Public Health England

Summary guidance for Acute Trust staff: Identifying and managing patients who require assessment for Ebola virus disease

Updated 24 September 2014

Introduction

This document should be used by clinical staff undertaking direct patient care in acute trusts.

The on-going outbreak of Ebola in West Africa, affecting Guinea, Liberia, Sierra Leone, Nigeria (Port Harcourt and Lagos)* and Senegal (Dakar)*, has been declared a Public Health Emergency of International Concern by the World Health Organization. This is the largest recorded outbreak of this disease. Aside from one individual who was repatriated to the UK, there have been no cases of Ebola in the UK to date.

Identifying patients at risk of Ebola

Ebola is spread through direct contact with blood and body fluids from infected people. The incubation period ranges from 2 to 21 days. It remains unlikely but not impossible that travellers infected in one of the affected countries could arrive in the UK while incubating the disease and develop symptoms after their return. Although the likelihood of imported cases is very low, healthcare staff in the UK need to remain vigilant.

Individuals may present in several different ways to hospitals: referral by NHS 111, referral by primary care, self-presentation directly to A&E, or transfer in by ambulance. Triage mechanisms need to be able to quickly identify patients at risk so that they can be isolated and a risk assessment completed.

Patients with a history of travel to an affected area within the last 21 days who have a fever (>38^{0}C), or a history of fever in the past 24 hours, should be isolated and any further assessment carried out by staff wearing appropriate personal protective

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equipment (PPE). Apart from fever, other symptoms of Ebola may include headache, sore throat, general malaise, diarrhoea, vomiting, bleeding and bruising.

Additional information that may assist with the subsequent risk assessment includes whether the individual has come into contact with a person known/suspected to have Ebola, cared for anyone with a severe illness or who has died of an unknown cause, attended any funerals, had any contact with dead bodies, visited any traditional or spiritual healers, or been admitted to hospital in the affected areas.

Guidance on the risk assessment and management of viral haemorrhagic fevers (including Ebola) was updated by the Advisory Committee on Dangerous Pathogens (ACDP) in August 2014 and is the principal source of guidance for clinicians risk assessing and managing suspected cases. This guidance is available from: https://www.gov.uk/government/publications/viral-haemorrhagic-fever-algorithm-and-guidance-on-management-of-patients

* Nigeria is currently different to other affected countries as transmission has been restricted to those who have had direct contact with cases imported from other affected areas. There is currently no evidence of widespread community transmission in Nigeria. In Senegal, only one imported case has been reported to date.

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Management in acute hospitals

Ebola should be suspected in individuals with a fever [>38°C], or history of fever in the previous 24 hours, who have visited an affected area within the past 21 days (or who have cared for or come into contact with body fluids or clinical specimens from a live or dead individual or animal known or strongly suspected to have Ebola virus disease).

Individuals should be **isolated in a side room straightaway**. They should not sit in the general waiting room before being assessed.

The ACDP risk algorithm should be reviewed and a **full history** should be taken by a clinician trained in the use of and wearing appropriate **PPE** (i.e. hand hygiene, gloves, plastic apron, fluid repellent surgical facemask and eye protection).
The history includes details of travel history, return date to the UK, presenting symptoms and any contact with persons known or suspected to have Ebola infection.

If the clinician is concerned about possible Ebola virus disease, then the case should be **discussed with an infection specialist** at their own/ other local trust (i.e. a consultant in microbiology, virology or an infectious diseases physician).
If the initial risk assessment indicates that there is a higher risk based on the patient's symptoms, then the additional control measures will need to be put in place.
Relevant diagnostic tests should not be delayed while awaiting the results of Ebola tests. These may include a malaria test, FBC, U&Es, LFTs, clotting screen, CRP, glucose and blood cultures.

If appropriate, the **infection specialist** will then contact the **Imported Fever Service** to discuss testing and further management issues. Further guidance is available at https://www.gov.uk/government/publications/viral-haemorrhagic-fever-algorithm-and-guidance-on-management-of-patients

The **local health protection team** should be contacted if a patient is being tested for Ebola or if there are additional public health issues to discuss. The contact details for the local health protection team can be found at: http://www.hpa.org.uk/AboutTheHPA/WhatTheAgencyDoes/LocalServices/PostcodeSearch