

MEASLES INFORMATION AND GUIDANCE

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This document replaces:	Measles Information and Guidance 2009

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

The Strategic Directions 2007-2012 were agreed by the Board of Directors in October 2007 to support the Trust's vision "Respond, Deliver, Enable". The Key Milestones below will ensure there is a shared understanding about what needs to be delivered.

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience		Waiting	
Assurance Framework		Privacy and Dignity	
Monitor/Finance/Performance		Efficiency and Effectiveness	
Care Quality Commission Outcomes:	8	Delivery of Care Closer to Home	
		Infection Control	✓
NHSLA Risk Management Standards for Acute Trusts			
NHSLA CNST Maternity Clinical Risk Management Standards:			
Other (<i>please specify</i>):			
Note: This policy has been assessed for any equality, diversity or human rights implications			

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1. General Information

Measles is an acute highly infectious viral illness that is comparatively rare in the UK following introduction of the MMR vaccine in 1988. However, if vaccine coverage falls below 90% in a community at any one time the probability of outbreaks is substantially increased. Measles remains a potentially highly dangerous disease in hospitals. This is partly due to the risk to susceptible immuno-compromised children but also due to the fact that it is highly infectious. The incubation period is between 7–14 days but may be prolonged to 21 days in the immunosuppressed. A prodromal phase (early warning signs) of two to four days starts with fever, conjunctivitis, cough, coryza and Koplik spots on the buccal mucosa (spots inside the mouth, in line with the molars). Exposed individuals are highly infectious from the beginning of this prodromal phase to four days after the appearance of the rash. The rash is made up of red or brown blotches which flow into each other. It usually starts behind the ears and spreads downwards over the face, neck and body and last 4-7 days. Other symptoms may include diarrhoea, vomiting and abdominal pain.(HPA 2010) (NHS Choices 2011)

2. Confirmation of diagnosis

Because of the rarity of measles and the fact that other conditions can produce similar rashes, it is essential to confirm the diagnosis virologically. This will normally involve a combination of blood for antibody testing and a saliva sample for PCR testing. Please liaise with a medical microbiologist to arrange this.

3. Notification

Measles remains a notifiable disease under the Health Protection Legislation (England) Guidance 2010, and therefore the Consultant for Communicable Disease Control must be informed about cases. This should be by phone as soon as possible (The CCDC, who is part of the Devon Health Protection Unit are contactable via the hospital switchboard) and in writing within three days. Please refer to the Policy for Surveillance and Reporting of Infectious Disease, Healthcare Associated Infection and Antibiotic Resistant Organisms. The Trust Infection Control Team must also be informed if a patient is suspected of having measles.

4. Transmission

The virus is transmitted via respiratory droplets that become airborne during coughing or sneezing, or via direct contact with respiratory secretions. Spending more than 15 minutes with someone infected with measles is sufficient to transmit measles.

5. Isolation

Admission of patients with measles should be avoided where possible. If admission is essential the patient must be isolated immediately in a single room, and doors must be kept closed. Isolation rooms with negative pressure ventilation must be used where available.

6. Staff Immunisation

Staff who have clinical or social contact with patients should be known to be immune to or immunised against measles. Latest Department of Health guidance (DH, 2006, updated December 2010 pg 218) states that protection of healthcare staff is especially important with regard to their ability to transmit measles infections to vulnerable groups. Staff should be able to provide documentary evidence of either having received two doses of MMR vaccination or positive antibody tests for measles – See Trust Policy on Staff Screening and Immunisation.

7. Contacts

Those born before 1986 are likely to have had measles and be naturally immune. However, immuno-suppressed individuals of all ages and those born after 1986 may be at risk. A list of probable patient and staff contacts should be made and an assessment made as to whether prophylaxis with Human Normal Immunoglobulin (HNIG) or MMR vaccination should be offered within 72 hours of contact, based on level of risk and contact time.

Individuals are infectious from 1 day before the beginning of the prodromal symptoms (usually about 4 days before rash onset) until 4 full days after the rash appears. Less than 15 minutes exposure to a case can lead to disease in a susceptible (non-immune) person.

Significant exposure time in an immuno-competent patient (including pregnant women and infants) or healthcare worker is considered to be face-to-face contact of any length or where exposure for 15 minutes or longer in the same room has occurred. (HPA 2010)

If an immuno-compromised person is exposed (e.g. patients with leukaemia, high dose immuno-suppressants) there is a very low threshold for follow-up: even a very short exposure (minutes) should trigger investigation. In a highly immuno-suppressed child who is unlikely to be immune prophylaxis should be considered where the possibility of exposure has occurred by entering a room within a short period after a case has been present. (HPA 2010)

Detailed guidance on assessing susceptibility and doses of post exposure prophylaxis is given by Ramsey et al, Post Exposure Prophylaxis for Measles: Revised Guidance May 2009

8. Susceptible Staff

The immune status of staff who have attended the patient needs to be established in co-operation with the Occupational Health Department.

Health care workers with satisfactory evidence (see 6 above) of protection can continue to work normally but should be advised to report to OH if they develop a fever or symptoms of measles in the next 18 days.

Healthcare workers who do not have satisfactory evidence of protection should be excluded from work from the 5th day after exposure, unless they can be tested and shown to be IgG positive. They should be given MMR within 72 hours of exposure where possible. The HCW can return to work 21 days after the final exposure, or earlier if symptom-free and found to be measles IgG positive at least 14 days after

MMR was given. The recommendation to exclude a key member of staff may need to be discussed with the Medical Director or Director of Nursing who will decide whether this is operationally feasible.

Healthcare workers who become ill with symptoms or rash should be excluded from work until 4 full days after onset of the rash: treat the HCW as a case and confirmation and notification should be sought in the usual way.

9. Case Discovered on Adult or Paediatric Ward

Case – If possible the patient should be discharged otherwise isolate as above.

Contacts – Patients on the ward during the time in which the index case was infectious must be identified. Contact has been defined as being in the same room (e.g. house, classroom or multibedded bay or nightingale ward for a significant period of time (15 minutes or more) or face-to-face contact; However, trivial contact may be sufficient for the virus to spread (HPA 2000,) and should be considered.

Take advice from the duty Medical Microbiologist regarding use of Human Normal Immunoglobulin or MMR.

Incubating cases - Susceptible contacts may be incubating infection and if likely to remain in hospital must be monitored closely for early signs of infection. The need for isolation should be considered.

GP must be informed if such contacts are discharged <13 days from the date of last contact with an infectious case.

References:

Department of Health (2006)

Immunisation against Infectious Diseases – The Green Book

Available on:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079917

Accessed: 13 July 2011

HPA (2010)

National Measles Guidelines local and regional services.

Available on:

http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1274088429847n:

Accessed: 13 July 2011

HPA (2011)

Viral rashes in pregnancy – HPA Guidelines, information and advice.

Available on:

<http://www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1200577813065>

Accessed on 13 July 2011

NHS Choices (2011)

Your Health Your Choices

Measles

<http://www.nhs.uk/Conditions/Measles/Pages/Symptoms.aspx>

Accessed: 13 July 2011

Ramsay, M. Manikkavasagan, G. Brown, K. Craig, L. (2009) *Post Exposure Prophylaxis for Measles: Revised Guidance May 2009*.

Available at:

http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1238565307587

Accessed: 13 July 2011