

MENINGITIS POLICY

		POLICY	
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	X		
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Lead Division/ Directorate	Clinical Support, Therapies & Outpatients		
Lead Specialty/ Service/ Department	Infection Prevention and Control Team		
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Not Applicable		Not Applicable	
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SUMMARY

- Meningitis is a notifiable disease; it is the responsibility of the medical team caring for the patient to notify United Kingdom Health Security Agency (UKHSA) promptly (see page 8)
- Inform the Infection Prevention and Control Team (IPCT) that you have a patient with a probable or confirmed diagnosis of meningitis
- If bacterial meningitis is suspected, isolate the patient for at least 24 hours after commencing appropriate antibiotic therapy - after starting antibiotic treatment for meningococcal infection, the carriage rate decreases rapidly such that meningococci are undetectable by nasopharyngeal swabbing after 24 hours on treatment
- Apply respiratory precautions during the 24 hours that the patient is treated (i.e. surgical mask and eye protection if there is a risk of droplet splashes)
- When undertaking airway management such as endo-bronchial intubation or suctioning on patients with suspected or confirmed invasive meningococcal disease, staff within 1 metre of the patient must wear an FFP3 respirator, eye protection, and an apron and gloves, as these are aerosol generating procedures
- Staff may require chemoprophylaxis if they are splashed with respiratory droplets, are involved in airway management including intubation without wearing PPE, or if they perform mouth to mouth resuscitation on such a patient
- The decision to administer chemoprophylaxis to staff will be made by the Occupational Health Team and the Consultant Microbiologist/Infection Prevention and Control Doctor. In the general medical and nursing care of such patients, healthcare staff are at low risk and do not require prophylactic antibiotics. If the decision is made that a staff member requires chemoprophylaxis, they will be signposted to the most appropriate route to obtain this by Occupational Health, e.g., GP or Trust Doctor
- Clinical waste bags and linen bags must be secured within the isolation room
- Visiting should be restricted to close family members/designated guardians. Staff must seek advice from the IPCT or on the on-call Consultant Microbiologist regarding the appropriate precautions, as these may vary depending on the ward, patient and visitor

1.0 INTRODUCTION

Meningitis is the inflammation of the meninges. Although vaccines are available against the most common types of meningitis i.e. Meningococcal Group C (Men C), pneumococcal, Haemophilus influenzae b (Hib), there are other equally severe forms of the disease that are not vaccine preventable. Therefore being able to recognise meningitis symptoms and understanding the infection prevention and control and public health precautions is vital (Meningitis Research Foundation 2013).

2.0 POLICY STATEMENT

The purpose/ aim of this policy is to provide guidance on the infection prevention and control measures required to minimise the risk of transmission of infection whilst caring for patients with probable or confirmed meningitis.

This policy applies to:

Staff group(s)

- all clinical staff
- all non-clinical staff when they enter a clinical environment

Clinical area(s)

- all clinical environments

Patient group(s)

- all patient groups (adult, maternity, paediatric)

Exclusions

- none

3.0 DEFINITIONS/ ABBREVIATIONS

3.1 Definition

Trust	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employers of the Trust including those managed by a third party on behalf of the Trust
IPC	Infection prevention and control processes to prevent and reduce to an acceptable minimum the risk of the acquisition of an infection amongst patients, healthcare workers and any others in the healthcare setting
Meninges	Lining around the brain and spinal cord, acts as a barrier to stop infection reaching the central nervous system
Meningitis	Infection and inflammation of the lining of the brain
Septicaemia	Blood poisoning

3.2 Abbreviations

HCAI	Healthcare Associated Infection
HAI	Hospital Acquired Infections
IPCT	Infection Prevention and Control Team
DIPC	Director of Infection Prevention and Control

IPCD	Infection Prevention and Control Doctor
IPCN	Infection Prevention and Control Nurse
CCDC	Consultant in Communicable Disease Control
IPCC	Infection Prevention and Control Committee
OH	Occupational Health
UKHSA	United Kingdom Health Security Agency
PPE	Personal Protective Equipment

4.0 ROLES AND RESPONSIBILITIES

4.1 Trust Board

The Trust Board has overall responsibility for ensuring there are effective strategic, corporate and operational arrangements in place to maintain an effective infection prevention and control programme and that appropriate financial resources are in place to support that programme.

4.2 Chief Executive

The Chief Executive is ultimately responsible for ensuring that there are effective arrangements for infection prevention and control and that the control of hospital infection is addressed accordingly in divisions and departments. This responsibility is delegated to the Director of Infection Prevention and Control.

4.3 Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) has Trust wide responsibility for the development of strategies and policies for the management of infection prevention and control, and for the organisational adoption of the meningitis policy.

