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### **Guideline Objective**


This guideline aims to ensure that systems are in place to prevent and control infection and communicable disease by underpinning national polices. It outlines the criteria, responsibilities and systems required to manage specific conditions/ infections. The goal of this guideline is to protect patients, staff and the public by effective prevention and control of infection and communicable disease.

***Compliance with this guideline is best practice. If you have any concerns please discuss with your line manager who will consult the local Infection Control/Health Protection Team for advice***

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## 1. PRINCIPLES OF INFECTION CONTROL

### 1.1 INTRODUCTION

There is a statutory responsibility under the Health & Safety at Work Act 1974 (HSWA) to create as safe an environment as is reasonably practicable. This includes the development and maintenance of good working practices, including infection control. All staff who have contact with patients or their blood, body fluids, secretions, excretions or contaminated items should receive infection control training commensurate with their work activity.

It is not always possible to identify people who are infectious from those who are not. For this reason the Scottish Infection Manual (1998) introduces a new approach to the prevention of transmission of infection. This is known as SICPs (Precautions) and should be used routinely for all patients.

Standard Infection Control Precautions (SICP's): incorporates the previously used terms Universal Precautions, designed to reduce the risk of transmission of bloodborne pathogens, and Body Substance Isolation, designed to reduce the risk from other moist body substances.

Standard Infection Control Precautions aim to protect health care workers, patients and visitors from the transmission of infection where the risk is known and also unknown.

Standard Infection Control Precautions will ensure maximum protection without divulging information which is either confidential or unknown and should be used at all times for all patients.

Transmission Based Precautions (TBP's): are extra measures used where patients are known or suspected to be colonised or infected with highly transmissible or epidemiologically important micro-organisms, or are at increased risk of infection, where additional measures are required.

Isolation: is a further method for the prevention of cross infection.


### 1.2 RISK ASSESSMENT

It is not possible to set out absolute rules for when and how care should be provided. The requirement for particular precautions must be assessed in each individual circumstance related to activity, based on the guidance provided. Thorough assessment of risk from known or potential sources of harm is a requirement under health and safety and environmental legislation, in terms of the Duty of Care obligations.


*“Risk assessment is nothing more than a careful examination of what, in your work, could cause harm to people, so that you can weigh up whether you have taken enough precautions or should do more to prevent harm. The aim is to make sure that no one gets hurt or becomes ill.”*

*Health & Safety Executive, 1999*

Members of staff are answerable for their actions or omissions and must follow safe practices in order to protect themselves and others. Infection control risk assessment is an ongoing process and should be a routine component of patient care.

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<b>Risk Factors for Transmission of Infection</b>		
	<b>Higher Risk of Transmission</b>	<b>Lower Risk of Transmission</b>
<b>Source Patient</b>	<ul style="list-style-type: none"> <li>• Incontinent of stool/stool not contained by nappies</li> <li>• Loose stools/diarrhoea</li> <li>• Draining skin lesions or wound not covered by dressings</li> <li>• Patients in intensive care or requiring extensive hands-on care</li> <li>• Invasive devices</li> <li>• Poor patient compliance with personal hygiene and infection control practices e.g. confused patients</li> </ul>	<ul style="list-style-type: none"> <li>• Continent</li> <li>• Good personal hygiene</li> <li>• Skin lesions or wounds covered with dressing</li> <li>• Able to control respiratory secretions</li> <li>• Capable of self care</li> <li>• Able to comply with infection control precautions.</li> </ul>
<b>Microorganism</b>	<ul style="list-style-type: none"> <li>• Able to survive in the environment</li> <li>• Low infective dose e.g. <i>E. coli O157</i>, <i>Shigella</i></li> <li>• High pathogenicity, high virulence</li> <li>• Airborne</li> <li>• Spread by contact</li> <li>• Able to colonise invasive devices</li> <li>• Propensity for asymptomatic/carrier state</li> </ul>	<ul style="list-style-type: none"> <li>• Unable to survive long in the environment</li> <li>• High infective dose, e.g., <i>Salmonella</i></li> <li>• Low pathogenicity</li> <li>• Short period of infectivity</li> </ul>
<b>Environment</b>	<ul style="list-style-type: none"> <li>• Poor domestic hygiene</li> <li>• Shared patient care equipment not decontaminated between patients</li> <li>• Crowded facilities</li> <li>• Shared facilities e.g. toilets, baths, sinks</li> <li>• High patient-nurse ratio</li> <li>• Absence of negative pressure rooms (if airborne)</li> </ul>	<ul style="list-style-type: none"> <li>• Good domestic hygiene</li> <li>• Dedicated equipment</li> <li>• Adequate spacing between beds</li> <li>• Own bathroom facilities</li> <li>• Low patient-nurse ratio</li> </ul>
<b>Susceptible Patient</b>	<ul style="list-style-type: none"> <li>• Patient in intensive care unit or requiring extensive hands-on care</li> <li>• Patient has invasive procedures or devices</li> <li>• Non-intact skin</li> <li>• Debilitated, severe underlying disease</li> <li>• Extremes of age</li> <li>• Recent antibiotic therapy</li> <li>• Immunosuppression</li> </ul>	<ul style="list-style-type: none"> <li>• Able to self care</li> <li>• No indwelling devices</li> <li>• Intact skin and mucous membranes</li> <li>• Strong immune system</li> </ul>
Reference: Canadian Communicable Disease Report: Infection Control Guidelines (1999) Health Canada		

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### 1.3 **STANDARD INFECTION CONTROL PRECAUTIONS (SICPS)**

SICPs applies to all patient contacts, including non-intact skin and mucous membranes, blood, all body fluids, secretions and excretions regardless of whether or not they contain visible blood.

#### 1.3.1 **HANDWASHING**

Wash hands before and after contact with each patient, immediately after removing gloves and, if necessary, between tasks on the same patient to prevent cross-contamination between body sites.

Wash hands after contact with blood, body fluids, secretions, excretions, contaminated items, broken skin and mucous membranes even when gloves are worn (see Section H).

#### 1.3.2 **WOUNDS/LESIONS**

Cover wounds, skin lesions and all breaks in exposed skin with an appropriate waterproof dressing. Wear gloves if hands are extensively affected.

#### 1.3.3 **DISPOSABLE GLOVES**

Gloves should be used as an additional measure, not as a substitute for hand washing. Wash hands immediately after removing gloves.

