## Measles Policy

<table>
<thead>
<tr>
<th>Post holder responsible for Procedural Document</th>
<th>Judy Potter, Lead Nurse, Infection Prevention and Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author of Guideline</td>
<td>Judy Potter, Lead Nurse, Infection Prevention and Control</td>
</tr>
<tr>
<td>Division/ Department responsible for Procedural Document</td>
<td>Specialist Services, Infection Prevention &amp; Control</td>
</tr>
<tr>
<td>Contact details</td>
<td>x2690</td>
</tr>
<tr>
<td>Date of original guideline</td>
<td>1997</td>
</tr>
<tr>
<td>Impact Assessment performed</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Ratifying body and date ratified</td>
<td>Infection Control &amp; Decontamination Assurance Group: 30th October 2017</td>
</tr>
<tr>
<td>Review date (and frequency of further reviews)</td>
<td>July 2022 (every 5 years)</td>
</tr>
<tr>
<td>Expiry date</td>
<td>January 2023</td>
</tr>
<tr>
<td>Date document becomes live</td>
<td>16 November 2017</td>
</tr>
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</table>

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

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<tr>
<th>Monitoring Information</th>
<th>Strategic Directions – Key Milestones</th>
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<tbody>
<tr>
<td>Patient Experience</td>
<td>Maintain Operational Service Delivery</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>Integrated Community Pathways</td>
</tr>
<tr>
<td>Monitor/Finance/Performance</td>
<td>Develop Acute Services</td>
</tr>
<tr>
<td>CQC Fundamental Standards Regulation No: 12</td>
<td>Delivery of Care Closer to Home</td>
</tr>
<tr>
<td></td>
<td>Infection Control</td>
</tr>
</tbody>
</table>

Other (please specify): |

**Note:** This policy has been assessed for any equality, diversity or human rights implications

### Controlled document

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**Measles Policy**
Ratified by: *Infection Control & Decontamination Assurance Group: 30th October 2017*
Review date: *July 2022*
<table>
<thead>
<tr>
<th>Full History</th>
<th>Status: Final</th>
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<tr>
<td><strong>Version</strong></td>
<td><strong>Date</strong></td>
</tr>
<tr>
<td>1.0</td>
<td>1997</td>
</tr>
<tr>
<td>2.0</td>
<td>2003</td>
</tr>
<tr>
<td>3.0</td>
<td>2005</td>
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<td>5.0</td>
<td>July 2009</td>
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<tr>
<td>6.0</td>
<td>Sept 2011</td>
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<td>6/8/2013</td>
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<td>8.0</td>
<td>17/09/2015</td>
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<td>9.0</td>
<td>11/07/2017</td>
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</table>

**Associated Trust Policies/Procedural documents:**
- Surveillance and reporting policy for infectious disease, healthcare associated infection and antibiotic resistant organisms
- Employee Screening and Immunisation policy

**Key Words**
- Measles

**In consultation with and date:**
- Infection Prevention & Control Team: 31/08/2017
- Consultant Microbiologists: 31/08/2017
- Governance Managers, Corporate Managers, Department Managers, Service Managers, Senior Operational Managers, Lead Nurses, Senior Nurses, Matrons, Community DD and ADN, Equality Team: 31/08/2017
- Policy Expert Panel: 03/10/2017
- Infection Control and Decontamination Assurance Group: 30th October 2017

**Contact for Review:**
- Lead Nurse, Infection Prevention & Control

**Executive Lead Signature:**
- Medical Director (Only applicable for Strategies & Policies)
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1. INTRODUCTION

1.1 Measles is an acute, highly infectious viral illness that is comparatively rare in the UK following introduction of the measles, mumps & rubella (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.

1.2 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 7–18 days (average 10-12 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 5-6 days. Other symptoms may include diarrhoea, vomiting and abdominal pain (Public Health England, 2014).

1.3 Failure to comply with this policy could result in disciplinary action.

2. PURPOSE

2.1 To provide a framework for treatment and management of patients with measles.

3. DEFINITIONS

3.1 Koplik spots – Small white spots (often on a reddened background) that occur on the inside of cheeks early in the course of measles.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 The Board of Directors, through the Medical Director, are responsible for ensuring the provision of suitable and sufficient resources and facilities to enable effective management of a patient admitted with measles.

