

MENINGOCOCCAL MENINGITIS POLICY

Version:	3
Date issued:	March 2017
Review date:	March 2020
Relevant Staff Groups:	All Staff

This document is available in other formats, including easy read summary versions and other languages upon request. Should you require this please contact the Equality and Diversity Lead on 01278 432000

DOCUMENT CONTROL

Reference KA/Mar17/MM	Version 3	Status Final	Author Head of Infection Prevention and Control and Decontamination Lead
Amendments			
1.6 – Reviewed and amended to reflect comments received from Clinical Policy Review Group			
November 2016: Reviewed and updated to reflect changes in clinical practice/treatment protocols and lead national bodies			
Document objectives: This policy aims to ensure that Somerset Partnership NHS Foundation Trust has adequate arrangements in place to mitigate the risk of onward transmission of the organism post diagnosis of a patient suffering from meningococcal meningitis. This should provide Trust assurance that Public Health England (Somerset Team in collaboration with Somerset Partnership NHS Foundation Trust Infection Prevention and Control Team and Occupational Health Provider; Optima) will manage the risk of ongoing spread of the organism by providing contact tracing and chemoprophylaxis, in accordance with national guidelines produced by the Department of Health			
Approving body	Clinical Governance Group	Date: February 2017	
Equality Impact Assessment	Impact Part 1	Date: May 2013	
Clinical Audit Standards	NO	Date: N/A	
Ratification body	Senior Management Team.	Date: March 2017	
Date of issue	March 2017		
Review date	March 2020		
Contact for review	Head of Infection Prevention and Control / Decontamination Lead		
Lead Director	Director of Nursing and Patient Safety		

CONTRIBUTION LIST Key individuals involved in developing the document

Designation or Group
Head of Infection Prevention and Control / Decontamination Lead
Health Protection Nurse Specialist, Public Health England
Senior Infection Prevention and Control Nurse
Infection Prevention and Control Assurance Group
Clinical Policy Review Group
Clinical Governance Group

CONTENTS

Section	Summary of Section	Page
Doc	Document Control	2
Cont	Contents	3
1	Introduction	4
2	Purpose & Scope	4
3	Duties and Responsibilities	4
4	Explanations of Terms used	6
5	Types of Meningitis	6
6	Mode of Spread	7
7	Period of Communicability	8
8	Notification of Meningococcal Disease	8
9	Management of Suspected Cases of Meningococcal Meningitis	9
10	Post Mortem Contact	9
11	Contact Tracing	9
12	Chemoprophylaxis	10
13	Dealing with an Outbreak of Meningococcal Infection	11
14	Incident Reporting, Investigation and Action Plans	11
15	Training Requirements	11
16	Monitoring Compliance and Effectiveness	11
17	References, Acknowledgements and Associated documents	11
18	Appendices	12
Appendix A	Infections/Infectious Diseases Which are Notifiable to the Consultant in Communicable Disease Control	14
Appendix B	Notification of Cases	15
Appendix C	Signs and Symptoms	16
Appendix D	Fact Sheet for Staff	17

**ALL CASES OF SUSPECTED MENINGOCOCCAL MENINGITIS OR
MENINGOCOCCAL SEPTICAEMIA MUST BE TRANSFERRED TO AN
ACUTE SECONDARY CARE PROVIDER AS AN EMERGENCY BY
TELEPHONING 999.**

1. INTRODUCTION

- 1.1 Meningitis can be caused by both viruses and bacteria. Viral meningitis is relatively common but rarely serious. However, meningitis caused by meningococcal bacteria can develop rapidly and cause serious illness.
- 1.2 Meningococcal meningitis and meningococcal septicemia are systemic infections caused by the bacteria *Neisseria meningitidis*. Humans are the only known reservoir for *Neisseria meningitidis*.
- 1.3 The incidence of meningococcal disease is highest in children aged one to five years, with a peak incidence in infants under one year of age. The next highest risk group is young people aged 15 to 19 years.
- 1.4 Infection is not easily spread. It is transmitted from person to person by inhaling respiratory secretions from the mouth and throat or by direct contact (kissing). Close prolonged contact is usually required to transmit the bacteria. They do not live long outside the body.
- 1.5 There is a marked seasonal variation in meningococcal disease, with peak levels in the winter months (coinciding with influenza) declining to low levels by late summer.
- 1.6 A fact sheet for staff with FAQ is available in Annex D

