Document Title:	**VIRAL HAEMORRHAGIC FEVER (VHF)**		
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Document type: (Policy/ Guideline/ SOP)	Guideline	**To be followed by:** (Target Staff)	All nursing and medical staff in Accident & Emergency and Emergency medical wards
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Developed in response to:	Health Care Act/ National guidance on the management of viral haemorrhagic fever		
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Related Trust Policies (to be read in conjunction with)	08029 Patient isolation policy 09033 Cleaning policy 04070 Decontamination and disinfection of equipment and environment 04071 Policy for standard infection prevention precautions 10078 Decontamination with Hydrogen Peroxide Vapour Technology (fogging) standard operating procedure

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ Record documents superseded by:**	**Issue Date:**
1.0	Angela Hyman		May 2008
2.0	Katheryn Hobbs		March 2014
2.1	Amanda Kirkham		August 2014
2.2	Amanda Kirkham		August 2014
2.3	Dr Louise Teare		20th Nov 2014
2.4	John Swanson	Extension agreed to May 2018	28th Nov 2017
2.5	Maggie Bayley	6 month extension request due MSB standardisation	6th November 2018
3.0	Judith Holdsworth	Full Review	27th August 2019

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1. Purpose

1.1 The purpose of this guideline is to provide guidance on the risk assessment and management of patients who are considered as having a risk of VHF Viral Haemorrhagic Fever.

1.2 To ensure any patient with suspected VHF is managed in an appropriate environment.

2. Aim

2.1 The aim is to minimise the risk of transmission to health care staff and others who may come into contact with the patient or their environment.

3. Scope

3.1 This guideline is relevant to all clinical staff working within emergency care areas.

4. Background

4.1 VHFs are severe and life threatening diseases caused by a range of viruses for example. Lassa fever and Ebola.

4.2 Most are endemic in a number of areas including Africa, South America, rural parts of the Middle East and Eastern Europe.

4.3 The UK does not support the natural reservoirs or vectors of any of these viruses.

4.4 VHFs are important because:

- They can spread rapidly in a hospital setting;
- They have a high case fatality rate;
- They are difficult to recognise and detect rapidly;
- There is no effective treatment.

4.5 VHFs must be considered for any patient presenting with an undiagnosed fever >38°C within 3 weeks of return from one of the high risk areas mentioned above. Further detail can be found in Appendix 1.

4.6 Other symptoms can include; chills, malaise, headaches, rash and bleeding.

4.7 The main routes of transmission of VHF infection are direct contact (infected blood or body fluids coming into contact with broken skin or mucous membranes) and indirect contact if broken skin comes into contact with environmental contamination.

4.8 There is no evidence of an aerosol transmission risk from VHF patients.

4.9 There is a risk of secondary infection among health care workers and laboratory staff as a result of inoculation from needle stick, contamination from broken skin or mucous membranes or by infected blood or bodily fluids. This includes indirect exposure through contaminated surfaces and equipment.

5. Roles and Responsibilities

5.1 **Chief Executive**
The Chief Executive has overall responsibility for ensuring that the Trust has the necessary management systems in place to enable the effective implementation of this policy and overall responsibility for the health and safety of staff, patients and visitors.

5.2 **Medical Director**
The Medical Director has strategic responsibility to ensure that systems are in place to make all medical staff aware of this policy and to give appropriate support to enable staff to adhere to practice as outlined in the document.

5.3 **Director of Nursing**
The Director of Nursing has strategic responsibility for ensuring systems are in place to facilitate nursing staff awareness of this policy and appropriate support is given to enable staff in delivering practice as outlined in this policy.

5.4 **Director of Infection Prevention and Control (DIPC):**

- The DIPC will have operational responsibility for the effective implementation of this policy and will give guidance to the Clinical Lead when a patient is suspected of having VHF;
- The DIPC is responsible for the formal external notification of a suspected case of VHF.

5.5 **Infection Prevention and Control Team (IPT)**
The Infection Prevention and Control Team is responsible for ensuring all relevant staff are made aware of this policy and will provide support to the emergency areas if a patient is admitted and suspected of having VHF.