Wear gloves when touching blood, body fluids, secretions, excretions, contaminated items, broken skin and mucous membranes.

Gloves are not required for routine patient care activities in which contact is limited to patient's intact skin (see also 1.3.2 above).

Change gloves between care activities and procedures on the same patient after contact with materials that may contain high concentrations of micro-organisms e.g. handling indwelling urinary catheter.

Change gloves between patients.

Gloves should not be reused or washed.


#### 1.3.4 **DISPOSABLE PLASTIC APRONS**

Aprons are not required for routine patient care activities in which contact is limited to patient's intact skin.

Wear a disposable plastic apron (or other appropriate protective clothing) for activities where the uniform comes into contact with the patient's skin.

Aprons must be worn for activities that are likely to result in contamination of clothing with blood, body fluids, secretions or excretions.

Change apron between patients.

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### **1.3.5 FACE PROTECTION**

Wear appropriate personal protective equipment to protect the mucous membrane of eyes, nose and mouth during activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions.

### **1.3.6 SPILLAGE/CONTAMINATION**

Clean up all blood, body fluid, secretion or excretion spillage or contamination as soon as possible (see Section I).

### **1.3.7 PATIENT-CARE EQUIPMENT**

Clean and decontaminate patient-care equipment safely between each patient use (see Section I).

### **1.3.8 SHARPS**

Avoid sharps usage wherever possible. Where sharps usage is essential, exercise particular care in handling and disposal (see Section G).

Avoid wearing open footwear in situations where sharp instruments or needles are handled or where blood may be spilt.

### **1.3.9 SHARPS INJURIES/CONTAMINATION WITH BLOOD OR BODY FLUIDS**

Take care to prevent sharps injuries or contamination of broken skin, mucous membrane or eyes with another person's blood or body fluid. Report accidental exposures promptly (see Section G).

### **1.3.10 LAUNDRY**

Handle and reprocess laundry safely (includes fabric lifting and handling equipment) (see Section D).

### **1.3.11 WASTE**

Handle and dispose of waste safely (see Section K).


## **1.4 ADDITIONAL TRANSMISSION BASED PRECAUTIONS**

### **1.4.1 CONTACT TRANSMISSION**

Contact transmission includes direct contact, indirect contact and large droplet transmission. Although droplet transmission is a type of contact transmission, it is considered separately as it requires different precautions.

#### **a) DIRECT AND INDIRECT CONTACT**

Transmission by direct contact occurs when a micro-organism is transferred by direct physical contact between an infected/colonised person and another person. Indirect

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contact occurs when a micro-organism is transferred to another person via an intermediate object, such as unwashed hands or contaminated instruments/equipment.

Standard Infection Control Precautions should prevent most transmission by this route. However, additional precautions may be required when standard precautions are not considered sufficient to prevent transmission of specific micro-organisms.

b) **DROPLET TRANSMISSION**

Droplet transmission refers to large droplets  $\geq 5 \mu\text{m}$  in diameter, generated from the respiratory tract during coughing or sneezing, or produced as a result of procedures such as bronchoscopy or tracheal suction. These droplets are propelled a short distance,  $< 1\text{m}$ , and deposited on the nasal or oral mucosa of another person.

Special ventilation is not required as large droplets do not remain suspended in the air and true aerosolisation does not occur.

**1.4.2 AIRBORNE TRANSMISSION**


Dissemination of micro-organisms by aerosolisation is termed airborne transmission. Micro-organisms are contained in droplet nuclei (the small airborne particles  $< 5 \mu\text{m}$ , which result from evaporation of large droplets) or in dust particles containing skin squames and other debris that remain suspended in the air for long periods of time. Air currents widely disperse such micro-organisms which can be inhaled by persons who may be some distance away from the source patient, even in a different room or ward. Control of airborne transmission can be difficult, as it may require special ventilation systems.

**1.5 ISOLATION**

In addition to standard precautions, appropriate patient placement is a significant component in infection control strategy. Single room accommodation or cohort nursing either in wards or in the Area Infectious Diseases Unit is often necessary for patients with certain infections. Additional Transmission Based Precautions may also be indicated (see Appendix 1 - Specific Infections table). The decision to isolate will be determined not only by the micro-organism concerned but also by risk assessment of individual patient and geographic factors, for example, symptoms (see Appendix 2 - Symptomatic Assessment table), mental state, clinical speciality, availability of single rooms, symptoms etc. Contact your local Infection Control Team for further advice.

**1.6 REFERRAL TO THE AREA INFECTIOUS DISEASES UNIT**

The Area Infectious Diseases (ID) Unit, based at Monklands Hospital, serves as a resource within Lanarkshire where expertise in the management of patients with clinical infection is concentrated and where appropriate isolation facilities are available. The role of the ID Unit is two-fold. Firstly, to admit patients with obvious infection for treatment and, where necessary,

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isolation. Secondly, to manage patients who do not require isolation, but who do require the specialist care provided by an ID Unit (Scottish Infection Manual, 1998).

### 1.6.1 ADMISSIONS

As an Area service, the ID Unit takes direct admissions from GPs, A&E departments or other clinical teams throughout Lanarkshire. Principal referral categories are:

- severe sepsis such as meningitis and septicaemia
- fever in returning travellers (see Section V for viral haemorrhagic fever (VHF) guidelines)
- infections in all compromised hosts (not just HIV/AIDS patients)
- gastroenteritis
- acute hepatitis
- infectious complications of injecting drug use
- pyrexia of unknown origin (PUO)
- patients requiring isolation, particularly respiratory isolation (e.g., tuberculosis<sup>1</sup>, chickenpox)
- severe pneumonias
- patients with an uncertain diagnosis, where it is felt that investigation by the ID team is appropriate

To arrange an admission to the ID Unit, the referring doctor should contact:

ADULT REFERRALS:

On-call ID SHO → Monklands Hospital ☎ 01236 748748

PAEDIATRIC REFERRALS<sup>2</sup>:(children aged 12 or under)

On-call paediatric SHO → Wishaw Hospital ☎ 01698 361100

Members of hospital Infection Control Teams have an important role to play in identifying existing in-patients who might benefit from transfer to the ID Unit.


### 1.6.2 ADVICE ON CLINICAL INFECTION

An important role of the ID Unit is to provide general advice regarding all aspects of clinical infection, as well specific areas such as the management of blood-borne virus exposure incidents (see Section G).