4.4 Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) will inform and support all staff in relation to the identification and management requirements of patients with suspected/known infection. The IPCT are also responsible for:

- Providing education to clinical staff on the early detection of possible infectious conditions
- Communicating up to date information relating to isolation issues
- Advising and co-ordinating the appropriate action to be taken to isolate patients

4.5 Microbiology Laboratory

The microbiology laboratory is responsible for conducting relevant investigations and if required sending samples to other laboratories for further microbiology investigations.

4.6 Consultant Microbiologist/Infection Prevention and Control Doctor

The Consultant Microbiologist/Infection Prevention and Control Doctor is responsible for providing advice regarding appropriate treatment for meningococcal infection.

4.7 Chief Operating Officer

Chief Operating Officer will ensure that the divisions implement the agreed processes for managing a transmissible disease.

4.8 General Managers/Divisional Directors of Nursing

They will ensure that the necessary management arrangements and structures are in place to support all employees to fulfil their obligations in their role of infection prevention and control practices.

4.9 Matrons

Matrons are responsible for ensuring that all staff accountable to them are aware of this policy and adhere to its statement. They will actively promote and support all current infection prevention and control measures.

4.10 Ward Sister/Charge Nurse/Departmental Leader

The ward sisters/charge nurses/departmental leaders will act as exemplary role models and are responsible and accountable for infection prevention and control within their sphere of responsibility. They will ensure that all staff are aware of all relevant infection prevention and control measures. They are also responsible for:

- Ensuring the IPCT are notified of any suspected cases of meningitis
- When required, completing staff contact list and forward to Occupational Health
- When required, completing a patient contact list and forward to IPCT
- Ensuring dissemination of this policy
- Ensuring compliance with this policy and ensuring patient safety is maintained
- Facilitating the delivery of education provided by the IPCT
- Ensuring staff in their area have the knowledge and skills to work safely
- Taking action when staff fail to follow the principles of this policy

4.11 Infection Prevention and Control Link Representatives

Infection Prevention and Control link representatives will disseminate all relevant infection prevention and control information to staff within their own work environment.

4.12 Clinical Team

Clinical teams are responsible for the prompt communication to the IPCT details of patients known or suspected of having meningitis, and for the clinical management of the patient and ensuring adherence to this policy. It is the responsibility of the clinician making a diagnosis of meningitis to inform Public Health England.

4.13 Occupational Health

Occupational Health (OH) will commence contact tracing if required, and will make a note in staff member's notes if they should require chemoprophylaxis.

Chemoprophylaxis is recommended only for those whose mouth or nose is directly exposed to droplets/secretions from the respiratory tract of a probable or confirmed case of meningococcal disease during acute illness, until 24 hours of systemic antibiotics has been completed. This type of exposure will only occur among staff who are working close to the face of the case without wearing a mask or other mechanical protection. In practice this implies a clear perception of facial contact with droplets/secretions and is unlikely to occur unless using suction during airway management, inserting an airway, intubating, or if the patient coughs in your face. General medical or nursing care of cases is not an indication for prophylaxis.

The Trust "Antibiotic guideline for the management of community –acquired meningitis and encephalitis" includes prophylactic regimens for both adults and children. See <http://sfhnet.notts.nhs.uk/content/showcontent.aspx?ContentId=58881>

Occupational Health has limited OH Doctor cover. In the absence of OH Doctor availability OH nursing staff will initially seek advice regarding the need for chemoprophylaxis from the Consultant Microbiologist/Public Health England. When chemoprophylaxis is indicated in the absence of OH Doctor availability to prescribe, staff will be advised to contact their GP or attend Primary Care 24.

4.14 All Staff

The onus for ensuring health and safety in the workplace is not placed entirely on the employer; the employee also has a duty to protect the health and safety, not only of themselves but also their fellow employees, patients and visitors. All staff are also responsible for ensuring that the correct lawful consent has been gained and documented prior to implementing care and treatment. If capacity is in doubt, a two-stage test should be undertaken. If the patient is found to lack capacity complete the best interests' checklist and plan care in their best interests. Please see the trust's "Consent Policy" and "Mental Capacity Act Policy" for further information.

4.15 Medirest

Medirest, as the Trust cleaning contractors are responsible for:

- Ensuring that the room/bed space used for patients with known or suspected infections are cleaned daily
- Ensuring that the room/bed space used for patients with known or suspected infections are cleaned according to the 'RAG: Isolation Level Clean' specifications following the discharge/transfer of the patient
- Ensuring that all healthcare cleaners have the knowledge and skills required to undertake daily and isolation cleaning of single rooms used for isolation purposes
- Ensuring that all Medirest staff comply with this policy

5.0 APPROVAL

Following appropriate consultation, this policy has been approved by the Trust's Infection Prevention and Control Committee.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

6.1 Meningitis

Meningitis is the inflammation of the meninges, which is the lining of the brain and spinal cord that acts as a barrier to stop infection. Meningitis remains a common and potentially fatal condition, therefore optimal management requires early diagnosis and initiation of appropriate treatment.