5.6 **Emergency ward/ department staff**
All relevant staff must comply with this policy and act in a responsible manner, liaising with the IPT in a timely manner if they need advice or support.

6. Patient Risk Assessment

6.1 The Control of Substances Hazardous to Health (COSHH) regulations require employers to assess risks to their employees in the workplace. This includes assessing the risk of acquiring VHF in the health care setting.

6.2 The patient risk assessment should be led by a Consultant, taking advice from the Consultant Microbiologist on call.

6.3 If the lead clinician or Microbiologist require further assistance they should contact the Imported Diseases Service on 0844 778 8990.

6.4 The patient's risk assessment will determine the level of protection required for staff and others in the environment and the management of the patient (refer to Appendix 1).

6.5 The risk category may change over time as the patient condition changes or as laboratory information becomes available.

6.6 If a patient has had a fever >38°C, or history of fever in the previous 24 hours and a travel history or known exposure within 21 days the algorithm in appendix 1 is to be followed. The established risk category will determine their management.

6.7 Strict infection control precautions (e.g hand hygiene, wearing protective clothing etc) are paramount to ensure that staff are not put at risk whilst the initial risk assessment is carried out.

7. Management of a Patient unlikely to have a VHF

7.1 Those who have been in a VHF endemic country more than 21 days ago.

7.2 The patient has had contact with an individual or animal known or strongly suspected to have had VHF, but has remained well for 21 days since the last contact.

7.3 The patient has been afebrile for over 24 hours.

7.4 If they have a confirmed alternative diagnosis and are responding to appropriate treatment.

7.5 The patient should be re-assessed if they develop any of the following:

- Nose bleed;
- Bloody diarrhoea;
- Sudden rise in AST (aspartate aminotransferase);
- Sudden fall in platelets;
- Clinical shock;
- Rapidly increasing oxygen requirements in the absence of any other diagnosis.

8. Management of a Patient Categorised as “low possibility of VHF”

8.1 A senior member of the medical team should be the lead clinician.

8.2 If the patient has extensive bruising or active bleeding, the lead clinician should discuss the case as a matter of urgency with the High Security Infectious Disease Unit and the patient should be managed as ‘high possibility of VHF’ (Section 9)

8.3 Ensure IPT are informed.

8.4 The number of staff giving care to the patient should be limited.

8.5 An urgent malaria screen must be instigated as well as other local diagnostic investigations. These can be classed as standard samples.

8.6 The patient must be isolated in a side room immediately with en-suite facilities or dedicated commode, these must be cleaned after each use with environmental disinfectant.

8.7 Personal protective equipment (PPE) required for staff is dependent on activities taking place as illustrated in the table below:

Staff protection	**Control measures**
Standard precautions	Hand hygiene Gloves Plastic apron
Additional protection for splash inducing procedures	Fluid repellent surgical mask Eye protection
Additional protection for potential aerosol generating procedures* based on risk assessment for other infections known to be transmitted by aerosol	FFP3 respirator for aerosol generating procedures Eye protection
* Endotracheal intubation; Bronchosopy; Airway suctioning; Positive pressure ventilation via face mask; High frequency oscillatory ventilation; Central line insertion; Diagnostic sputum induction	

8.8 Single use equipment must be used whenever possible.

8.9 Needle free intravenous systems should be used to reduce the risk of needle stick injury.

8.10 Disposable cutlery and crockery must be used and disposed of in the orange waste stream.

8.11 All linen and waste must be disposed of as infectious waste. Disposable linen is preferable if it is available.

8.12 Timely communication between teams is essential, and all staff on duty must be made aware and understand the risks associated with a patient who is at risk of having a VHF.

8.13 If the malaria result is positive, treatment can be given immediately using treatment guidelines from the HPA, whilst continuing to evaluate the patient's condition.

8.14 If the malaria result is negative and no other diagnosis is made, an urgent VHF screen must be undertaken. The Microbiologist should contact the Imported Fever Service to access urgent diagnostic services.