**Calls for ID advice (rather than admission) should be directed to the on-call ID consultant (Monklands Hospital ☎ 01236 748748), not to the on-call SHO.**


1 Note that respiratory consultants usually look after the cases of pulmonary TB from the immediate Monklands Hospital catchment area who are admitted to the ID Unit

2 Paediatric ID cases are admitted to the ID Unit, but are cared for by the paediatrician

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1.7 **INFECTION CONTROL PRACTICE** (see also specific infection table at Appendix 1) Contact the Infection Control Team for further advice

	<b><u>STANDARD INFECTION CONTROL PRECAUTIONS</u></b> (TO BE USED AT ALL TIMES FOR ALL PATIENTS)	<b><u>ADDITIONAL TRANSMISSION BASED PRECAUTIONS</u></b>	
		CONTACT	AIRBORNE/DROPLET
HANDWASHING	Between patient contacts, immediately after removing gloves and if necessary between tasks on the same patient to prevent cross-infection between body sites. After contact with blood, body fluids, secretions, excretions, contaminated items, non-intact skin and mucous membranes, even if gloves were worn.	Wash hands before leaving room.	Wash hands before leaving room.
WOUNDS/ LESIONS	Cover cuts and grazes etc., with an appropriate waterproof dressing.	As SICPs.	As SICPs.
DISPOSABLE GLOVES	Wear when touching blood, body fluids, secretions excretions, contaminated items, non-intact skin and mucous membranes.	Remove after contact with infective materials and before leaving room.	Remove after contact with infective materials and before leaving room.
DISPOSABLE PLASTIC APRONS	Wear apron (or other appropriate protective clothing) for direct patient care and when contamination of clothing with blood, body fluids, secretions or excretion is likely. Change between patients.	Remove before leaving room.	Remove before leaving room.
FACE PROTECTION	Protect eyes, nose and mouth when splashes or sprays of blood, body fluids, secretion or excretions is likely.	As SICPs.	Additional respiratory protection may be required – see specific infection table.
SPILLAGES / CONTAMINATION	Clean up all blood, body fluid, secretion or excretion spillages or contamination as soon as possible ( <i>see Section I</i> ).	As SICPs.	As SICPs.
EQUIPMENT	Clean and decontaminate between patients ( <i>see Section I</i> ).	Dedicate equipment to single patient use (or cohort where applicable).	Dedicate equipment to single patient use (or cohort where applicable).
LAUNDRY	Handle and reprocess laundry safely (includes fabric lifting and handling equipment) ( <i>see Section D</i> ).	As SICPs.	As SICPs.
WASTE	Handle and dispose of waste safely ( <i>see Section K</i> ).	As SICPs.	As SICPs.
SHARPS	Avoid usage where possible. Handle and dispose of all sharp items safely ( <i>see Section G</i> ).	As SICPs.	As SICPs.
EXPOSURE TO BLOOD/ BODY FLUIDS	Take care to prevent sharps injuries or contamination of non-intact skin, mucous membrane or eyes with another person's blood or body fluid. Report accidental exposures promptly ( <i>see Section G</i> ).	As SICPs.	As SICPs.
ACCOMMODATION	Isolation may be required for some infections – see Specific Infections table. Appropriate cleaning between patients (see Section I).	Single room; if not available cohort nurse with other patient(s) with active infection with the same micro-organism but with no other infection.	Single room, with negative pressure ventilation for airborne transmission. Keep door closed.
MOVEMENT AND TRANSPORT	Maintain precautions during transportation.	Essential movement and transport only.	Essential movement and transport only.

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## 2. CONFIDENTIALITY

It is the responsibility of all members of staff, irrespective of their function, to ensure that any information to which they are party to remains confidential. Where it is deemed appropriate to share information in the course of professional practice, the professional must ensure, before its release that it is imparted in strict professional confidence and for a specific purpose.

Examples of ways in which disclosure of information to others might occur:


- with the consent of the patient
- without the consent of the patient when the disclosure is required by law e.g., notifiable diseases, or order of a court
- in the “public interest” in order to protect others from risk of death or serious harm: The patient must be made aware of the disclosure of such information and the professional must be prepared to justify and record such a decision in the appropriate notes. The professional, before disclosure, can take the opportunity to discuss the matter with a more experienced colleague or a regulatory body
- where a communicable disease has contributed to the cause of death, information will be recorded on the death certificate
- if it is known or there is good reason to believe that a medical colleague/health care worker who has, or may have, a serious communicable disease, is practising or has practised, in a way which places patients at risk, the appropriate person in the employing authority must be informed e.g., Occupational Health Consultant or where appropriate the relevant regulatory body

### 2.1 RECORD KEEPING

The principles of the confidentiality of information held about patients apply to both written and computer held records. Whatever system is used each patient has the right to have information about themselves kept secure and private and that information given in confidence will be used only for the purpose for which it was given and will not be released to others without their permission.

## 3. COMMUNICATION

To minimise the potential transmission of infection, provide a safe working environment and facilitate good professional relationships, it is essential that there are defined and clear channels of communication.

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### 3.1 WITH THE PATIENT

- the nature of the disease, its subsequent medical, social and occupational implications
- ways of protecting others
- the importance of giving other care providers information about their condition, which will enable them to provide optimal clinical management and care

### 3.2 WITHIN THE WARD/CLINICAL AREA

- visitors to the area should be informed by the nurse in charge of any relevant precautions they should observe
- when patients are being nursed in isolation a notice requesting visitors to report to the nurse in charge prior to entering the patients room should be prominently displayed
- inform the Infection Control Team (ICT)

### 3.3 WITH OTHER DISCIPLINES AND DEPARTMENTS


- The nurse in charge must ensure that the relevant additional precautions are explained to any staff working in the affected ward/area
- Where possible, any care interventions outwith the ward/area must be planned, with prior notification given and appropriate precautions taken
- The clinician in charge of the case must ensure that notification, where appropriate, is made to the Director of Public Health or his/her deputy [CPHM (CD & EH)]
- Inform the ICT

### 3.4 BETWEEN HEALTH CARE SETTINGS

- Where possible a member of the ICT should be notified **before** any proposed transfer, to another healthcare facility, of a patient receiving additional transmission based precautions or isolation for any other reason
- The IC colleague in the receiving area should be informed by the ICT member responsible for the patient at the time of transfer
- The nurse in charge of the receiving unit must also be informed of the patient's infection status by the transporting unit

### 3.5 WITH AMBULANCE TRANSPORT

The nurse in charge of the patient must ensure when arranging an ambulance that the correct patient infection categorisation code is used (see Appendix 5).