2. PURPOSE & SCOPE

- 2.1 This policy will ensure that:
 - Appropriate arrangements are in place for the involvement of the relevant NHS body providing contact tracing and chemoprophylaxis advice to staff caring for patients with confirmed/probable/possible meningococcal meningitis or meningococcal septicaemia.
 - Infection prevention and control advice is accessed via the relevant Infection Prevention and Control Team.

3. DUTIES AND RESPONSIBILITIES

- 3.1 **The Trust Board, via the Chief Executive, is responsible for:-**
 - Ensuring there are effective and adequately resourced arrangements for the detection and management of meningococcal meningitis and meningococcal septicemia within the Trust;
 - Identifying a Trust Board Lead for Infection Prevention and Control.

- Ensuring the role and functions of the Director of Infection Prevention and Control are satisfactorily fulfilled by appropriate and competent persons as defined by the Department of Health, (2008, revised (updated 2015).

3.2 Director for Infection Prevention and Control is responsible for:

- Overseeing the local control of and the implementation of the Meningococcal Meningitis Policy.

3.3 The Trust Infection Prevention and Control Assurance Group is responsible for:

- Ensuring procedures for the implementation of the Meningococcal Meningitis Policy are continually reviewed and improved within the Trust;
- Ensuring that lessons learned from any meningococcal meningitis or meningococcal septicemia are actioned and learning is disseminated throughout the Trust.

3.4 Infection Prevention and Control Team are responsible for:

- Assisting with root cause analysis of any meningococcal meningitis, meningococcal septicemia or related outbreak and sharing results including lessons learned with the Trust Board, Divisional and Ward managers, Matrons and the Infection Prevention and Control Assurance Group.
- Undertaking mandatory reporting any meningococcal meningitis or meningococcal septicemia to all relevant national bodies.
- Surveillance of meningococcal meningitis and identification of potential outbreaks.
- Education and training in the detection of meningococcal meningitis in all relevant patients, either within inpatient settings or community based healthcare environments;
- Education and training in the Infection Prevention and Control management of patients with meningococcal meningitis or meningococcal septicaemia;
- Monitoring of isolation practice of patients isolated with suspected meningococcal meningitis or meningococcal septicaemia; advising patients if requested by staff on any issues relating to meningococcal meningitis or meningococcal septicaemia;

3.5 Hospital Matron / Deputy / Ward and Team Managers are responsible for:

- Ensuring infection prevention and control precautions are implemented as detailed in this policy;
- Instigating remedial action to address any issues around infection prevention and control practice compliance, as detailed in this policy, in their area;
- Ensuring staff are aware of the policy and requirements for attending training as identified in the Training Needs Analysis Matrix. Managers will ensure staff have attended all relevant training and have current updates;

- Ensuring staff are released to attend relevant training and for recording attendance at training in local training records. All non-attendance at training will be followed up by managers.
- Ensuring individual staff and team's training needs are met through appraisal and in line with the Training Needs Analysis. Training information should be passed to the Learning and Development Department who will update the electronic staff record.

3.6 **Ward / Clinical staff are responsible for:**

- Adhering to the Infection Prevention and Control precautions detailed in this policy;
- Referring any suspected or confirmed cases of meningococcal meningitis or meningococcal septicaemia to the infection prevention and control team;
- Keeping the patient informed of their bacterial meningitis status and providing written information as necessary;
- Ensuring communication of suspected or confirmed meningococcal meningitis or meningococcal septicaemia status of patient is transferred to another NHS body or healthcare facility;
- Booking themselves onto initial and update mandatory training and for attending mandatory training, regardless of their grade, role or status, including permanent, temporary, full-time, part-time staff and locums, bank staff, volunteers, trainees and students;
- Administration of appropriate treatment

3.7 **Learning and Development Training Team is responsible for:**

- Recording attendance at Mandatory Training and will advise Operational Managers of non-attendance.