8.15 If the VHF screen is positive then follow the actions in section 11.

9 Management of a Patient Categorised as "High possibility of VHF"

9.1 A senior member of the medical team should be the lead clinician.

9.2 If the patient has bleeding or uncontrolled diarrhoea, the lead clinician should ensure that VHF testing is carried out and seek urgent advice from the high security diseases unit at the Royal Free NHS Trust London on 02077940500 (ask for the infectious diseases Consultant physician on call) (refer to Appendix 3 on safe collection of specimens).

9.3 Ensure IPT are informed.

9.4 The patient must be isolated in a side room with en-suite facilities or a dedicated commode immediately to limit contact.

9.5 The number of staff in contact with the patient **must** be restricted.

9.6 Investigations will URGENT malaria tests as well as FBC, U&Es, LFTs, clotting screen, CRP, glucose and blood cultures. These tests should be carried out using CL2 laboratory procedures. Analysis of specimens should not be delayed whilst awaiting the result of the VHF screen.

9.7 If the malaria screen is negative and VHF is still suspected clinically, the case should be discussed promptly with the Consultant Microbiologist who will contact the Imported Fever Service (0844 778890) to arrange an **urgent VHF screen**. The HPU should also be informed.

9.8 If the VHF screen results are negative, the infection must still be considered until the patient has been afebrile for over 24 hours.

9.9 The level of staff protection required depends on the patients symptoms as set out in the table below:

Staff Protection	**Control measures**
Standard precautions plus droplet precautions where the patient DOES NOT have extensive bruising, active bleeding, uncontrolled diarrhoea or uncontrolled vomiting	Hand hygiene Gloves Plastic apron Fluid repellent surgical facemask Eye protection
Additional respiratory protection for potential aerosol generating procedures*	FFP3 respirator
Standard plus droplet plus respiratory precautions when the patient DOES have extensive bruising, active bleeding, uncontrolled diarrhoea or uncontrolled vomiting	Hand hygiene **Double** Gloves Fluid repellent disposable gown or suit Eye protection FFP3 respirator
* Endotracheal intubation; Bronchosopy; Airway suctioning; Positive pressure ventilation via face mask; High frequency oscillatory ventilation; Central line insertion; Diagnostic sputum induction	

9.10 Single use equipment must be used whenever possible.

9.11 Needle free intravenous systems should be used to reduce the risk of needle stick injury.

9.12 Disposable cutlery and crockery must be used and disposed of in the orange waste stream.

9.13 All linen and waste must be disposed of as infectious waste. Disposable linen is preferable if it is available.

9.14 Timely communication between teams is essential, and all staff on duty must be made aware and understand the risks associated with a patient who is at risk of having a VHF, for example:

- The severity of a VHF if infection is confirmed;
- That virus may be present;
  - In blood;
  - In body fluids, including urine;
  - On contaminated instruments and equipment;
  - In waste;
  - On contaminated clothing;
  - On contaminated surfaces.

- That exposure to the virus may occur:

  - **Directly** – through exposure (broken skin or mucous membranes) to blood and/or body fluids during invasive, aerosolising or splash procedures,
  - **Indirectly** - through exposure (broken skin or mucous membranes) to environments, surfaces, equipment or clothing contaminated with splashes or droplets of blood or body fluids.

10. Management of a Patient with a Positive VHF Screen

10.1 A patient with a positive VHF screen must be urgently transferred to a high security infectious disease unit. Patients from this hospital are transferred to the Royal Free in London where management is conducted on a case by case basis.

10.2 Whilst waiting for transfer the enhanced precautions documented in section 9 should continue to be used.

10.3 Ensure the IPT are informed of the result.

10.4 Compile a list of all staff who have been in direct contact with the patient.

10.5 Launch full public health actions including formation of an Incident Control Team.

11. Formal External Notification/ Public Health Actions

11.1 Early public health actions are to be launched if a patient is categorised as high possibility of VHF:

- Notify the local health protection team, PHE on 0345 1550069. Out of hours the team should be contact via the Essex Ambulance Service on 01245 444417;
- Contacts must be identified, assessed and categorised to ensure the appropriate monitoring can be undertaken (Appendix 4).

