<table>
<thead>
<tr>
<th>NAME OF DOCUMENT</th>
<th>Meningococcal Disease – Patient Contact Management</th>
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<tr>
<td>TYPE OF DOCUMENT</td>
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<td>FORMER REFERENCE(S)</td>
<td>Replacing former IAHS Meningococcal Disease – Patient Contact Management Section M:M1</td>
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<td>Documents that are replaced by this one</td>
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<td>Former SESIAHS M1</td>
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<td>EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR</td>
<td>Director of Clinical Governance</td>
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<tr>
<td>AUTHOR</td>
<td>Infection Control Manual Working Party</td>
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<td>Position responsible for the document including email address</td>
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<tr>
<td>KEY TERMS</td>
<td>Droplet precautions, Meningococcal disease, Contact, Meningococcal meningitis, Meningococcal septicaemia</td>
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<tr>
<td>SUMMARY</td>
<td>To outline the procedure for the management of a patient infected or suspected to be infected with Meningococcal disease and any identified contacts</td>
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<td>Brief summary of the contents of the document</td>
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COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

Feedback about this document can be sent to areaexecutiveservices@sesiahs.health.nsw.gov.au
**1. POLICY STATEMENT**
Additional (Transmission Based) Precautions (Droplet Precautions) must be implemented immediately a potential diagnosis of Meningococcal Disease is made.

Droplet Precautions must be applied until the patient has completed 24 hours of appropriate antibiotic therapy

Suspected or confirmed Meningococcal disease must be notified to the Public Health Unit as soon as possible by phone

The follow up and care of contacts of a suspected case is managed by the Public Health Unit

**2. BACKGROUND**
Meningococcal septicaemia has considerably greater mortality than meningococcal meningitis and if often characterised by rapidly evolving petechial or purpuric rash that does not blanch under pressure. In the early stages the rash may not be present or may be atypical

Meningococcal disease is frequently a cause of public alarm and high level of media attention

**3. DEFINITIONS**

**Droplet Precautions**: precautions applied to reduce the risk of disease transmission from any patients known or suspected to be infected with pathogens that can be transmitted by droplets

**Droplet transmission**: involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large particle droplets (larger than 5μm in size) containing micro-organisms generated from a person who has a clinical disease. Droplets do not remain suspended in the air

**Contact**: a significant exposure to a case in the 7 days prior to onset of the illness and within 24hrs of commencement of appropriate antibiotics including:
- all household, dormitory, sexual contacts and travellers in adjacent seats (duration of travel ≥ 8 hours)
- visitors who have stayed overnight
- children and staff in same room group at childcare facility for any one period of ≥ 4 hours
- Health Care Workers (HCWs) who have been:
  - directly exposed to infectious respiratory droplets/secretions within a distance of one metre from a probable or confirmed case for a period of greater than 30 minutes
  - involved in mouth to mouth resuscitation or airway management during resuscitation (intubation, suctioning) without facial protection or mask
NB: HCWs managing the patient who have not been directly exposed to the case’s nasopharyngeal secretions do not require chemoprophylaxis

**Meningococcus:** bacterial group to which the species *Neisseria meningitidis* belongs

**Meningococcal disease:** disease caused by the gram-negative coccus *Neisseria meningitidis*. This can include meningitis, sepsis, bacteraemia or pneumonia

- **Incubation period:** 2 to 10 days, more commonly 3 to 4 days. The infectious period probably begins with onset of symptoms
- **Transmission:** through significant contact with secretions (refer to contact definition) including respiratory droplets from the nose and throat of infected persons (nasopharyngeal secretions). It can be carried asymptomatically by 5 to 10 percent of the community

**Meningococcal meningitis:** an acute bacterial disease characterised by sudden onset with fever, intense headache, nausea and vomiting, stiff neck with or without a petechial or purpuric rash, sometimes progressing to delirium or coma and death

**Meningococcal septicaemia:** bacteraemia caused by *Neisseria meningitidis*. May include fever, vomiting, headache, myalgia, abdominal pain, petechial or purpuric rash, tachycardia and hypotension. Initially there may be a normal level of consciousness, followed rapidly by further hypotension, shock and increasing confusion. Sometimes, overwhelming sepsis may lead to a rapid death. Meningocaeemia can cause overwhelming sepsis in otherwise healthy young people. It can occur without extension to the meninges

4. **RESPONSIBILITIES**

4.1 **Employees will:**
- Comply with management procedures for patients with suspected or confirmed meningococcal disease
- Provide education and to the patient and visitors on how they must comply with additional precautions
- Ensure the patient and visitors understand the need for additional precautions
- Document the care given to the patient

4.2 **Line Managers will:**
- Ensure all patients with suspected or confirmed meningococcal disease are managed as outlined in this document
- Ensure all staff comply with this procedure
- Ensure all staff receive education regarding the management of patients with suspected or confirmed meningococcal disease
- Ensure all patients and visitors understand the requirement for additional precautions
4.3 Infection Prevention and Control Staff will:
Ensure that Medical staff have notified Public Health of suspected or confirmed Meningococcal disease
Provide education to staff to ensure they understand the rationale for this procedure
Assist with ensuring the patient, family and visitors understand the requirement for additional precautions