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#### 4. **INVASIVE PROCEDURES**

Recommended Standard Infection Control Precautions and any additional Transmission Based Precautions also apply whenever and wherever invasive procedures are being carried out. Specific extra precautions, however, may be required for certain procedures and within certain departments. Where necessary local protocols should be developed by departments in conjunction with the local Infection Control Team. Some specific extra precautions are noted as follows:

- Departments (e.g., operating theatres, X-Ray) **must** be notified in advance, by the clinician and nurse in charge, if any case is considered to constitute an infection risk
- Where a patient is considered to pose an infection risk it is preferable for the case to be placed at the end of the list/session
- Only essential personnel should be present
- Clinical areas should not be cluttered with unnecessary equipment and furnishings
- Where there are practical options for using single-use instruments, which do not compromise clinical outcome, consideration should be given to using these for surgical procedures
- For guidance on ways to reduce the risk of blood borne virus transmission during surgical procedures see *Section G*
- Routine theatre cleaning procedures should be carried out after each case (*see Section I*). If tuberculosis is known or suspected, allow 1 hour to ensure sufficient air changes, prior to reuse of the theatre
- For guidance on the management, including handling of instruments, of patients with confirmed or suspected human prion disease e.g. Creutzfeldt-Jakob disease of any type, see *Section I – Appendix 1* and *Section W*
- Single-use kits must always be used for lumbar-puncture on all patients
- Contact lenses, including trial contact lens fitting sets (diagnostic lens fitting sets) must not be used on more than one patient
- Components of ophthalmic devices that touch the surface of the eye should be restricted to single patient use whenever practicable and where this does not compromise clinical outcome

#### 5. **VISITORS**

Patients may constitute an infection risk to visitors. Visitors must be informed of any precautions they should observe to protect themselves from the risk of infection (see 3.2 *Communication - Within the Ward/Clinical Area*). Persons who are not considered to be immune to a particular infection e.g., chickenpox, should be excluded from contact with that

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disease. A risk assessment should be undertaken by health care professionals before children are allowed to visit individuals being nursed in isolation.

Before handing over contaminated clothing to relatives/visitors staff should advise them of any potential risk (see *Section D - Laundry Guidelines*).

Visitors may be a source of infection. If they have current symptoms of infection most would in all probability seek advice or telephone before visiting. Under certain circumstances however, it may be necessary to explain firmly but kindly that visits should not be made. Special precautions may be necessary at times for visitors to patients with impaired immunity. Local guidelines related to visitors should be agreed with the local Infection Control Team.


## 6 PETS

Certain areas e.g., medical, psychiatric and long stay wards may wish to adopt the use of animals as part of their therapeutic process. While pets can provide valuable companionship, stimulation and comfort, they represent an infection control hazard through the diseases that they can transmit to patients. **Facilities considering the use of animals in therapy should do so against a background of comprehensive risk assessment and against written operating procedures which specify the veterinary and other care required to minimise these dangers. The Infection Control Team must be consulted.** Appendix 4 gives details of some of the issues which need to be considered.

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## 7. REFERENCES


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**Appendix 1**

Disease/causative organism	Incubation Period	Period of Communicability	Route of Transmission	Precautions required	Isolation Options	Notification required	Comments
<b>Anthrax</b>	2-7 days	Person to person transmission very rare	Multiple routes:	SICPs.	ID Unit	Yes	Inform ICT ↓ Telephone CPHM
<b>Campylobacter</b>	1-10 days, usually 3-5 days	While diarrhoea persists	Faecal-oral Food Pets faeces	SICPs.	Home ID Unit Single room	Yes	See Sections E & F
<b>Chickenpox (Varicella-zoster virus)</b>	14-21 days	5 days before the onset of 1st crop of vesicles to 6 days after the onset of last crop of vesicles.	Airborne Contact with fluid from vesicles.	SICPs. + Airborne and Contact	Home ID Unit Single room	Yes	Non-immune pregnant women and Immunosuppressed patients should avoid contact. Susceptible individuals should be considered to be infective 10-21 days following exposure. See Section P
<b>Clostridium difficile</b>	Uncertain	While diarrhoea persists	Faecal-oral Air-Borne/contact by spore environmental contamination	SICPs.	Home Single room ID Unit	No	See Sections E & F Inform ICT Telephone CPHM if 3 or more linked cases

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<b>Disease/causative organism</b>	<b>Incubation Period</b>	<b>Period of Communicability</b>	<b>Route of Transmission</b>	<b>Precautions required</b>	<b>Isolation Options</b>	<b>Notification required</b>	<b>Comments</b>
<b>Creutzfeldt-Jakob disease (CJD)</b> and other Transmissible Spongiform Encephalopathie	See Section W See Section I – (A to Z – Instruments and Appendix 1)						Inform ICT& CPHM
<b>Cryptosporidium</b>	1-2 weeks	While diarrhoea persists	Water Faecal-oral Contact with farm animals	SICPs.	Home ID Unit Single room	Yes	No specific treatment See Sections E & F
<b>Diphtheria</b>	1-7 days	Until bacteriologically negative, usually 2wks	Airborne Contact with discharges from lesions	SICPs + Airborne and Contact	ID Unit	Yes	Inform ICT  Telephone CPHM
<b>E. coli O157</b>	Uncertain, usually 12-60 hours but may be 1-10 days (average 3 days)	Usually 1-3 weeks	Food Faecal-oral Water Contact with farm animals or land contaminated with their faeces	SICPs.	Home ID Unit Single Room	Yes	Monitor renal function. Inform ICT Telephone CPHM  See Sections E & F
<b>Gas gangrene</b>	2-7 days	Not applicable	Wound contamination e.g., soil/faeces	SICPs.	Not required	No	