3.8 **Staff Occupational Health Provider is responsible for:**

- Managing and co-ordinating contact tracing which involves Somerset Partnership NHS Foundation Trust staff.

4. **EXPLANATION OF TERMS USED**

- **Meningitis:** inflammation of meninges (lining of the brain).
- **Septicemia:** bacteria enter the bloodstream resulting in blood poisoning.
- **CCDC:** Consultant in Communicable Disease Control.

5. **TYPES OF MENINGITIS**

5.1 **VIRAL MENINGITIS**

- 5.1.1 More common than the bacterial meningitis and can be very debilitating but is generally less serious and rarely fatal.

5.1.2 Can be caused by a variety of viruses with an incubation period of up to three weeks.

5.1.3 Viral meningitis is not usually associated with septicaemia. Treatment with antibiotics may be advised before a positive diagnosis can be made.

5.2 BACTERIAL MENINGITIS

5.2.1 Bacterial meningitis can be caused by at least 50 different bacteria, however most are rare.

5.2.2 Bacterial meningitis is fatal in one in ten cases; however, more deaths are caused by septicemia than by meningitis. In about one in seven, it will cause long term side effects such as deafness and brain damage.

5.2.3 The main types of meningococcal infection are:

- ***Neisseria meningitidis* (meningococcal)** – the most common bacterial form in the UK. Occurs predominantly in children under 5. It is an acute infectious disease often associated with septicaemia. *Neisseria meningitidis* is found naturally in the back of the throat or nose. Approximately 10% of the population will carry *Neisseria meningitidis*, it is unknown why some individuals carry the bacteria without harm while others go on to develop meningococcal disease.

The infection may present as meningitis, septicaemia or a combination of both. Early diagnosis and prompt antibiotic treatment is needed.

- ***Streptococcus pneumoniae* (pneumococcal)** – occurring more commonly in older adults and small children and may be as result of an infection of the middle ear.
- ***Haemophilus influenzae type b* (Hib)** – a major cause of bacterial meningitis, it has nearly been eliminated by vaccination of infants. Almost exclusively affects children under the age of nine, but may also be seen in older age patients.

5.3 Most cases of meningococcal disease occur sporadically, with less than 5% of cases occurring in clusters. Outbreaks of meningococcal disease are more common among teenagers and young adults, and outbreaks have been reported in schools and universities. Public health interventions may include vaccination (depending on serogroup) and chemoprophylaxis.

5.4 Meningococci are divided into distinct serogroups, according to their polysaccharide outer capsule. The most common serogroups that cause disease worldwide are groups B, C, A, Y and W135. Most disease in the UK is caused by serogroups B and C.

6. MODE OF SPREAD

6.1 It is transmitted by direct close contact, including respiratory droplets from nose and throat of infected individuals.

- 6.2 Transmission sufficient to cause systemic disease is comparatively rare.
- 6.3 Contact transmission from surfaces is insignificant.
- 6.4 The incubation period is between 2-10 days. Those most at risk include:
- children under five
 - teenagers and young adults
 - the elderly and/or
 - the immunocompromised, including those who have had a splenectomy.

7. PERIOD OF COMMUNICABILITY

- 7.1 Transmission lasts until 24 hours of treatment with appropriate antibiotics has been administered. After this time, on appropriate medication, the carriage rate of meningococci falls dramatically.

8. NOTIFICATION OF MENINGOCOCCAL DISEASE

- 8.1 Under the Public Health (Control of Diseases) Act 1984, once the diagnosis has been made on clinical grounds together with preliminary laboratory results, the clinician who makes the identification must immediately inform the Consultant in Communicable Disease Control (CCDC) via telephone and notification form. **Do not** wait for bacterial confirmation.

