual_39_ods_vhf.pdf (for advice on transport)
- The CCDC must be informed immediately when a patient is categorised as high risk.
- Blood and body fluids from such patients are likely to contain high concentrations of virus therefore specimens for patient management tests and virological investigations must be sent to an HSID viral diagnostic laboratory equipped to handle Hazard Group 4 biological agents.

For confirmed cases use (in addition to above PPE)

- Double gloves
- Disposable visor
- FFP3 respirator or equivalent

Appendix (iv) – additional information on PPE

PPE when working with specimens in the laboratory

The PPE selected must be of high quality and construction to provide the required level of protection in the working conditions and must bear a “CE” mark that signifies compliance with the Personal Protective Equipment Regulations 2002. This implements the European PPE Directive concerning design and manufacture and demonstrates conformance with European (EN) or International (ISO) standards.
Further guidance on the selection of Respiratory Protective Equipment (RPE) is given in the HSE guidance http://www.hse.gov.uk/pubns/priced/hsg53.pdf

It is imperative that the PPE provides a barrier of adequate coverage and integrity to prevent staff contact (direct or indirect) with contamination. The barrier function must be maintained throughout all clinical/nursing procedures, and when following appropriate procedures for the removal and disposal or decontamination of potentially contaminated equipment by the wearer.
The PPE combination has to establish a barrier against contact with contaminated surfaces, splash, spray, bulk fluids and aerosol particles as follows:

- Must provide complete adequate coverage of all exposed skin, with sufficient integrity to prevent ingress or seepage of bulk liquids or airborne particles, under foreseeable conditions of usage;
- The materials from which the PPE is made must resist penetration of relevant liquids/suspensions and aerosols;
- The various components (body clothing, footwear, gloves, respiratory/face/eye protection) must be designed to interface sufficiently well to maintain a barrier, e.g., sleeves long enough to be adequately overlapped by glove cuffs.

Whilst inhalation is not strongly linked to transmissibility of VHF, as a precaution RPE to a high level Assigned Protection Factor of 20 (APF20) may be considered appropriate. This would normally be achieved by the use of a disposable filtering face-piece (FFP) respirator type FFP3, certified as PPE under the European Directive 89/686/EEC.

It is important that wearers have undergone face-fit testing to ensure such respirators achieve a good seal. While disposable RPE may be more practical to avoid the need for decontamination of re-usable RPE, facial hair (a beard or stubble) may prevent a good seal being achieved with a disposable respirator. In this instance a powered hood type respirator given a classification of TH2 according to European Standard EN 12941 may be necessary.

Putting on and taking off PPE

As described above, PPE must be chosen to ensure an adequate barrier to exposure is created and maintained. This must be taken into consideration when putting on the various items of PPE. After use, it should be assumed that PPE may be contaminated and an inappropriate removal procedure therefore could expose the wearer. Consequently, a detailed and pre-defined sequence for putting on and taking off items should be developed, implemented and monitored.

PPE should be put on before starting procedures likely to cause exposure and only removed after moving away from a source of exposure. For example, PPE must be put on and removed in the HSIDU anteroom if present.

PPE should not be a source of further contamination e.g. by being removed and left on environmental surfaces.

Disposal or decontamination

Following removal, disposable PPE must be placed into suitable disposal receptacles and treated as clinical infectious waste for incineration (Category A). If re-usable PPE is unavoidable, it must be decontaminated prior to storage. The method must be validated as effective against VHF and compatible with the PPE to ensure it is not damaged so that its effectiveness in subsequent use is not compromised.

Storage and Maintenance

PPE should be stored to prevent accidental damage and contamination. RPE requiring powered respirator units should be thoroughly examined, tested and maintained at suitable intervals (at least once a month). Records of the tests should be kept for at least five years after the date of the test.

Staff training on the use of PPE
Staff should be trained in procedures to put on and especially to take off PPE, including the correct order to avoid cross contamination, and to check that the RPE with which they are provided fits properly. They should also receive clear instructions on when it is to be used and how it is to be disposed of or, as appropriate, decontaminated, maintained and stored.