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Disease/causative organism	Incubation Period	Period of Communicability	Route of Transmission	Precautions required	Isolation Options	Notification required	Comments
<b>Gastroenteritis (Includes undiagnosed and viral)</b>	Depends on organism	Depends on organism, usually 48 hours after diarrhoea stopped	Food Faecal-oral Airborne	SICPs.	Home ID Unit Single room	Depends on cause	Inform ICT  Telephone CPHM if 3 or more linked cases See Sections E & F
<b>Giardia</b>	4 - 25 days, usually 7-10 days	Until treated	Water Faecal-oral	SICPs.	Home ID Unit Single room	Yes	
<b>Glandular fever (Mononucleosis)</b>	4-6 weeks	Variable - may be several weeks	Contact with saliva e.g., mouth kissing, sharing drinks containers	SICPs.	Not required	No	
<b>Hepatitis A</b>	15-50 days	10 days before & until a few days after jaundice appears	Faecal-oral Food	SICPs.	Home ID Unit Single room	Yes	See Sections E & F
<b>Hepatitis B</b>	6wks – 6mths	Variable, can be for life.	<ul style="list-style-type: none"> <li>• Contact with infected blood or other body fluids.</li> <li>• Sexual transmission</li> <li>• Mother to child (before or at time of birth)</li> </ul>	SICPs.	Home ID Unit Single room (see comments box)	Yes.	Single room only required where exposure to blood & body fluids difficult to control  See Section G

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<b>Disease/causative organism</b>	<b>Incubation Period</b>	<b>Period of Communicability</b>	<b>Route of Transmission</b>	<b>Precautions required</b>	<b>Isolation Options</b>	<b>Notification required</b>	<b>Comments</b>
<b>Hepatitis C</b>	2 wks–6mths, commonly 6-9 weeks	Probably for life	<ul style="list-style-type: none"> <li>Contact with infected blood or other body fluids.</li> <li>Sexual transmission is rare.</li> <li>Mother to child (before or at time of birth)</li> </ul>	SICPs.	Home ID Unit Single room (see comments box)	Yes	Single room only required where exposure to blood & body fluids difficult to control  See Section G
<b>Herpes simplex (Cold sore) including genital herpes</b>	2-12 days	Until lesions crusted and dry.	Direct contact with lesions	SICPs.	Home ID Unit if severity warrants hospital admission.	No	
<b>HIV / AIDS</b>	Variable – infection to development of detectable antibodies generally 1-3 months.	Unknown; presumed to begin early after onset of infection and extend throughout life.	<ul style="list-style-type: none"> <li>Contact with infected blood or other body fluids.</li> <li>Sexual transmission</li> <li>Mother to child (before or at time of birth or through breast-feeding)</li> </ul>	SICPs.	ID Unit Single room (see comments box)	No	Single room only required where exposure to blood & body fluids difficult to control or if indicated for other infection.  See Section G

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Disease/causative organism	Incubation Period	Period of Communicability	Route of Transmission	Precautions required	Isolation Options	Notification required	Comments
<b>Impetigo</b> <b>Streptococcal (1)</b> - <b>Staphylococcal (2)</b> -	1)1-3 days (2)Variable - commonly 4-10 days	Until crusted and dry.	Direct contact with lesions	SICPs.	Home Single room ID Unit	No	Inform ICT ↓ Telephone CPHM if 3 or more linked case.
<b>Influenza or influenza –like illness</b>		While symptomatic	Airborne	SICPs & Airborne	Home Single room ID Unit	No	Where several cases – Appropriate to ICT
<b>Legionellosis</b>	2-10 days	No person-person transmission	Airborne	SICPs.	Not required	Yes	Inform ICT Inform CPHM
<b>Leptospirosis (Weil’s disease)</b>	4-19 days	Person to person transmission rare	Contact with water etc., contaminated with the urine of infected animals, often rats	SICPs.	Not required	Yes	
<b>Lice</b>	Eggs hatch in 7-10 days. Egg to egg cycle averages 3 wks.	Until treated	Person to person	SICPs.	Single room until 24 hours after treatment	No	See Section U  Body Lice Contact Precautions
<b>Lyme disease</b>	3-32 days	No person to person transmission	Tickborne	SICPs.	Not required	Yes	

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<b>Disease/causative organism</b>	<b>Incubation Period</b>	<b>Period of Communicability</b>	<b>Route of Transmission</b>	<b>Precautions required</b>	<b>Isolation Options</b>	<b>Notification required</b>	<b>Comments</b>
<b>Measles</b>	6-12 days	Onset of prodromal symptoms to 4 days from onset of rash	Airborne spread. Contact with nasal/throat secretions.	SICPs + Airborne	Home ID Unit Single room	Yes	Inform ICT
<b>Meningitis (<i>Haemophilus influenzae</i>)</b>	Unknown; probably short, 2-4 days	Until 48 hours after the start of appropriate antibiotic therapy	Direct contact with respiratory droplets	SICPs	ID Unit Single room	Yes	Inform ICT Telephone CPHM See Section M
<b>Meningitis (Viral)</b>	3-10 days	Variable - depends on causative organism	Variable -depends on causative organism	SICPs.	ID Unit or single room	No	See poliomyelitis
<b>Meningococcal infections</b>	2-10 days	Until 48 hours after the start of appropriate antibiotic therapy	Direct contact with respiratory droplets	SICPs.	ID Unit or single room	Yes	Inform ICT Telephone CPHM See Section M
<b>Meticillin Resistant <i>Staphylococcus aureus</i> (MRSA)</b>	Not applicable	Complex	Contact Airborne	SICPs.	Depends on risk assessment	No	See Section J
<b>Mumps</b>	12-26 days	3 days before swelling, until swelling subsides	Airborne droplets. Contact with saliva	SICPs.	Home ID Unit	Yes	

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Disease/causative organism	Incubation Period	Period of Communicability	Route of Transmission	Precautions required	Isolation Options	Notification required	Comments
<b>Parvovirus</b>	Variable : 4-20 days to developme nt of rash or symptoms of aplastic crisis.	<ul style="list-style-type: none"> <li>• People with rash alone greatest before onset and probably not after onset of rash.</li> <li>• People with aplastic crisis – up to 1 week after onset of symptoms.</li> <li>• Immunosuppressed perhaps for months to years</li> </ul>	<ul style="list-style-type: none"> <li>• Contact with respiratory secretions.</li> <li>• Mother to fetus</li> <li>• Parenterally by blood/blood product transfusion</li> </ul>	SICPs.	Home ID Unit	No	Contact ICT for advice. Possible problems in pregnancy and immunosuppressed/ haematology patients.
<b>Pertussis (Whooping cough)</b>	7-20 days	<ul style="list-style-type: none"> <li>• Untreated cases, from early catarrhal stage to 21 days from onset of paroxysmal cough</li> <li>• Treated cases, until 5 days after the start of appropriate antibiotic therapy</li> </ul>	Direct contact with respiratory discharges. Airborne droplets	SICPs.	Home ID Unit	Yes	

