From the Chief Medical Officer
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HSS(MD)28/2014

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To: Chief Executives, Public Health Agency/Health & Social Care Board/HSC Trusts/NIAS
GP Medical Advisers
All General Practitioners and GP Locums (*for onward distribution to practice staff*)

Your Ref:
Our Ref: HSS(MD)28/2014
Date: 21st August 2014

Dear Colleague

ONGOING EBOLA OUTBREAK IN WEST AFRICA UPDATE AND NORTHERN IRELAND INTERIM CARE PATHWAY

ACTION REQUIRED

Chief Executives should ensure that this letter is circulated to:

- **all frontline clinical staff who may be treating or admitting patients and**
- **all Infection Prevention and Control staff.**

The HSCB should ensure that this letter is circulated to all GPs and practice staff.

Summary

1. The purpose of this letter is to update you on the current outbreak of Ebola Virus Disease (EVD) in West Africa, and to reinforce the need to remain vigilant for any cases that may be imported into Northern Ireland.

2. This letter provides an updated position from previous communications on this topic; Ebola Outbreak in West Africa HSS (MD) 17/2014 and Update Ongoing Ebola outbreak HSS (MD) 22/2014.

3. The letter provides local frontline staff in Trusts with an **interim care pathway for the management of patients presenting in Emergency Departments**.

4. This letter highlights **updated ACDP guidance and an associated risk assessment algorithm** on the management of Viral Haemorrhagic Fever which replaces previous guidance on this topic.

5. Colleagues are directed to other currently available sources of information on Ebola which are regularly updated. All relevant information is in the attached annex.

Action required

6. Chief Executives should ensure that this letter is circulated to frontline clinical staff who may be admitting patients, all infection prevention and control staff and General Practitioners.

7. Organisations should be aware of the contents of the new ACDP guidance on the management of VHF and the associated risk assessment algorithm and their responsibilities in respect of preparedness of in the event of managing a patient suspected of having Ebola.

8. Every effort should be made to ensure that relevant staff continue to be aware of the symptoms of Ebola; are vigilant for travellers who have visited areas affected and know the necessary infection and control measures which should be taken in the event of a possible case. Clinical staff should follow the interim care pathway attached to this letter and be aware that *in exceptional circumstances* a patient with confirmed Ebola who is too ill to be moved to a specialist unit may have to be cared for in a local hospital. Hence organisations should be prepared for such an eventuality in accordance with the latest ACDP guidance.

Yours sincerely

Dr Michael McBride
Chief Medical Officer

This letter is available on the DHSSPS website at
www.dhsspsni.gov.uk/index/phealth/professional/cmo_communications.htm

Circulation List:

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Annex

Ebola outbreak in West Africa; current situation

The outbreak of Ebola virus disease (EVD) first reported in March 2014 continues in three countries: Guinea, Liberia and Sierra Leone. This is the first documented EVD outbreak in West Africa, and is the largest known outbreak of this disease.

EVD is a form of viral haemorrhagic disease. Most human infections result from direct contact with the bodily fluids or secretions of infected patients, particularly in hospitals, and as a result of unsafe burial procedures, use of contaminated medical devices (including needles and syringes) and unprotected exposure to contaminated bodily fluids. Further general information on EVD is available here: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Ebola/GeneralInformation/

New cases continue to be reported from the countries affected and, while further actions are being put in place, transmission currently continues in both community and health-care settings. The capital cities of all three countries have been affected: Conakry (Guinea), Monrovia (Liberia) and Freetown (Sierra Leone). There have also been a small number of cases and fatalities in Nigeria related to imported cases. The situation continues to extremely challenging for the WHO and the health authorities in the affected countries. As the situation changes daily, up to date figures on the numbers affected are available through the following link.

http://www.afro.who.int/en/clusters-a-programmes/dpc/epidemic-a-pandemic-alert-and-response/outbreak-news.html

Updated maps of the specific areas affected are available here: http://www.cdc.gov/vhf/ebola/resources/distribution-map-guinea-outbreak.html