11.2 Full public health actions must be launched when a positive screen result is received; this includes the formation of an incident control team with representatives from all involved parties including the local PH body and the hospital trust who will:

- Ensure the relevant bodies are informed of the result;
- Manage contacts appropriately;
- Decide upon actions to be taken and advice to be given;
- Determine responsibility for media handling and agree all key media messages.

12. Transfer of Patient

12.1 A patient will require transfer to the high security infectious diseases unit if:

- They have been categorised as " high possibility of VHF";
- If a positive VHF screen result has been received.

12.2 The decision to transfer must be made by the lead clinician following consultation with the clinicians at the specialist unit.

12.3 A category 4 road ambulance transfer is required.

12.4 The ambulance crew must be fully informed of the patient's clinical condition and the routes of transmission of VHF prior to attending to the patient.

13. Death of a Patient Confirmed or Suspected of VHF

13.1 As far as possible the wishes of the deceased's family must be respected, however, it is important they are informed of the serious nature of the infection and the risks associated with it.

13.2 The family must be made aware that religious/ritual preparations as well as washing, dressing and viewing the body need to be avoided in this case.

13.3 When the body of a confirmed or suspected case of VHF is not in an isolator, staff must ensure they are wearing appropriate PPE as already described, the body is to be placed in a double body bag with absorbent material placed between each bag. Once sealed the outer bag is to be disinfected with a chlorine based product at 1000ppm. The bag must be labelled as high risk of infection.

13.4 The ward team is responsible for ensuring mortuary staff are informed of the risk prior to transfer of the body.

14. Decontamination of the Patient Environment

14.1 The viruses that cause VHF are not highly resistant to chemical or heat.

14.2 The cleaning of the environment and equipment should be carried out in accordance with the trust cleaning and decontamination policies.

14.3 Single use equipment should be used whenever possible

14.4 Reusable instruments must be sent to sterile services ensuring that the department is informed first of the infection risk.

14.5 Any domestic or nursing staff involved in the decontamination process must wear suitable PPE.

14.6 The isolation room should be cleaned as a terminal clean in line with the cleaning and isolation policies.

14.7 For cleaning of small blood or bodily fluid spillages:

- Any lesions must be covered with a waterproof dressing prior to using PPE;
- The spillage should be wiped up using absorbent towels and disposed of in the clinical waste stream;
- The area must be disinfected using a chlorine based product at 10,000 ppm;
- Following this, the area should be washed using water and detergent;
- All waste must be incinerated.

14.8 For cleaning larger spillages as above but with the addition of the following:

- Allow any aerosols to settle;
- Depending on risk assessment rubber boots or overshoes may be required;
- If rubber boots are worn they must be disinfected with a chlorine based product at 10,000 ppm.

14.9 Any grossly contaminated areas will require the use of hydrogen peroxide vapour (HPV) fogging after the terminal clean has taken place in line with the HPV policy.

15. Audit and Monitoring

15.1 The effectiveness of the policy is monitored through the annual trust wide documentation audit coordinated through the Clinical Audit Department. The Infection Prevention and Control Group reviews the Infection Control policies and directorates are required to develop localised action plans which are monitored through their Directorate Governance Improvement Plans.

15.2 A Trust wide Clinical Documentation summary report is presented annually to the Information Governance Committee for review to enable monitoring at a wider level across the organisation- good standards of clinical documentation help reduce the potential for clinical risk incidents occurring.

15.3 Any breaches in this policy must be reported via the Datix web system and investigated

16. Implementation and Communication

16.1 This policy will be issued to the following staff groups to disseminate and ensure their staff are made aware of the policy:

- Ward Sisters/Charge nurse – issue to all staff within their ward;
- Clinical Directors are to ensure all Consultants are made aware of this policy;
- Departmental Managers - issue to all relevant staff;
- Bed Management Team / Service Co-ordinators;
- Directorate Managers & Director of Operations;
- Heads of Nursing and Lead Nurses;
- Head of Hotel Services;
- Communications Manager;
- Occupational Health Manager.