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<b>Disease/causative organism</b>	<b>Incubation Period</b>	<b>Period of Communicability</b>	<b>Route of Transmission</b>	<b>Precautions required</b>	<b>Isolation Options</b>	<b>Notification required</b>	<b>Comments</b>
<b>Pneumonia</b>	Not applicable	Depends on causative organism	Unlikely to be infectious to others unless associated with viral influenza-like illness	SICPs.	Not usually required	No	
<b>Poliomyelitis</b>	10-15 days	Until virus no longer present in faeces	Faecal-oral Respiratory	SICPs.	ID Unit	Yes	Only immunised staff to attend. Inform ICT Telephone CPHM
<b>Psittacosis</b>	1 – 4 weeks	No person to person spread	By inhaling agent from desiccated droppings, secretions and dust from feathers of infected birds	SICPs.	Not required	Yes	Pregnant women should avoid contact.

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Disease/causative organism	Incubation Period	Period of Communicability	Route of Transmission	Precautions required	Isolation Options	Notification required	Comments
<b>Rabies</b>	Usually 2-8 weeks but can range from 9 days to 2 years.	Secretions contain rabies virus (saliva, tears, urine, CSF and tracheal aspirate) for at least 2 weeks after onset of symptoms.	Animal bites. Person to person transmission has never been documented although theoretically possible	SICPs(see comments box)	ID Unit	Yes	Inform ICT Telephone CPHM <ul style="list-style-type: none"> <li>• Pre-exposure prophylactic immunisation recommended for attending staff</li> <li>• Post-exposure prophylaxis required in the event of skin or mucous-membrane contamination with patient's secretions</li> <li>• PPE – gowns, gloves, face visors</li> <li>• Staff with cuts and abrasions on hands not allowed contact with patient</li> <li>• Specimens – special arrangements required</li> </ul>

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Disease/causative organism	Incubation Period	Period of Communicability	Route of Transmission	Precautions required	Isolation Options	Notification required	Comments
<b>Ringworm of Scalp</b> (Tinea capitis) and <b>Body</b> (Tinea corporis)	10-14 days	Until adequately treated. Viable fungus may persist on contaminated articles for long periods	Direct skin to skin contact. Contact with contaminated articles	SICPs.	Not required	No	
<b>Ringworm of Body</b> (Tinea corporis)	4 -10 days	As above	As above	SICPs.	Not required	No	
<b>Rotavirus</b>	24-72 hrs	Up to 48 hours after symptoms settle	Faecal-Oral and possible contact or respiratory spread	SICPs.	Home Single room	No	Inform ICT ↓ Telephone CPHM if 3 or more linked cases
<b>Rubella</b> (German measles)	14-21 days	7 days from onset of rash	Droplet spread. Contact with nasopharyngeal secretions (and urine in infants with CRS*)	SICPs.	Home ID Unit Single Room	Yes	Non-immune pregnant women should avoid contact.  *CRS = Congenital rubella syndrome
<b>Salmonella</b> (excluding typhoid & paratyphoid)	6-72 hrs	Variable, but unlikely to infect others by 48 hours after diarrhoea stops unless poor hygiene or incontinent	Food Faecal-oral	SICPs.	Home ID Unit Single room	Yes	See Sections E & F

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<b>Disease/causative organism</b>	<b>Incubation Period</b>	<b>Period of Communicability</b>	<b>Route of Transmission</b>	<b>Precautions required</b>	<b>Isolation Options</b>	<b>Notification required</b>	<b>Comments</b>
<b>Scabies</b>	2-6 wks	Until effectively treated	Direct skin to skin contact (5-10 minutes approx.)	SICPs.	Not required Unless crusted scabies	No	Inform ICT (See Section S)
<b>Scarlet Fever</b>	2-5 days	<ul style="list-style-type: none"> <li>48 hours after adequate therapy.</li> <li>Untreated cases 10-21 days</li> </ul>	Airborne droplets. Direct contact	SICPs.	Home ID Unit Single room	Yes	
<b>Shigella</b> (Bacillary dysentery)	1-7 days, usually 1-3 days	Variable, but unlikely to infect others by 48 hours after diarrhoea stops unless poor hygiene or incontinent	Food Water Faecal-oral	SICPs.	Home ID Unit	Yes	
<b>Small round structured virus</b> (Norwalk-like viruses)	4-48 hrs	Up to 48 hours after symptoms settle	Faecal-oral and possible contact or airborne spread.	SICPs.	Single room	No	Inform ICT ↓ Telephone CPHM if 3 or more linked cases.
<b>Tetanus</b>	3-21 days	No person to person spread	Spores usually introduced via contaminated puncture wound	SICPs.	Not required	Yes	Consider transfer to ID Unit for specialist management Inform CPHM (office hours and weekends)


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<b>Toxoplasmosis</b>	5-23 days	No person to person spread		SICPs.	Not required	Yes	Possible problems in pregnancy and the immunosuppressed
<b>Transmissible spongiform encephalopathy agents – (CJD<sup>3</sup>, GSS<sup>4</sup>, FFI<sup>5</sup>, kuru)</b>	See Section W See Section I – (A to Z – Instruments and Appendix 1)						
<b>Tuberculosis (Pulmonary)</b>	Variable. Can be as short as 2 wks.	Normally 2 weeks after starting treatment	Airborne droplets	SICPs. + Airborne	See Section N	Yes	See Section N
<b>Typhoid &amp; Paratyphoid</b>	7-21 days	Variable as long as bacilli appear in excreta, commonly 1-2 weeks for paratyphoid. 3 months in 10% of untreated typhoid fever cases	Food and water. Faecal/urine-oral	SICPs.	ID Unit	Yes	See Sections E & F Inform ICT Telephone CPHM
<b>Viral haemorrhagic fevers</b>	Depends on specific infectious agent			SICPs. + Contact	Required – see Section V	Yes	See section V


<sup>3</sup> Creutzfeldt-Jacob disease (CJD) including classical sporadic; familial; iatrogenic and variant

<sup>4</sup> Gerstmann-Straussler-Scheinker syndrome (GSS)  
 Fatal familial insomnia (FFI)