A full list of notifiable diseases and contact details for the CCDC can be found in Annex A and B.

Confirmed case

- 8.2 Clinical diagnosis of meningitis, septicaemia, or other invasive disease (e.g. orbital cellulitis, septic arthritis) which has been confirmed microbiologically by culture or non-culture methods from at least one of the following:
- *Neisseria meningitidis* isolated from a normally sterile site
 - Gram negative diplococci in cerebral spinal fluid.
 - Meningococcal DNA in a normally sterile site.
 - Meningococcal antigen in blood, CSF or urine.

Probable case

- 8.3 Clinical diagnosis of meningococcal meningitis or septicaemia without microbiological confirmation in which the CCDC, in consultation with the clinician managing the case, considers that meningococcal disease is the likeliest diagnosis. In the absence of an alternative diagnosis a feverish, ill patient with a petechial/purpuric, non-blanching rash should be regarded as a probable case of meningococcal septicaemia.

Possible case

- 8.4 As probable case, but the CCDC, in consultation with the clinician managing the case, considers that diagnoses other than meningococcal disease are at

least as likely. This category includes cases treated with antibiotics whose probable diagnosis is viral meningitis.

- 8.5 Only confirmed and probable cases necessitate contact tracing but a possible must still be notified.

9. MANAGEMENT OF SUSPECTED CASES OF MENINGOCOCCAL MENINGITIS

- 9.1 **All cases of suspected meningococcal meningitis or meningococcal septicemia must be transferred to an acute secondary care provider as an emergency by telephoning 999.**

- 9.2 Suspected cases presenting **without** a non-blanching rash will not require parenteral antibiotics unless urgent transfer to an acute hospital is not possible (remote location, severe weather etc.) or their symptoms trigger the Sepsis 6 proforma

- 9.3 Suspected cases presenting **with** a non-blanching rash should receive parenteral antibiotics as per current CCG guidance at the earliest opportunity, either in primary or secondary care, but urgent transfer should not be delayed in order to administer them.

- 9.4 Standard isolation procedures are required until the patient had received 24 hours of appropriate treatment.

- 9.5 Face masks/protection are required if undertaking procedures which may result in exposure to infectious respiratory droplets, including airways management during active resuscitation.

- 9.6 Standard universal precautions apply for dealing with all other body fluids.

- 9.7 Standard cleaning procedures for isolation rooms and terminal cleans are sufficient and detergent or universal wipes are suitable for decontamination of equipment.

10. POST MORTEM CONTACT

- 10.1 Body bags are not required, unless indicated for another reason.

- 10.2 It is not considered to be a cross infection risk if the deceased visitors wish to kiss the body.

- 10.3 Transport to other counties/countries for burial or cremation does not pose a risk.

11. CONTACT TRACING

- 11.1 Public Health England (Health Protection), is responsible for contact tracing should a case of meningitis occur in the community setting. Staff contacts of cases identified in the Acute Trusts are managed via the Staff Occupational Health Provider (Optima).