16.2 Junior and middle grade medical staff will be made aware of the policy via email.

16.3 The guideline will also be issued via the Staff Focus and made available on the Intranet.

17.0 Equality Impact Assessment

17.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix 5)

18. References

Department of Health (2014) Management of Hazard Group 4 viral haemorrhagic fevers and similar human infectious diseases of high consequence. Can be found on : http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1194947382005

Appendix 1

VHF endemic areas: List of diseases by country

Afghanistan: Crimean-Congo Haemorrhagic Fever

Albania: Crimean-Congo Haemorrhagic Fever

Angola: Marburg

Argentina: Argentinian Haemorrhagic Fever (limited agricultural region in the pampas)

Armenia: Crimean-Congo Haemorrhagic Fever

Bolivia: Bolivian Haemorrhagic Fever (Machupo virus in Benin province; Chapare virus in Cochabamba province)

Brazil: Brazilian Haemorrhagic Fever

Bulgaria: Crimean-Congo Haemorrhagic Fever

Burkina Faso: Lassa fever

Congo: Crimean-Congo Haemorrhagic Fever

Democratic Republic of the Congo: Ebola, Marburg

Cote d'Ivoire: Ebola, Lassa fever

Gabon: Ebola

Ghana: Lassa fever

Greece: Crimean-Congo Haemorrhagic Fever

Guinea: Ebola, Lassa fever

India: Kyasanur forest disease (Karnataka State)

