Viral Haemorrhagic Fevers
(Hazard Group 4) Procedure

(IPC Manual)
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>INTRODUCTION</td>
</tr>
<tr>
<td>2.</td>
<td>PROCEDURE</td>
</tr>
<tr>
<td>2.1</td>
<td>Risk Assessment</td>
</tr>
<tr>
<td>2.2</td>
<td>VHF Unlikely</td>
</tr>
<tr>
<td>2.3</td>
<td>Low Possibility VHF and High Possibility VHF</td>
</tr>
<tr>
<td>3.</td>
<td>DEFINITIONS/EXPLANATION OF TERMS USED</td>
</tr>
<tr>
<td>4.</td>
<td>RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES</td>
</tr>
<tr>
<td>4.1</td>
<td>Refer to the home page, section 4, of the Infection Prevention and Control Policy</td>
</tr>
<tr>
<td>5.</td>
<td>LINKS TO ASSOCIATED POLICIES/DOCUMENTS</td>
</tr>
<tr>
<td>6.</td>
<td>REFERENCES/FURTHER READING</td>
</tr>
<tr>
<td>7.</td>
<td>APPENDICES</td>
</tr>
</tbody>
</table>

Appendix 48 - Advisory Committee on Dangerous Pathogens’ (ACDP) Group Hazard Group 4 Viral Haemorrhagic Fever viruses

Appendix 49 - Viral Haemorrhagic Risk Assessment

Appendix 50 - Viral Haemorrhagic Action Card

Appendix 51 - Viral Haemorrhagic Fever - Staff Contact List

Appendix 52 - Viral Haemorrhagic Fever Action Log
1. **INTRODUCTION**

Viral Haemorrhagic Fevers (VHFs) are severe, life-threatening viral diseases that have been reported in parts of Africa, South America, the Middle East and Eastern Europe. VHFs are of particular public health importance because they can spread within a hospital setting; they have a high case fatality rate; they are difficult to rapidly recognise and detect; and there is no effective treatment.

Environmental conditions in the United Kingdom (UK) do not support the natural reservoirs or vectors of any of the haemorrhagic fever viruses, and all recorded cases of VHF in the UK have been acquired abroad, with the exception of one laboratory worker who sustained a needle-stick injury.

Evidence from outbreaks strongly indicates that the main routes of transmission of VHF infection are direct contact (through broken skin or mucous membranes) with blood or body fluids, and indirect contact with environments contaminated with splashes or droplets of blood or body fluids. Experts agree that there is no circumstantial or epidemiological evidence of airborne transmission risk from VHF patients. In the UK, only persons who have; (i) travelled to an area where VHFs occur; and/or (ii) been exposed to a patient or animal infected with VHF (including their blood, body fluids or tissues); or (iii) worked in a laboratory with the infectious agents of VHFs; are at risk of infection from VHFs. For the latest updates on countries affected please use the link below:

http://www.promedmail.org/

This procedure is directed at the Advisory Committee on Dangerous Pathogens’ (ACDP) Group Hazard Group 4 Viral Haemorrhagic Fever viruses (appendix 48).

2. **PROCEDURE**

2.1 **Risk Assessment**

For any patient who has had a fever (≥37.5°C) or history of fever in the previous 24 hours AND a travel history or epidemiological exposure within 21 days, a risk assessment (appendix 49) must be undertaken. This is a legal obligation and will establish the patient’s VHF risk category, which determines the subsequent management of the patient and the level of protection for staff.

If a patient telephones RDaSH services for advice, request that they telephone their General Practitioner (GP) or the Emergency Services.

An action card (appendix 50) has been produced for reception/front facing staff.

The risk to staff may change over time, depending on the symptoms of the
patien, diagnostic tests results and/or information from other sources. Patients with confirmed VHF can deteriorate rapidly.

The risk assessment (appendix 49) will assist in categorising patients as one of the following:

- VHF unlikely
- Low possibility of VHF
- High possibility of VHF

2.2 VHF Unlikely

Patients with a fever ≥37.5°C are highly unlikely to have a VHF infection if:

- They have not travelled to endemic areas before the onset of illness
- They have travelled to endemic areas or had contact with a known or suspected source of VHF, but in whom the onset of illness occurred > 21 days after their last contact with this source
- They have not become unwell within 21 days of coming in contact with the blood, body fluid or caring a live or dead individual or animal known or strongly suspected to have a VHF
- If their malaria screen in the UK is negative and they are afebrile after more than 24 hours
- If their malaria screen in the UK is positive and they are responding to anti-malaria appropriately
- If they have an alternative diagnosis confirmed and are responding appropriately

In community settings clinicians will need to direct the patient to their GP for further clinical review.