Public Health Agency (PHA) and Public Health England (PHE) Advice

Colleagues are directed to PHE's website where comprehensive and regularly updated information on Ebola is available. Recent additions include the management of assessment of Ebola in acute hospitals, advice on environmental cleaning (non healthcare settings) and advice for educational institutions. The latter is of particular relevance within the context of new terms starting shortly in universities and schools. There is also advice for humanitarian and healthcare workers intending to travel to and returning from affected areas.

https://www.gov.uk/government/collections/ebola-virus-disease-clinical-management-and-guidance

The Public Health Agency also provides updated information and links on Ebola on their website.

http://www.publichealth.hscni.net/

Implications for Northern Ireland

It is unlikely but not impossible that people infected in endemic areas could arrive in the UK while incubating the disease, and then develop symptoms after their return (the incubation period of EVD ranges from 2 to 21 days). Although there have been several previous outbreaks of EVD, exportation of the virus from an outbreak to a non-endemic country has historically been an exceptionally rare event. Nevertheless this has occurred in this outbreak with two healthcare workers with Ebola having been repatriated back to the USA and a Spanish National being repatriated back to Madrid and who since has succumbed to the virus. No previous outbreak has been as widespread and resistant to management/control as the current one.

Clinical Symptoms of Ebola

Although the likelihood of imported cases is low, health care providers in the UK are reminded to remain vigilant for those who have visited areas affected by viral haemorrhagic fever and who develop unexplained illness. Patients should receive rapid medical attention and be asked about potential risk factors and the details of their recent travel if:

- they have recently visited any of the affected areas (currently, Guineas, Sierra Leone and Liberia

and

- report any of the following symptoms, particularly of sudden onset, within 21 days of visiting affected areas:
    - fever
    - headache
    - sore throat
    - profuse diarrhoea and vomiting (which has been a notable feature in the current outbreak)
    - general malaise
- Viral haemorrhagic fever should be suspected in individuals with a fever [> 38^{o}C] or history of fever in the previous 24 hours who have visited an affected area within 21 days (or who have cared for or come into contact with body fluids or clinical specimens from alive or dead individual or animal known or strongly suspected to have viral haemorrhagic fever).

In situations in which viral haemorrhagic fever is suspected, alternative diagnoses (such as malaria) should not be overlooked.

Updated ACDP Guidance and Risk Assessment Algorithm

New ACDP guidance on the management of Viral Haemorrhagic Fever and the associated risk assessment algorithm was published on 13 August. This replaces previous guidance on this topic. Important features of the new guidance include the following;

- Risk categorisation has changed from highly unlikely/possibility/high possibility/confirmed to unlikely/low possibility/high possibility/confirmed.
- Providing clarity on testing of patient specimens, where a VHF is suspected, without delay (that is without awaiting outcome of a VHF screen).
- The new guidance retains the option of caring for people on a PPE / negative pressure approach, as opposed to isolator based care, including the option of care in a non HLIU (High Level Isolation Unit – previously HSIDU).
- Update of advice on waste management.

http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ViralHaemorrhagicFever/Guidelines/

Interim Clinical Care Pathway for Trust Emergency Departments

The Public Health Agency, in conjunction with HSC partners have developed an interim clinical care pathway in order to assist front line staff who may have to manage a suspected case of imported Ebola. This follows the principles of the ACDP guidance highlighted above but takes into account the characteristics and configuration of Health and Social Care services in Northern Ireland. The care pathway will assist those assessing patients in Emergency Departments in Trusts.

HSC Public Health Agency

Interim

Northern Ireland HSC Patient Care Pathway

On presentation of Patient with possible Viral Haemorrhagic Fever (including Ebola Virus Disease (EVD)) to a Trust Emergency Department (ED)

Step 1: **Patient should be isolated in a side room right away.**
Step 2: Initial local Trust Risk Assessment by ED clinician with Specialist advice from local Infection Consultant (Consult Microbiologist/Virologist/Infectious Disease Physician) using the Advisory Committee on Dangerous Pathogens (ACDP) Algorithm at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/343186/VHF_algorithm_11_08_20141.pdf and wearing appropriate Personal Protective Equipment.