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<b>Disease/causative organism</b>	<b>Incubation Period</b>	<b>Period of Communicability</b>	<b>Route of Transmission</b>	<b>Precautions required</b>	<b>Isolation Options</b>	<b>Notification required</b>	<b>Comments</b>
<b>Warts (Plantar)</b>		While visible lesion exists	Direct contact with contaminated surfaces or lesions.	SICPs.	Not required	No	
<b>Whooping Cough</b>	See under Pertussis						

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## Appendix 2

### DISEASES TO BE NOTIFIED BY REGISTERED MEDICAL PRACTITIONERS WITH EFFECT FROM 1 JANUARY 2010: NOTIFICATIONS ARE BASED ON REASONABLE SUSPICION AND SHOULD NOT AWAIT LAB. CONFIRMATION

<ul style="list-style-type: none"> <li>* Anthrax</li> <li>* Botulism</li> <li>Brucellosis</li> <li>* Cholera</li> <li>* <b>Clinical syndrome due to</b> E.coli O157 infection (see Note 1)</li> <li>* Diphtheria</li> <li>* <b>Haemolytic Uraemic</b> Syndrome (HUS)</li> <li>* <b>Haemophilus influenzae</b> type b (Hib)</li> <li>* <b>Measles</b></li> <li>* Meningococcal disease</li> <li>Mumps</li> <li>* Necrotizing fasciitis</li> <li>* Paratyphoid</li> </ul>	<ul style="list-style-type: none"> <li>* Pertussis</li> <li>* <b>Plague</b></li> <li>* Poliomyelitis</li> <li>* Rabies</li> <li>Rubella</li> <li>* <b>Severe Acute Respiratory</b> Syndrome (SARS)</li> <li>* Smallpox</li> <li>Tetanus</li> <li><b>Tuberculosis (respiratory or</b> non-respiratory) (see Note 2)</li> <li>* <b>Tularemia</b></li> <li>* Typhoid</li> <li>* Viral haemorrhagic fevers</li> <li>* West Nile fever</li> <li>Yellow Fever</li> </ul>
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\*It is recommended that those diseases above marked with an \* require urgent notification, i.e. within the same working day. Follow up written / electronic notification within 3 days is still required.

#### **Note 1: E.coli O157**

Clinical suspicion should be aroused by (i) likely infectious bloody diarrhoea or (ii) acute onset non-bloody diarrhoea with a biologically plausible exposure and no alternative explanation. Examples of biologically plausible exposures include:

- contact with farm animals, their faeces or environment;
- drinking privately supplied or raw water;
- eating foods such as undercooked burgers or unpasteurised dairy products;
- contact with a confirmed or suspected case of VTEC infection.

Further guidance is available at:

<http://www.hps.scot.nhs.uk/giz/e.coli0157.aspx?subjectid=18>

Cases notified as HUS (Haemolytic Uraemic Syndrome) should NOT be notified as “Clinical syndrome due to *E.coli* O157 infection” as well.

#### **Note 2: Tuberculosis**


For the purposes of notification, respiratory TB or non-respiratory TB should be taken to have the same meanings as the World Health Organisation definitions of **pulmonary TB** and **non-pulmonary TB** respectively.

**Pulmonary TB** is tuberculosis of the lung parenchyma and/or the tracheobronchial tree.

**Non-pulmonary TB** is tuberculosis of any other site.

Where tuberculosis is clinically diagnosed in both pulmonary and non-pulmonary sites, this should be treated as pulmonary TB.


**If you are in any doubt about the diagnosis of suspected cases, you should contact the local Health Protection Team for advice. Telephone 01698 206326 or Out of Hours via Monklands Hospital 01236 748748.**

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**Appendix 3**

**INFECTION RISK ASSESSMENT BY SYSTEM WHEN DIAGNOSIS UNCERTAIN**

System	Type Of Infection	Precautions Required	Isolation	ID Unit
<b>Respiratory</b>	A. Upper respiratory tract infection (“viral infection”, pharyngitis, mumps, diphtheria).	SICPs& Airborne	Yes	If possible (essential if diphtheria suspected)
	B. Lower respiratory tract infection with sputum production (community-acquired pneumonia) ➤ Tuberculosis unlikely ➤ Tuberculosis possible	SICPs.	No	No
		SICPs.& airborne	Yes	Sometimes
<b>Intra-abdominal</b>	A. Gastrointestinal: diarrhoea and/or vomiting suspected infectious origin.	SICPs.	Yes	If specialist management required
	B. Hepatitis, possibly infective (hepatitis A, CMV)	SICPs.	Yes	Not normally required
<b>Skin</b>	Impetigo, cellulitis with broken skin, infected underlying dermatological condition, scabies, headlice, chickenpox*, shingles* (if on head or face), measles*, other exanthematous infection	SICPs. Contact *Airborne	Yes	Particularly for conditions marked*
<b>Urinary Tract</b>		SICPs.	Not required but do not nurse catheterised patients in adjacent beds.	
<b>Central Nervous system</b>	A. Meningitis	SICPs.	Yes – until proven not to be meningo-coccal	If specialist management require
	B. Encephalitis	SICPs.	No	If specialist management required
<b>Blood-borne Virus</b>	Hepatitis B, C & HIV	SICPs.	Yes –where exposure to blood or body fluids difficult to control or if indicated for other infection.	If specialist management required
<b>Pyrexia of Unknown Origin (PUO)</b>	A. Patient <b>not</b> recently been abroad or recently returned from mainland Europe of N. America.	SICPs.	Yes	If specialist management required.
	B. Viral Haemorrhagic fever a possibility (see Section V)	See Section V	See Section V	See Section V

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## Appendix 4

### PETS


Pets can provide valuable companionship, stimulation and comfort; however, they represent an infection control hazard through diseases that they can transmit to patients. Some issues that need to be considered in before proceeding to introduce pets to an area are noted below.