- 11.2 A Primary Contact is an individual who has had DIRECT contact with the index case during the seven days prior to onset.
- 11.3 Contacts who may require chemoprophylaxis are:
- Those who have had *prolonged close contact* with the case in a *household type setting* during the seven days before onset of illness. Examples of such contacts would be those living and/or sleeping in the same household (including extended household), pupils in the same dormitory, boyfriends/girlfriends or university students sharing a kitchen in a hall of residence.
 - Those who have had *transient close contact* with a case *only* if they have been directly exposed to a large particle droplets/secretion from the respiratory tract of a case around the time of admission to hospital.
- 11.4 Health care worker exposure is most likely to occur in staff who undertake airway management during resuscitation without wearing a mask or other mechanical protection. In most cases, this would imply a clear perception of physical contact with droplets/secretions. General medical or nursing care of cases should not be regarded as an indication for prophylaxis. Exposure of the eyes to respiratory droplets is not considered an indication for prophylaxis.
- 11.5 **Retrospective diagnosis**
- If a delayed report of a case is received, household contacts and equivalents should be offered chemoprophylaxis, and vaccine if appropriate, up to four weeks after the index case became ill. The CCDC must be informed to facilitate contact tracing.
- 11.6 **Nurseries, crèches and schools**
- After one case in a nursery, crèche, playgroup or school, prophylaxis would not usually be advised for other children and staff, but information will be provided to parents and staff by the Public Health England (Health Protection).
- 12. CHEMOPROPHYLAXIS**
- 12.1 This is given under the guidance of the CCDC to close contacts of the index case.
- 12.2 All primary contacts should be treated in accordance with current BNF guidance. Contacts should be reminded of the persisting risk of disease and of the need to contact their GP urgently if they develop any symptoms suggestive of meningococcal disease. Rifampicin is also recommended for the convalescent index case before discharge as penicillin does not eliminate nasal carriage.
- 12.3 Contacts of meningococcal conjunctivitis cases should also receive chemoprophylaxis in accordance with current BNF guidance.
- 12.4 A staff information leaflet can be found at Annex D.

13. DEALING WITH AN OUTBREAK OF MENINGOCOCCAL INFECTION

13.1 Should there be two or more associated cases of meningococcal infection, in a school, college, playgroup, etc., outbreak control will be handled by the CCDC.

14. INCIDENT REPORTING, INVESTIGATION AND ACTION PLANS

14.1 All staff are responsible for reporting any incident or near miss.

14.2 Managers are responsible for ensuring that a suitable investigation is carried out according to the consequence of the incident and action plans are created and carried out in a suitable time frame. The ward or team manager is also responsible for ensuring that the Datix report contains a full history of the process followed on each occasion and the eventual outcome.

14.3 Managers are responsible for ensuring that incidents are investigated promptly, within the timescales given in the Trust Untoward Event Reporting Policy

15. TRAINING REQUIREMENTS

15.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

16. MONITORING COMPLIANCE AND EFFECTIVENESS

16.1 Monitoring arrangements for compliance and effectiveness

- Overall monitoring will be by the Infection Prevention and Control Implementation Group. These incidents will be monitored by the Infection Prevention and Control team using DATIX Untoward Events Reporting system. The Infection Prevention and Control report at the conclusion of an outbreak should include comment as to whether the procedure within this policy has been followed. Any actions identified will be implemented and monitored via the Infection Prevention and Control Implementation Group. Areas of concern will be escalated to the Clinical Governance Group within the quarterly report.

16.2 Process for reviewing results and ensuring improvements in performance occur.

Any associated audit results will be presented to the Infection Prevention and Control Assurance Group for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring improvements, where necessary, are implemented. Meningococcal Meningitis is not currently on the Trust audit schedule.

17. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

17.1 References

Department of Health (2008) *The Health Act 2008. Code of Practice for the Prevention and Control of Healthcare Associated Infections*. London: DH (Revised 2015)

Department of Health (2016) Immunisation against Infectious Disease DH, London

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/554011/Green_Book_Chapter_22.pdf

Meningococcal disease: guidance, data and analysis. From: Public Health England First published: 31 July 2014 Last updated: 28 August 2015, see all updates Part of: Infectious diseases.

The characteristics, diagnosis, management, surveillance and epidemiology of meningococcal disease.

Bacterial meningitis and meningococcal septicaemia in under 16s: recognition, diagnosis and management published by the National Institute for Health and Care Excellence (NICE) [NICE, 2010], (updated 2015)

Guidance for public health management of meningococcal disease in the UK published by Public Health England [PHE, 2012], and Meningococcal meningitis and septicaemia guidance notes: diagnosis and treatment in general practice published by the Meningitis Research Foundation [Meningitis Research Foundation, 2014].