- Local Risk assessment determines it is very unlikely the patient has Viral Haemorrhagic Fever - arrange for local investigation and management as appropriate.
- If determine patient has low possibility of VHF - patient remains at local Trust for investigation. If on-going clinical concern or fever **after 72 hours**. – proceed to Step 3.
- If determine patient has high possibility of VHF - isolate patient in a side room and proceed immediately to Step 3.

Step 3: Local Infection Consultant seeks Specialist advice from National Imported Fever Service and/or Rare & Imported Pathogens Laboratory

- If National advice is Low possibility of VHF – patient remains at local Trust for investigation and VHF screen.
- If National advice is High Possibility of VHF – arrange for urgent transfer of patient to Regional Infectious Disease Unit, Belfast HSC Trust. Northern Ireland Ambulance Service to transfer. Infectious Disease Consultant to arrange VHF screen and immediate care at Regional Unit. Infectious Disease Consultant to notify PHA Health Protection Immediately. *See Note 1 below

Step 4: Action to be taken once VHF Screen Results Available

Patient with positive VHF Screen -Infectious Disease consultant to discuss with High Level Isolation Unit (HLIU) in England (Royal Free) to arrange for transfer to HLIU. * See Note 1
Patient with negative VHF screen - work up and care in Regional Infectious Disease Unit.

Note 1
In exceptional case patients may be too ill to be moved OR the transfer itself presents too great an infection control risk (bleeding or uncontrolled diarrhoea/vomiting). Management and placement of these patients should be discussed urgently with the HLIU and the HSE. In exceptional circumstances these patients may have to be managed in the hospital where they initially presented.

Note 2

The Advisory Committee on Dangerous Pathogens has produced updated guidance on the management of viral haemorrghagic fevers - https://www.gov.uk/government/publications/viral-haemorrhagic-fever-algorithm-and-guidance-on-management-of-patients

This guidance provides the definitive advice on infection prevention and control in health care settings, including advice on what level of PPE is required.

Note 3

In certain instances where a patient is being transferred to an ED by ambulance the receiving department should note any clinical information relayed by NIAS and take appropriate infection control measures in advance of arrival. When patients with a high possibility of Ebola are being transferred from a local hospital to the Regional IDU the clinical team should relay appropriate clinical information to NIAS to enable appropriate infection control procedures to be instituted.

Advice for Primary Care in the event of the presentation of a suspected case of Ebola

If a suspected case presents in Primary Care, they should be placed in a side room. The local Infection Consultant (Consultant Microbiologist or Virologist, or Regional Infectious Diseases Consultant) should be contacted for advice. This will inform the care pathway for the patient. The PHA should be informed of all suspected cases of Ebola on the duty room number **(telephone 0300 5550119)** or out of hours through **Belfast Ambulance Control (028 9040 4045)**. If hospital admission is advised, the GP should contact the ambulance service and advise this is a possible Ebola case.

Contact Details

1. In the first instance, clinical advice should be sought from a local consultant microbiologist, virologist or infectious disease physician. Further specialist advice on testing and management is then available from the **Imported Fever Service (0844 778 8990)**. http://www.hpa.org.uk/ProductsServices/MicrobiologyPathology/LaboratoriesAndReferenceFacilities/RareAndImportedPathogensDepartment/ImportedFeverService/

2. The PHA should be informed of all suspected cases and can be contacted on the duty room number **(telephone 0300 555 0119)** or out of hours through **Belfast Ambulance Control (028 9040 4045)**.

3. The **Rare and Imported Pathogens Laboratory** will test patient samples if appropriate, and can be contacted **on 0844 775 5990** but should be accessed following discussion with the imported fever service.

4. In Northern Ireland specialist infectious disease advice can be obtained by phoning Ward 7A in the **Royal Victoria Hospital and asking for the Infectious Disease Consultant (telephone 028 9063 4402)**.

5. **Regional Virology Laboratory Contact** (9 to 5.30 Monday-Friday contact duty virologist 0788 908 6946). Out Of Hours, ask for virology on call via RVH switchboard 028 9024 0503 and the Biomedical Scientist will facilitate contact with the clinical virologist on call).