4.4 Network Managers/ Service Managers will:
Distribute information to line managers
Assign responsibility and resources to ensure the appropriate management of patients with suspected or confirmed meningococcal disease

4.5 Medical staff will:
Comply with the management procedures for all patients with suspected or confirmed meningococcal disease
Notify the Public Health Unit of all suspected cases of meningococcal disease
Provide information and explanation to the patient on their disease process
Document care given n to the patient

5. PROCEDURE
Refer to SESLHN Infection Control Manual: Additional Precautions Procedure for patient management
A case can be regarded as non-infectious after 24 hours of appropriate antimicrobial therapy
Droplet precautions must be implemented until patient has received appropriate antimicrobial treatment for 24 hours
During this 24 hour period all persons entering the room must wear a surgical mask
During this 24 hour period, if the patient must leave the room, they must wear a surgical mask

5.1 Chemoprophylaxis
- Chemoprophylaxis is not recommended for HCWs unless they fulfil the criteria as per the contact definition
- The rationale for contact chemoprophylaxis is to eliminate meningococci from any carrier within the network of contacts close to the case, thereby reducing the risk of transmission to other susceptible individuals in the network. Advice must be sought from Public Health Unit

Contacts:
- Chemoprophylaxis (or “clearance antibiotics”) should be commenced as soon as possible after diagnosis of the index case. There is no purpose in administering chemoprophylaxis if more than 2 weeks have lapsed following the most recent contact with the case.
• Persons with only brief contact (less than that of a defined contact) with a case should be offered counselling, where appropriate, but not prophylaxis.

Healthcare Workers
• Chemoprophylaxis should be commenced as soon as possible after diagnosis of the index case.

5.2 Education of Contacts
Potentially exposed persons should be advised:
• of the risk of infection
• of the signs and symptoms of infection – fever, rash, lethargy, irritability, headache, nausea or vomiting
• to seek prompt medical attention if any suspicion of meningococcal disease

6. DOCUMENTATION
Patient Clinical Notes
Contact tracing records maintained with case notes by Public Health Unit

7. AUDIT
Not required

8. REFERENCES
• Communicable Disease Network Australia. Guidelines for the early clinical and public health management of meningococcal disease in Australia. Commonwealth of Australia. 2007
• NSW Health Department. PD. 2007_036: Infection Control Policy. 2007
9. **REVISION AND APPROVAL HISTORY** (state the author of the document, the date it was written, its revision number and approval history)

<table>
<thead>
<tr>
<th>Date</th>
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<th>Author and Approval</th>
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<tr>
<td>June 04</td>
<td>Draft</td>
<td>Infection Control Coordinators – Illawarra Health</td>
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<tr>
<td>Dec 04</td>
<td>Draft</td>
<td>Infection Control Coordinators - Illawarra Health- changes to Contact Definition and Flowchart including updates to References and prophylaxis for contact treatment</td>
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<tr>
<td>Feb 05</td>
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<td>Approved by Area Policy and Procedure Committee on 10 Feb 05 and ratified by executive on 21 Feb 05 for a six month period- review August 05</td>
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PUBLIC HEALTH UNIT (PHU) MENINGOCOCCAL CONTACT MANAGEMENT PROTOCOL

PROBABLE OR CONFIRMED MENINGOCOCCAL INFECTION

Ensure facility Infection Control Nurse is notified

Phone the PHU- Sydney office 9382 8333, after hours: 9382 2222 & page Public Health Officer on call

PHU Response

- Confirm onset date and symptoms
- Confirm results of pathology tests or recommend relevant testing, which may include:
  - Acute and convalescent serology on unconfirmed cases
  - Referral of all invasive isolates for urgent serogrouping (or confirmation) to SEALS Randwick
  - Request PCR testing on relevant specimens when indicated to SEALS St George
- Seek permission to contact patient or relevant care-giver
- Implement and coordinate contact management procedures
- Give NSW Health disease and medication fact sheets to contacts

Contact Definition

The PHU will coordinate contact management using the following criteria:
In the last 7 days prior to onset of the illness and within 24hrs of commencement of appropriate antibiotics:

- all household, dormitory, sexual contacts and travellers in adjacent seats (duration ≥ 8 hrs)
- visitors who have stayed overnight
- children and staff in same room group at childcare facility for any one period of ≥ 4 hours
- Health Care Workers who have been directly exposed to infectious respiratory

Prophylaxis for Contacts

NB: Chemoprophylaxis is not indicated if > 14 days since most recent contact

Provided free of charge by the hospital pharmacy.

Oral Rifampcin:
- Adults: 600mg 12 hourly for 2 days
- Children: 10mg/kg (max. 600mg) 12 hourly for 2 days
- Neonates: < 1 month 5mg/kg 12 hourly for 2 days or

Ciprofloxacin: (NOT FOR USE IN CHILDREN UNDER 12yrs) 500mg oral single dose (preferred for woman on oral contraceptives).

When either are contraindicated:

IMI Ceftriaxone:
- Adults: 250mg single dose
- Children: < 12 y/o give 125mg
- do not use in infants < 6 weeks old