The person in charge of the area/ward must ensure that a knowledgeable person will be responsible for the animal and that there must be no risk of contravening relevant safety legislation. There must be a written local protocol to ensure full understanding of:

- the types of animals allowed for the purposes of “pet therapy” - only mature house trained pets are acceptable
- their control and permitted behaviour whilst on the premises
- the routes for entry to and passage through the premises
- the areas where pets are not allowed
- any insurance liability of owners and handlers

### TO REDUCE THE RISK OF INFECTION

- All animals must be regularly groomed and checked for signs of infection or other illness. If pets become ill, diagnosis and treatment by a vet must be sought. All animals must have received relevant inoculations. Dogs should be wormed every six months
- Pets should be discouraged from licking residents or jumping on them in a manner which may cause accidents
- Claws must be kept trimmed to reduce risk of scratches
- Any injuries to patients must receive prompt treatment and an incident/accident report completed
- After patients or staff have touched animals, they should wash their hands
- Pet feeding areas should be kept clean. Pets should have their own feeding dishes, which should be washed separately from dishes and utensils, used for patients and staff. Pets should not be allowed into or fed in the kitchen or other food preparation areas
- Recognised commercial brands of pet food should be used. Pet food containers, once opened, should be kept separate from food for human consumption
- Food not consumed in about 20 minutes should be taken away or covered and spillages cleared up to prevent attracting pests
- Pets should have been exercised before being allowed to meet patients

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- All pets, but especially cats and dogs, should have their coats cleaned regularly
- Bedding should also be cleaned regularly and insecticides used, as necessary, on the environment and the pet to control fleas. Specialist advice should be sought if problems occur

### **LITTER TRAYS**


- Litter trays should be cleaned by someone who is healthy and not pregnant
- A protective apron and gloves should always be worn when cleaning litter trays
- A disposable liner should be fitted to litter trays for easy cleaning
- The litter tray should not be sited near food preparation, storage or eating areas
- Litter should be changed daily, sealed in a plastic bag and disposed of in accordance with local guidance
- The litter tray should be disinfected weekly by filling with boiling water which is allowed to stand for at least 5 minutes in order to kill toxoplasmosis eggs and other germs

### **RISK FROM DIFFERENT ANIMALS**

Vets have identified some animals more likely to carry diseases which could be spread to humans:

- Stray animals
- Sick animals/birds
- Wild animals/birds
- Animals with diarrhoea
- Exotic animals
- Cage birds may carry psittacosis
- Tropical fish may carry a form of TB
- Domestic pets who hunt and eat wild animals


***Good general hygiene and hand washing are essential for risk reduction.***

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<b>Appendix 5</b>
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**CATEGORISATION OF PATIENTS FOR AMBULANCE TRANSFERS**


<b>CATEGORY 1</b>	<b>CATEGORY 2A</b>	<b>CATEGORY 2B</b>	<b>CATEGORY 2C</b>	<b>CATEGORY 2D</b>	<b>CATEGORY 3</b>
Brucellosis Erysipelas Glandular Fever Hepatitis B** HIV/ AIDS** Intestinal worms Legionellosis Leprosy Leptospirosis Listeriosis Malaria MRSA# Ophthalmia Neonatorum Q Fever Scabies Tetanus Toxoplasmosis Whooping Cough  **unless when category B visible blood spillage  #heavily colonised patients e.g., those with skin conditions, exposed wounds or burns should go into category 2b	Encephalitis Measles Meningitis Mumps Pneumonias Psittacosis Rubella Scarlet Fever Strep Tonsillitis Strep Pharyngitis	Anthrax Cutaneous Impetigo Ophthalmia Neonatorum Pyrexia of Unknown Origin Puerperal Fever Tuberculosis (non-pulmonary) Infestation (lice) MSRA (if not category 1) Herpes Zoster Chickenpox Hepatitis B (if not category 1) Hepatitis C (if not category 1) HIV/ AIDS (if not category 1)	Campylobacter Cholera Diarrhoea in HIV Dysentery Food Poisoning Gastroenteritis Hepatitis A Paratyphoid Poliomyelitis Salmonella Typhoid	Anthrax (pulmonary) Diphtheria Tuberculosis (pulmonary)	Viral Haemorrhagic Fevers Ebola Fever Lassa Fever Marburg Disease Pneumonic Plague Rabies

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## INFECTION GLOSSARY

## Appendix 6

<b>Acute</b>	rapid onset; severe
<b>Antibody</b>	a protein which appears in the body fluids after contact with a foreign molecule, ‘antigen’, and combines specifically with that antigen
<b>Antibiotic</b>	a substance which is toxic to micro-organisms
<b>Antigen</b>	any substance, usually proteins, which the body regards as foreign and produces antibodies against
<b>Antiseptic</b>	a chemical used to kill microbes on body surfaces
<b>Aseptic</b>	free of micro-organisms
<b>Carrier</b>	an individual who persistently excretes a microbe or who has a body surface colonised by a microbe, but who is obviously not ill with this infection
<b>Chronic</b>	a long standing disease, reverse of acute
<b>Colonisation</b>	a microbe establishes itself in a particular environment, such as, a body surface without producing disease or symptoms
<b>Commensal</b>	lives in association with another, without benefiting or harming it
<b>Communicable</b>	a disease that can be transmitted from one person to another
<b>Disinfection</b>	a process which reduces the number of micro-organisms to a level which they are not harmful, but does not usually destroy spores
<b>Epidemiology</b>	the study of the occurrence of diseases, how and when they occur, how they are transmitted, etc
<b>Gene</b>	DNA molecules transmitting hereditary characteristics
<b>Handwashing</b>	the aim is to remove micro-organisms from the hands and prevent their potential transfer
<b>Immunity</b>	the result of infection by a particular microbe or immunisation against that microbe
<b>Immunisation</b>	the process of artificially inducing immunity to infection by a particular microbe
<b>Immunodeficiency</b>	impairment of the immune response rendering the host particularly susceptible to infection

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<b>Infection</b>	entry of harmful microbes into the body and their multiplication in the tissues
<b>Isolation</b>	special procedures used to prevent the transmission of micro-organisms from an infectious patient or staff (barrier nursing)
<b>Latent Infection</b>	a condition in which the clinical signs of infection are absent and the causative organism may be temporarily undetectable; under certain conditions the infection may again become obvious
<b>Microbe</b>	a creature too small to be seen with the naked eye
<b>Normal Flora</b>	community of microbes that colonises a body surface
<b>Opportunistic Pathogen</b>	a micro-organism which causes an infection in a host with an impaired immune system
<b>Pathogen</b>	a microbe capable of causing disease
<b>Resident Organisms</b>	microbes that are persistently present on the skin and are part of its normal flora
<b>Seroconversion</b>	the production of specific antibodies in response to an antigen
<b>Serology</b>	the study of the blood constituents that protect the body against infection
<b>Systemic</b>	involving the whole body
<b>Transient Organisms</b>	picked up on contact with people, equipment, etc., and do survive indefinitely on the hands
<b>Virus</b>	micro-organism only capable of reproduction within living cells