Iran: Crimean-Congo Haemorrhagic Fever

Kazakhstan: Crimean-Congo Haemorrhagic Fever

Kenya: Ebola, Marburg

Kosovo: Crimean-Congo Haemorrhagic Fever

Liberia: Ebola, Lassa fever

Mali: Ebola, Lassa fever

Mauritania: Crimean-Congo Haemorrhagic Fever

Nigeria: Lassa fever

Pakistan: Lassa fever

Russian Federation: Crimean-Congo Haemorrhagic Fever

Serbia: Crimean-Congo Haemorrhagic Fever

Senegal: Crimean-Congo Haemorrhagic Fever

Sierra Leone: Lassa fever

South Africa: Crimean-Congo Haemorrhagic Fever Lujo virus

Sudan: Ebola virus

Tajikistan: Crimean-Congo Haemorrhagic Fever

Turkey: Crimean-Congo Haemorrhagic Fever

Turkmenistan: Crimean-Congo Haemorrhagic Fever

Uganda: Ebola, Marburg

Ukraine: Crimean-Congo Haemorrhagic Fever

Uzbekistan: Crimean-Congo Haemorrhagic Fever

Venezuela: Venezuelan Haemorrhagic Fever

Zimbabwe: Crimean-Congo Haemorrhagic Fever, Marburg

Appendix 2

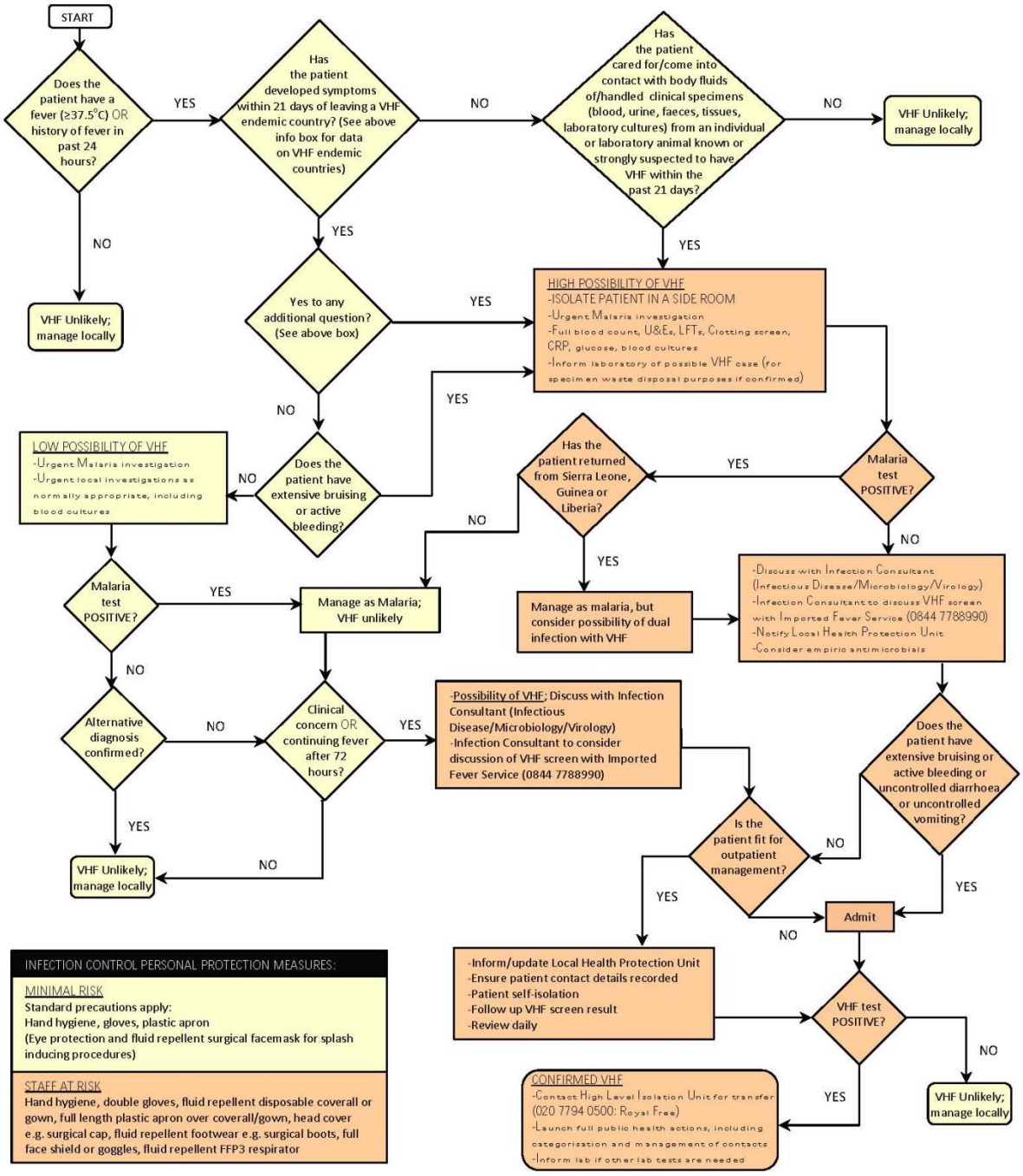
VIRAL HAEMORRHAGIC FEVERS RISK ASSESSMENT (Version 5: 06.11.2014)

VHF ENDEMIC COUNTRIES:

Information on VHF endemic countries can be found at https://www.gov.uk/viral-haemorrhagic-fevers-origins-reservoirs-transmission-and-guidelines
or see VHF in Africa map at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365845/VHF_Africa_960_640.png

ADDITIONAL QUESTIONS:

-Has the patient travelled to any area where there is a current VHF outbreak? (http://www.promedmail.org/) OR
-Has the patient lived or worked in basic rural conditions in an area where Lassa Fever is endemic? (https://www.gov.uk/lassa-fever-origins-reservoirs-transmission-and-guidelines) OR
-Has the patient visited caves / mines, or had contact with or eaten primates, antelopes or bats in a Marburg / Ebola endemic area? (https://www.gov.uk/ebola-and-marburg-haemorrhagic-fevers-outbreaks-and-case-locations) OR
-Has the patient travelled in an area where Crimean-Congo Haemorrhagic Fever is endemic (http://www.who.int/csr/disease/crimean_congoHF/Global_CCHFRisk_20080918.png?ua=1) AND sustained a tick bite* or crushed a tick with their bare hands OR had close involvement with animal slaughter? (*If an obvious alternative diagnosis has been made e.g. tick typhus, then manage locally)