.British National Formulary, London, British Medical Association and Royal Pharmaceutical Society of Great Britain. Joint Formulary Committee

Relevant National Requirements

Meningitis (bacterial) and meningococcal septicaemia in under 16s: recognition, diagnosis and management

Clinical guideline [CG102] Published date: June 2010 last updated: February 2015

Meningococcal disease: guidance, data and analysis From: Public Health England. First published: 31 July 2014 Last updated: 28 August 2015

17.2 Acknowledgements

Meningitis Research Foundation

17.3 Cross reference to other procedural documents

Equality and Diversity Policy
Hand Hygiene Policy

Infection Control Standard Precautions incorporating Blood and Body Fluids Spillage Policy
Infection Prevention and Control Policy
Learning Development and Mandatory Training Policy
Record Keeping and Records Management Policy
Risk Management Policy and Procedure
Staff Mandatory Training Matrix (Training Needs Analysis)
Untoward Event Reporting Policy and Procedure

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

18. APPENDICES

18.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A	Infections/Infectious Diseases Which are Notifiable to the Consultant in Communicable Disease Control
Appendix B	Notification of Cases
Appendix C	Signs and Symptoms
Appendix D	Fact Sheet for Staff

**INFECTIONS/INFECTIOUS DISEASES WHICH ARE NOTIFIABLE TO THE
CONSULTANT IN COMMUNICABLE DISEASE CONTROL (CCDC)**

If there is a strong clinical suspicion of any of the following, notification should be done urgently by telephone without waiting for culture or serology results. The appropriate phone numbers are on the next page.

Acute Encephalitis	Malaria
Acute Meningitis	Measles
Acute Infectious Hepatitis	Meningococcal Septicaemia
Anthrax	Mumps
Botulism	Rabies
Brucellosis	Rubella
Cholera	SARS
Diphtheria	Scarlet Fever
Enteric Fever (Typhoid or paratyphoid fever)	Smallpox
Food poisoning *	Tetanus
Haemolytic uremic syndrome (HUS)	Tuberculosis
Infectious bloody diarrhoea	Typhus
Invasive Group A Streptococcal Disease	Viral Haemorrhagic Fever
Legionella	Whooping Cough
Leprosy	Yellow Fever

Since the introduction of Haemophilus Influenzae B vaccination, any deep infection (e.g., Meningitis, Osteomyelitis, etc.) caused by Haemophilus Influenzae B should be notified.

Notification of Cases

REPORTING OF NOTIFIABLE INFECTIOUS DISEASE SHOULD BE REFERRED TO
PUBLIC HEALTH ENGLAND HEALTH PROTECTION TEAM (SOUTH WEST)

Telephone: 0900-17.00.Monday-Friday:

0300 303 8162

Telephone: Out of hours:

Contact First on Call for PHE Health Protection (Southwest) via Taunton and
Somerset NHS Foundation Trust switchboard: 01823 333444

For any other queries please contact:

Somerset Partnership Infection Prevention and Control Team:

Monday – Friday 0900-17.00

Team Office: 01278 432132

Occupational Health Provider (Optima):

Monday to Friday 09.00 -17.00. Closed Weekends

Optima Health General Enquiries - 0844 826 0306

SIGNS AND SYMPTOMS

APPENDIX C

		Septicaemia	Meningitis
	Fever and/or vomiting	✓	✓
	Severe headache		✓
	Limb/joint/muscle pain (sometimes with pain/diarrhoea)	✓ red flag	
	Cold hand and feet/shivering	✓ red flag	
	Pale or mottled skin	✓	
	Breathing fast/breathless	✓	
	Rash (anywhere on the body)	✓ red flag	✓ red flag
	Stiff neck (less common in young children)		✓ red flag
	Dislike of bright lights (less common in young children)		✓ red flag
	Very sleepy /vacant /difficult to wake	✓	✓
	Confused /delirious	✓ red flag	✓ red flag
	Seizures (fits) may also be seen		✓ red flag

Fact Sheet - Meningococcal Infections

Information for staff

FACT SHEET FOR STAFF

MENINGOCOCCAL INFECTIONS

What illnesses do meningococcal infections cause?