Taken and adapted from;
http://www.hse.gov.uk/aboutus/meetings/committees/acdp/070612/acdp97P5-annex-1.pdf

Appendix (v) - Additional/supporting information

Each of these families shares a number of features:

- They are all RNA viruses, and all are covered, or enveloped, in a fatty (lipid) coating.
- Their survival is dependent on an animal or insect host, called the natural reservoir.
- The viruses are geographically restricted to the areas where their host species live.
- Humans are not the natural reservoir for any of these viruses. Humans are infected when they come into contact with infected hosts. However, with some viruses, after the accidental transmission from the host, humans can transmit the virus to one another.
- Human cases or outbreaks of hemorrhagic fevers caused by these viruses occur sporadically and irregularly. The occurrence of outbreaks cannot be easily predicted.
- With a few noteworthy exceptions, there is no cure or established drug treatment for VHF.

In rare cases, other viral and bacterial infections can cause a hemorrhagic fever; scrub typhus is a good example.

Viruses associated with most VHF are zoonotic. This means that these viruses naturally reside in an animal reservoir host or arthropod vector. They are totally dependent on their hosts for replication and overall survival. For the most part, rodents and arthropods are the main reservoirs for viruses causing VHF's. The rat, house mouse, and other field rodents are examples of reservoir hosts. Arthropod ticks and mosquitoes serve as vectors for some of the illnesses. However, the hosts of some viruses such as Ebola and Marburg remain unknown.

Lassa fever is found in West Africa especially Nigeria, Sierra Leone and Liberia. Primary infection occurs when broken skin or mucous membranes are contaminated with urine from the natural host of the virus, the multimammate rat in Africa **or** person to person via blood, pharyngeal secretions or urine. Variation in virulence has been observed, and in hospital outbreaks in West

Africa there have been mortality rates of up to 60% and approximately 100,000 cases per year.

Ebola fever - there have been cases in DR Congo, Sudan, Côte d'Ivoire and Gabon. The natural reservoir of Ebola virus is unknown but monkeys may be the link to human cases of infection. In an outbreak in Zaire (now named DR Congo) in 1995 the mortality rate was 77% more than 50% of those affected were carers of Ebola patients.

Marburg fever - Marburg disease was first described when laboratory workers in Germany and the former Yugoslavia became infected. All cases were traced either to direct contact with blood, organs or cell cultures from a batch of African green monkeys that had been caught in Uganda, or had been exposed to the blood of the primary human cases. As with Ebola virus, the natural reservoir of Marburg virus is unknown.

Crimean/Congo Haemorrhagic Fever (CCHF) is caused by a virus that is widespread in East and West Africa, Central Asia and the former USSR. More recently CCHF or its antibody has been detected in Dubai, Iraq, South Africa, Pakistan, Greece, Turkey, Albania, Afghanistan, and India; transmission is by tick bite.

Disease	Incubation in days (d)	Possible Presenting Symptoms	Clinical Features	Diagnostic Samples (use appropriate sterile container(s))	Infection Control	Initial Treatment (symptomatic and supportive therapy is essential in all cases)	Post-exposure Prophylaxis
				SEEK ADVICE FROM MICROBIOLOGIST on diagnostic assays		SEEK ADVICE FROM ID CONSULTANT on treatment	
VHF (Viral Haemorrhagic Fever) Lassa fever, Crimean/Congo fever (CCHF), Ebola and Marburg viruses	Lassa fever 3-21d CCHF 1-12d Ebola HF 2-21d Marburg HF 3-16d	Acute febrile illness with prostration and signs of increased vascular permeability and circulatory failure NB: Clinical symptoms and features vary with infecting agent-onset may be flu-like with sustained high temperature Haemorrhage is marked in CCHF, with nose and gum bleeding as first signs, otherwise it is often a late feature	Febrile illness with facial oedema and tendency to haemorrhage (e.g. nosebleed) Vomiting and diarrhoea (may be bloody) and petechial or purpuric rashes are common Warning signs are rapid rise in Aspartate transaminase and sometimes a rapid fall in platelet count.	Blood culture Clotted blood	Person-to-person transmission only through blood and body fluids (via coughing or vomiting) Airborne precautions Patients should be admitted to a designated high security infectious disease unit or an intermediate isolation facility Identify contacts - make aware of signs and symptoms - Local HPU organise follow-up	Supportive care with hydration maintenance Minimal trauma (injections or parenteral interventions) Replacement of coagulation factors and platelets may be of value Ribavirin (Lassa fever and CCHF): Loading dose 30 mg/kg IV; first 4d 16 mg/kg IV every 6 hrs; next 6d 8 mg/kg IV every 8 hrs Duration: 10d	PEP is only based on an appropriate risk assessment after discussion with consultant specialist