INFECTION CONTROL PERSONAL PROTECTION MEASURES:

MINIMAL RISK
Standard precautions apply:
Hand hygiene, gloves, plastic apron
(Eye protection and fluid repellent surgical facemask for splash inducing procedures)

STAFF AT RISK
Hand hygiene, double gloves, fluid repellent disposable coverall or gown, full length plastic apron over coverall/gown, head cover e.g. surgical cap, fluid repellent footwear e.g. surgical boots, full face shield or goggles, fluid repellent FFP3 respirator

Please note this algorithm is a guide designed to aid early diagnosis of VHF cases and should be used in conjunction with ACDP guidance:
https://www.gov.uk/government/publications/viral-haemorrhagic-fever-algorithm-and-guidance-on-management-of-patients

Appendix 3

The safe collection of specimens

From patients with a “possibility of VHF”;

No extra precautions are required when taking a specimen, disposable gloves and aprons are sufficient.

However, the laboratory staff must be informed to expect the sample, and need to eye protection for procedures where aerosolisation or splashing may occur (in addition to laboratory coat and gloves).

Routine laboratory tests should be carried out where possible in closed system analysers at standard containment level 2 conditions.

From patients categorised as “high possibility of VHF”;

The main risk is any contact with blood or bodily fluids

During specimen collection enhanced precautions must be used including staff wearing PPE which includes fluid repellent disposable gowns, **double gloves,** a disposable visor, eye protection and an FFP3 face mask.

The samples **must not** be sent using the pneumatic tube but delivered promptly in person to enable timely transfer of the specimen to the reference laboratory.

The laboratory **must** be notified prior to receipt that specific samples have been requested in order for them to be segregated and processed separately using dedicated equipment.

Laboratory staff must wear a laboratory coat, gloves and eye protection as well as a fluid repellent facemask for procedures with a risk of aerosolisation or splashing.

Samples may be analysed at containment level 2 with some additional precautions (as described in *Management of Hazard Group 4 viral haemorrhagic fevers and similar human infectious diseases of high consequence – Advisory Committee on Dangerous Pathogens* [DoH 2012]).

Appendix 4

Contact surveillance

The trust has a public health responsibility to:

- Assess and categorise contacts of a patient with VHF
- Ensure appropriate monitoring of those contacts takes place
- To arrange further evaluation of any contacts who develop a temperature >38°C within 21 days of exposure
- To consider antiviral prophylaxis and arrange when required.

A contact is defined as a person who has been exposed to an infected person, their blood or bodily fluids, excretions or tissues following the onset of their fever.

As soon as patient is identified as “high possibility of VHF” all those who have had contact must be identified promptly.

Those who may be incubating the infection are not infectious themselves until symptoms develop.

The nurse in charge of the ward involved must create a list of medical, nursing and other staff that have had direct contact with the patient.

Any family and other contacts of the patient are to be recorded and followed up by the Consultant in Communicable Disease Control (CCDC).

All close contact must be kept under daily surveillance for 21 days form the last exposure including twice daily body temperature recordings and the presence of any symptoms.

Those with a temperature >38°C should remain at home and the CCDC informed.

Those without symptoms are not required to be restricted from working and normal daily activities.

Visitors to the patient must be restricted to those who may have already been exposed at home but must be instructed on the use of PPE.

Appendix 5: Preliminary Equality Analysis

This assessment relates to: 08007 Viral Haemorrhagic Fever

A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	**Answers**
1. What are you proposing to change?	Full Review
2. Why are you making this change? (What will the change achieve?)	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

Name	Judith Holdsworth	**Job Title**	Infection prevention Lead	**Date**	August 2019