4.2 The Directors of Infection Prevention and Control (DsIPC) are responsible for providing expert guidance and advice to the Infection Prevention and Control Team, clinical and managerial staff about measures needed to protect staff, patients and members of the public from infection.

4.3 The nursing staff in the clinical area/ward where a patient who may have measles is recognised are responsible for ensuring that appropriate actions with regards to the implementation of source isolation and/or other infection control interventions are implemented.

4.4 The medical staff are responsible for diagnosing and treating the patient with measles, if required; and informing the GP’s about any patients who have been in contact via the discharge summary.

4.5 The Infection Prevention & Control Team are responsible for advising on infection control measures.
4.6 The **Infection Control Doctor and Consultant Microbiologists** are responsible for providing advice on the diagnosis of measles.

4.7 The **Occupational Health Physician** is responsible for ensuring that processes are in place to screen new employees who may be required to have contact with patients with measles in accordance with the Employee Screening and Immunisation policy and will follow up any staff who have had contact with a case of measles.

4.8 **Patient Flow Manager and Site Management Team** are responsible for organising patient movements to isolation rooms.

4.9 **Ward staff** are responsible for ensuring that patients are managed in an appropriate isolation room, with adherence to appropriate source isolation precautions and non-immune staff are excluded.

4.10 **All staff** required to have contact with patients are responsible for ensuring that they are compliant with the Employee Screening and Immunisation policy.

5. **CONFIRMATION OF DIAGNOSIS**

5.1 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.

6. **NOTIFICATION**

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

7. **TRANSMISSION**

7.1 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 time to transmit measles. In a susceptible (non-immune person) less than 15 minutes exposure to a case can lead to disease.

8. **ISOLATION**

8.1 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. In the acute hospital, the patient must be admitted to a single room on Torridge Ward. Gloves, apron and FFP3 respirators must be worn by all staff entering the room. Staff must be fit tested to wear FFP3 respirators.
8.2 In a community setting, where FFP 3 respirators are not available or staff are not fit tested for the wearing of FFP3 respirators, a surgical mask should be used. The patient should be nursed in a single room and gloves and aprons used for direct care.

9. STAFF IMMUNISATION

9.1 Staff who have clinical or social contact with patients should be known to be immune to, or immunised against measles. The Green Book (Public Health England, 2013) requires that healthcare and laboratory staff be up to date with immunisation as a means of protecting themselves and to assist in protecting vulnerable patients whilst the General Medical Council (GMC, 2013) state “you should be immunised against common serious communicable disease (unless otherwise contraindicated)”. 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 Employee Screening and Immunisation Policy.

10. CONTACTS

10.1 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.

10.2 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.

10.3 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 (Public Health England, 2014).

10.4 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 (Public Health England, 2014).


11. SUSCEPTIBLE STAFF

11.1 The immune status of staff who have attended the patient needs to be established in cooperation with the Occupational Health (OH) Department.
11.2 Occupational health will advise healthcare workers (HCW) with satisfactory evidence (see section 9.1) of protection that they 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.

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

11.4 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.

12. CASE DISCOVERED ON INPATIENT WARD

12.1 Case – If possible, the patient should be discharged otherwise isolated as above (see section 8).

12.2 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 multi-bedded bay or nightingale ward) for a significant period of time (15 minutes or more) or face-to-face contact.

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

12.3 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.

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

13. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the Lead Nurse, Infection Prevention and Control. An electronic copy will be maintained on the Trust Intranet, (A-Z) P – Policies (Trust-wide) – M – Measles. Archived electronic copies will be stored on the Trust’s “archived policies” shared drive, and will be held indefinitely. A paper copy (where one exists) will be retained for 10 years.

14. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

14.1 To monitor compliance with this policy the auditable standards will be monitored as follows:

<table>
<thead>
<tr>
<th>No</th>
<th>Minimum Requirements</th>
<th>Evidenced by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Annual Audit</td>
<td>Appropriate isolation of patients during the annual patient placement audit</td>
</tr>
</tbody>
</table>
14.2 **Frequency**
On a case by case basis, as part of a routine review of infectious patients. In each financial year, the Infection Prevention and Control Nurse Specialist will audit patient placement to ensure that this policy has been adhered to and a formal report will be written and presented at the Infection Control and Decontamination Assurance Group. Significant incidents will be included in the DIPC annual report.