Cardinal signs and tips for key biological agents (15/02/11)

http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1194947321070

Appendix (vi) - Useful contacts

High Security Infectious Disease Units

Royal Free Hampstead NHS Trust, London
Telephone (24 hrs, ask for infectious disease physician on call)
+44 (0)20 7794 0500 or 0844 8480700 (local rate number when calling from outside London)
www.royalfree.nhs.uk

The Newcastle upon Tyne Hospitals NHS Foundation Trust, Newcastle
Telephone (24 hrs, ask for infectious disease physician on call)
+44 (0)191 233 6161
www.newcastle-hospitals.org.uk
This unit is currently closed until 2013.

Reference Laboratories – for VHF screen

HPA Viral Zoonosis Unit
Virus Reference Department
61 Colindale Avenue
London NW9 5HT
Tel: 0208 327 6017 or 0208 200 4400 (24 hour)

HPA Special Pathogens Reference Unit
Centre for Emergency Preparedness and Response Porton Down
Salisbury SP4 0JG
Tel: 01980 612224 or 01980 612100 (24 hour)

Appendix A Equality Impact Assessment Tool

To be completed when submitted to the appropriate committee for consideration and approval.

Name of Policy:	

1.	**What are the intended outcomes of this work?** *Inform clinical staff of best practice clinical care for patients with Extended Spectrum Beta Lactamase isolated in microbiological specimens*	
2	**Who will be affected?** *Patients, staff*	
3	**What evidence have you considered?**	
a	**Disability**	
b	**Sex**	
c	**Race**	
d	**Age**	
e	**Gender Reassignment**	
f	**Sexual Orientation**	
g	**Religion or Belief**	
h	**Pregnancy and Maternity***.*	
i	**Carers**	
j	**Other Identified Groups**	
4.	**Engagement and Involvement**	

a.	Was this work subject to consultation?	Yes
b.	How have you engaged stakeholders in constructing the policy	No
c.	If so, how have you engaged stakeholders in constructing the policy	
d.	For each engagement activity, please state who was involved, how they were engaged and key outputs	
5.	**Consultation Outcome** Approved by Hospital Infection Prevention Committee *Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups*	
a	Eliminate discrimination, harassment and victimisation	
b	Advance Equality of Opportunity	
c	Promote Good Relations Between Groups	
d	What is the overall impact?	
	Name of the Person who carried out this assessment:	
	Date Assessment Completed	
	Name of responsible Director	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Committee, together with any suggestions as to the action required to avoid/reduce this impact.

Appendix B Checklist for the Review and Approval

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1	**Development and Management of Policies**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or procedures?		
2	**Rationale**		
	Are reasons for development of the document stated?		
3	**Development Process**		
	Is the method described in brief?		
	Are individuals involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
	Has an operational, manpower and financial resource assessment been undertaken?		
4	**Content**		
	Is the document linked to a strategy?		
	Is the objective of the document clear?		
	Is the target population clear and		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
	Are the references cited in full?		
	Are local/organisational supporting documents referenced?		
5a	**Quality Assurance**		
	Has the standard the policy been written to address the issues identified?		
	Has QA been completed and approved?		
6	**Approval**		
	Does the document identify which committee/group will approve it?		
	If appropriate, have the staff side committee (or equivalent) approved the document?		
7	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		
8	**Document Control**		
	Does the document identify where it will		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	be held?		
	Have archiving arrangements for superseded documents been addressed?		
9	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?		
	Is there a plan to review or audit compliance with the document?		
10	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so, is it acceptable?		
11	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?		

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name		Date	
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it			

and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	
Signature			

Appendix C Plan for dissemination of policy

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	
Date finalised:	
Previous document in use?	
Dissemination lead	
Which Strategy does it relate to?	
If yes, in what format and where?	
Proposed action to retrieve out of date copies of the document:	**Compliance Unit will hold archive**

Dissemination Grid

To be disseminated to:	**1)**	**2)**
Method of dissemination		
who will do it?		
and when?		
Format (i.e. paper or electronic)	**Electronic**	

Dissemination Record

Date put on register / library	
Review date	
Disseminated to	
Format (i.e. paper or electronic)	
Date Disseminated	
No. of Copies Sent	
Contact Details / Comments	