In inpatient settings a medical review will be required. Clinicians will need to monitor the patient and the risk of VHF should be reassessed if a patient with a relevant history of adequate exposure fails to improve and develops one or more of the following symptoms or complications:

- Bloody diarrhoea
- Nose bleed
- Increasing oxygen requirement in absence of other diagnosis
- Clinical shock

Other indicators include:

- Sudden fall in platelets count
- Sudden rise in aspartate transaminase (AST)

2.3 Low Possibility VHF and High Possibility VHF

In the event of a patient being categorised as low possibility or high
possibility of VHF the clinician **must** immediately:

- Advise the patient of the need for isolation and implement this. No person is to make further physical contact with the patient
- Advise the patient that admission/transfer to hospital will be required
- Inform the senior clinician/line manager (or out of hours person providing senior cover)
- Complete IR1 form and update clinical records

On notification from the clinician the Senior Clinician/Line Manager must:

- Inform Public Health England (PHE) on relevant number below. It will automatically re-direct staff out of hours:
  
  Doncaster and Rotherham localities - 0114 321 1177
  North Lincolnshire localities - 01904 687100

PHE will:

- Notify the relevant Local Authority Department of Public Health
- Lead and provide advice on post transfer arrangements in regards to cordonning off the premises, environmental cleaning, waste disposal, contact tracing etc.
- Advise whether staff that have been in contact with the patient can continue to work

The senior Clinician/Line Manager must:

- Arrange for transfer to secondary care by telephoning the ambulance service on (9)999. Ensure the ambulance service is fully aware of the risk assessment outcome so that they can ensure appropriate transfer arrangements are in place
- Alert the hospital where the patient is to be admitted
- In the patient’s own home setting inform the police service that a cordon of the premises will be required post patient transfer. Advise the police service to liaise with PHE
- Advise staff that following patient transfer from all other settings they must cordon off all areas (including toilet facilities) occupied by patient and must advise people not to enter
- Inform staff that they must not clean the areas the patient has occupied or remove waste/linen/equipment/furniture etc. until advised by PHE on the processes required
- Commence a list of staff who have had contact with the patient during the incident (appendix 51)
- Commence a log of who has been contacted, what has been reported and when it was reported (appendix 52)
The situation must be escalated, as a priority, through the most appropriate channel to:

- The Care Group Director, via TRH switchboard for the care group in which the incident occurred, or the on-call manager out of hours
- Associate Nurse Director (AND), Associate Medical Director (AMD) for the care group in which the incident occurred, via Tickhill Road Hospital (TRH) Switchboard on 01302 796000, or the on-call manager out of hours

The Care Group Director/AND/AMD will make the decision in regards to who will take responsibility for leading on the situation and who will inform the following people/services:

- The Care Group Service Manager
- The Interim Director of Nursing & Allied Health Professionals/ Director for Infection Prevention & Control (IPC) via TRH Switchboard 01302 796000
- The Consultant Microbiologist for the care group the patient is in:
  - Doncaster and North Lincolnshire areas contact Doncaster Royal Infirmary on 01302 366 666.
  - Rotherham area contact Rotherham Hospital on 01709 424242. Out of hours contact switchboard on 01709 820 000
- The Trust IPC Team on 01302 796237
- The Accountable Emergency Officer (Chief Operating Officer) on 01302 798028
- The Emergency Planning Officer on 01302 796532 / 07500 127831
- The Head of Health Safety & Security on 01302 796479
- RDaSH Estates on 01302 796000. For buildings outside RDaSH control contact relevant building manager (RDaSH Estates hold details of landlords)
- RDaSH Communications Team on 01302 796204
- The Clinical Commissioning Group (CCG) in area where the incident occurred:
  - Doncaster 01302 566300
  - Rotherham 01709 302000
  - Bassetlaw 01777 274400
  - North Lincolnshire 01652 251000

Out of hours inform:

- NHS England EPRR Team: 0333 012 4267 (North Yorkshire & Humber Option 1, South Yorkshire & Bassetlaw Option 2, (ask for NHS England 1st On Call)
- South Yorkshire CCGs: 01709 820 000 (ask for South Yorkshire &
Bassetlaw CCG on call officer
- North Lincolnshire: 01482 301700 – Request the On Call CCG Director.

The relevant Care Group Director should:

- Appoint a Trust spokesperson to agree the lines to take in case of media enquiries. Response to enquiries must correspond and be agreed with PHE and NHS England Area Team
- Ensure switchboard and all staff are given guidance on media handling in the event of media attention
- Consider opening Incident Coordination Centre/Trust Gold Command (Boardroom 2 Woodfield House) to coordinate response to incident
- Consult Major Incident Plan Action Cards

The Police may convene a Multi-Agency Strategic Coordinating Group to manage the response to the incident.

The CCG may convene a Local Health Economy Tactical Coordinating Group.

Trust Directors may choose to declare a critical or major incident depending on advice from CCGs, PHE and NHS England.

3. DEFINITIONS

Aspartate transaminase – an enzyme found in high levels in the liver, heart and muscles.

Mucous membrane - a membrane that lines various cavities in the body including the mouth, nose, eyelids, trachea (windpipe) and lungs, stomach and intestines, and the ureters, urethra, and urinary bladder. It consists of one or more layers of epithelial cells overlying a layer of loose connective tissue.

Platelet - a small colourless disc-shaped cell fragment without a nucleus, found in large numbers in blood and involved in clotting.

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

4.1 Refer to the home page, section 4, of the Infection Prevention and Control Policy

5. LINKS TO ASSOCIATED POLICIES/DOCUMENTS


6. REFERENCES/FURTHER READING


7. APPENDICES

To access the following Appendices please see IPC Manual homepage. [https://www.rdash.nhs.uk/46192/infection-prevention-and-control-manual/](https://www.rdash.nhs.uk/46192/infection-prevention-and-control-manual/)

Appendix 48 - Advisory Committee on Dangerous Pathogens’ (ACDP) Group Hazard Group 4 Viral Haemorrhagic Fever viruses

Appendix 49 – Viral Haemorrhagic Risk Assessment

Appendix 50 - Viral Haemorrhagic Action Card

Appendix 51 - Viral Haemorrhagic Fever - Staff Contact List

Appendix 52 - Viral Haemorrhagic Fever Action Log