14.3 **Undertaken by**
Infection Prevention and Control team

14.4 **Dissemination of Results**
At the Infection Control and Decontamination Assurance Group which is held quarterly and the relevant Divisional Governance Groups if there is failure to comply with the policy.

14.5 **Recommendations/ Action Plans**
Implementation of the recommendations and action plan will be monitored by the Infection Control and Decontamination Assurance Group which meets quarterly.

14.6 Any barriers to implementation will be risk-assessed and added to the risk register.

14.7 Any changes in practice needed will be highlighted to Trust staff via the Governance Managers’ cascade system.

15. **REFERENCES:**


General Medical Council (2013). *Good Medical Practice - Risks posed by your health.* Available at: http://www.gmc-uk.org/guidance/good_medical_practice/your_health.asp [online only]


The following action plan will be enacted once the document has gone live.

<table>
<thead>
<tr>
<th>Staff groups that need to have knowledge of the guideline/SOP</th>
<th>All staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The key changes if a revised document</strong></td>
<td>Routine update with no significant changes</td>
</tr>
<tr>
<td><strong>The key objectives</strong></td>
<td>This policy provides information and guidance for patients with Measles</td>
</tr>
<tr>
<td><strong>How new staff will be made aware of the procedure/guideline and manager action</strong></td>
<td>Induction process</td>
</tr>
<tr>
<td><strong>Specific Issues to be raised with staff</strong></td>
<td>Measles is a highly infectious disease that can have severe consequences Only immune staff should have contact with measles If admitted to hospital, strict respiratory isolation precautions are required preferably in a negative pressure isolation room.</td>
</tr>
<tr>
<td><strong>Training available to staff</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Any other requirements</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Issues following Equality Impact Assessment (if any)</strong></td>
<td>Positive impacts only</td>
</tr>
<tr>
<td><strong>Location of hard / electronic copy of the document etc.</strong></td>
<td>Trust intranet</td>
</tr>
</tbody>
</table>
APPENDIX 2: EQUALITY IMPACT ASSESSMENT TOOL

Name of document: Measles Policy
Division/Directorate and service area: Trust wide
Name, job title and contact details of person completing the assessment: Diane Melling-Picken, Infection Prevention and Control Nurse Specialist
Date completed: 20/9/2017

The purpose of this tool is to:
- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. **What is the main purpose of this document?**

   The purpose of this policy is to prevent the spread of Measles in the hospital environment.

2. **Who does it mainly affect?**

   Carers ☐ Staff ☐ Patients ☒ Other (please specify)

3. **Who might the policy have a ‘differential’ effect on, considering the “protected characteristics” below?**

<table>
<thead>
<tr>
<th>Protected characteristic</th>
<th>Relevant</th>
<th>Not relevant</th>
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<tbody>
<tr>
<td>Age</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Disability</td>
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</table>
   | Sex - including: 
   Transgender, and 
   Pregnancy / Maternity | ☐        | ☒            |
   | Race                    | ☐        | ☒            |
   | Religion / belief       | ☐        | ☒            |
   | Sexual orientation – 
   including: 
   Marriage / Civil 
   Partnership | ☐        | ☒            |

4. **Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to... (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?**
5. Do you think the document meets our human rights obligations? ☐

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:

- **Fairness** – how have you made sure it treat everyone justly?
- **Respect** – how have you made sure it respects everyone as a person?
- **Equality** – how does it give everyone an equal chance to get whatever it is offering?
- **Dignity** – have you made sure it treats everyone with dignity?
- **Autonomy** – Does it enable people to make decisions for themselves?

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

There were no concerns that may be relevant to equality or human rights identified during the creation of this policy.

The Infection Control & Decontamination Assurance Group, Occupational Health and the Policy Expert Panel were involved in the review.

7. If you have noted any ‘missed opportunities’, or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

<table>
<thead>
<tr>
<th>“Protected characteristic”:</th>
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<tbody>
<tr>
<td><strong>Issue:</strong></td>
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<tr>
<td><strong>How is this going to be monitored/addressed in the future:</strong></td>
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<tr>
<td><strong>Group that will be responsible for ensuring this carried out:</strong></td>
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</table>