Neisseria meningitidis, or the meningococcus, can cause two types of illness: meningitis and septicaemia. Septicaemia can occur on its own, which is the more serious of the two types of illness, or as part of an attack of meningitis. In septicaemia, and in many cases of meningitis, there is a rash that does not appear (blanche) when pressure is applied; this rash may become extensive and bleed.

How many cases of meningococcal disease are seen locally?

Each year Acute NHS Trusts expect to see between 5 and 10 cases each of serious meningococcal disease. About 10% of cases are fatal. Most cases occur during infancy or in teenagers and young adults. The highest number of cases is seen during the winter month. Apart from age, risk factors include passive smoking, preceding influenza A infection and living in overcrowded conditions.

How common is meningococcal throat carriage?

N meningitidis is a normal inhabitant of the human nasopharynx and is transmitted from person to person by large droplets or secretions from the upper respiratory tract. Saliva inhibits meningococcal growth and transmission by contaminated equipment is considered rare. Throat carriage of meningococci is relatively common in the general population ranging from 2% in children under 5 years old to 25% in 15 to 19 year olds.

What is the level of risk to staff when caring for meningococcal cases?

The risk of becoming infected while caring for patients with meningococcal disease remains very small. A 15 years study (1982-1996) in England and Wales identified only three healthcare workers who developed meningococcal disease as a consequence of caring for an infected patient. All three (a doctor, ambulance worker, and nurse) had spent at least 30 minutes with the case at the time of their admission. Two of the healthcare workers had undertaken procedures that would have resulted in direct exposure to respiratory droplets from the patient. None had worn masks or taken prophylactic antibiotics. The same study failed to identify any healthcare workers developing meningococcal conjunctivitis as a consequence of their work.

Has a risk assessment been carried out?

Neisseria meningitidis dies quickly outside the body. Respiratory droplets are unlikely to remain airborne beyond a distance of about one metre (3 feet). After starting treatment with intravenous benzylpenicillin, cefotaxime or ceftriaxone, throat carriage rates decrease rapidly so that meningococci are rarely detectable by nasopharyngeal swabbing after 24 hours. Hence most patients after 24 hours of suitable intravenous antibiotics will be a very low infection risk.

What can staff do to reduce their risk of acquiring infection?

Staff must wear full face protection of the nose, mouth and eyes when carrying out procedures which may result in exposure to respiratory droplets or secretions e.g. during airway care and endotracheal intubation. Closed suction apparatus also reduces the risk. Traditional infection control measures such as disposable gloves and aprons, careful disposal of sharps, handwashing and appropriate management of needlestick injuries as well as blood/body fluid splashes all help to reduce the risk of infection.

Who should receive antibiotic prophylaxis?

Antibiotic prophylaxis is recommended only for those whose mouth or nose is directly exposed to large particle droplets/secretions from the respiratory tract of a probable or confirmed case of meningococcal disease around the time of admission to hospital. This type of exposure will only occur among staff who are working close to the face of the case, i.e. within one metre, without wearing a mask or other facial protection, and there is a clear perception of facial contact with droplets/secretions.

How will it be arranged?

Antibiotic prophylaxis will be arranged by the Somerset Consultant for Communicable Disease Control (CCDC).

Who does not need antibiotic prophylaxis?

General medical or nursing care of cases is not an indication for prophylaxis. Exposure to cases who have been treated with an appropriate antibiotic for more than 24 hours is not an indication for prophylaxis. Contacts of contacts also do not need prophylaxis; their risk is no more than that of the general population.

Where can I get more local information?

More information is available from the Infection Prevention and Control Nurse Team or Occupational Health Department. Numbers listed in Annex B

Meningitis Research Foundation: <http://www.meningitis.org>

Meningitis Trust: <http://www.meningitis-trust.org>

<https://www.gov.uk/government/collections/meningococcal-disease-guidance-data-and-analysis>