Transmission mode:	Bacterial: respiratory droplets Viral: transmission mode depends on causative virus but most commonly enteric (however meningitis can be caused by respiratory viruses eg measles– contact IPCT/ microbiologist for advice if such a cause is suspected)
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Acute meningitis is nearly always viral in aetiology and is usually mild and self-limiting; although bacterial is less common it is much more severe and life-threatening. Occasionally meningitis is due to fungal and protozoal infections.

- **Fungal meningitis:** may be caused by several types of fungus; generally only people with deficiencies of the immune system or premature babies are affected
- **Bacterial meningitis:** is more serious and can be caused by a range of different bacteria; at least 50 types of bacteria have been identified. Meningococcal bacteria are one of these (*Neisseria meningitidis*), which can cause meningitis or septicaemia or a combination of both; together they are referred to as meningococcal disease. Meningococcal infection is the most common cause of bacterial meningitis in the UK-

there are approximately 750 cases of meningococcal disease per year in the UK, with more due to meningococcal group B than group C.

- Other forms of bacterial meningitis include:
 - Pneumococcal – *Streptococcus pneumoniae*
 - Haemophilus influenzae b (Hib)
 - Group B *Streptococcal* (GBS)
 - *E. coli*
 - Listeria
- **Viral meningitis:** can be caused by several different viruses, most commonly enteroviruses. Viral meningitis is most common in young adults and can be very unpleasant but it is rarely life threatening and most people quickly make a full recovery.

6.2 Notification

All cases of meningitis (if possible, probable or confirmed), including meningococcal septicaemia and viral meningitis are notifiable. It is the responsibility of the clinician making or suspecting the diagnosis to notify the proper officer verbally and by completing the notifiable disease form. This process triggers a contact tracing procedure and provides surveillance data to detect outbreaks and monitor epidemiological trends. Failing to notify could lead to the inadequate tracing and treating of close contacts. The IPCT must be informed (during working hours or on the next working day), as well as the Consultant Microbiologist.

- Notify UKHSA by phone: telephone number 0344 225 4524.
 This is the responsibility of a member of the **Medical Team** looking after the patient. Please note that meningococcal meningitis and meningococcal septicaemia are both statutorily notifiable. Please complete meningococcal contact tracing form.
- If transferred to another hospital, ward, or department, relevant staff **must** be told about the diagnosis by the nurse-in-charge or deputy. This principle **must** also be applied if an infected deceased person is transported anywhere; in this case, a cadaver bag is not normally necessary.

6.3 Infection control precautions

For bacterial meningitis, the mode of transmission is via the nasopharynx either from patients with disease or asymptomatic carriers. Transmission occurs by close facial contact with respiratory droplets or secretions.

- Inform the IPCT that you have a patient with a probable/confirmed diagnosis of meningitis.
- Source isolation under contact precautions, (i.e. single room, gloves and aprons; negative pressure NOT required)
 - if bacterial meningitis is suspected, isolate the patient for at least 24 hours after commencing antibiotic therapy, or until meningococcal disease is excluded or thought unlikely (British Infection Society 2016). After starting antibiotic treatment, carriage rates decrease rapidly so that meningococci are undetectable by nasopharyngeal swabbing after 24 hours on treatment.
 - if viral meningitis is suspected isolate and implement enteric precautions for 7 days after the onset of illness unless a non-enteroviral diagnosis can be made. This is due to the possibility of the virus being shed in the faeces.

- For bacterial meningitis, during the isolation period gloves and aprons are required for routine care and surgical face masks and eye protection are recommended when there is a risk of secretions splashing into the face and eyes until the first 24 hours of systemic antibiotic treatment is completed (Pratt 2004). **It is not necessary to wear face protection for routine care.**
- FFP3 masks are recommended when carrying out airway management procedures i.e. intubation, endotracheal suction, as these are considered to be aerosol generating procedures.
- Clinical waste should be disposed of, and linen managed, in line with Trust policy.
- Routine cleaning of the side room is adequate as the microorganisms responsible for meningitis die rapidly in the environment.
- Visiting should be restricted to close family members/designated guardians; staff must seek advice from the IPCT or the on-call Consultant Microbiologist regarding the appropriate precautions, as these may vary depending on the ward, patient and visitor.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Audits to monitor compliance with hand hygiene and standard infection prevention and control precautions will be carried out by the IPCT and the IPC Links as part of the annual audit programme. Clinical practice and environmental standards will be monitored on identification of a case of meningitis as part of the IPCN risk assessment.

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Use of personal protective equipment	IPCT	Audit	Monthly	IPCC
Hand hygiene compliance	IPCT	Audit	Monthly	IPCC

8.0 TRAINING AND IMPLEMENTATION

There is no specific training requirement in relation to this policy. If required, further assistance can be sought from senior colleagues and/or the Infection Prevention and Control Team. Resources can be accessed from the Meningitis Research Foundation for patients and staff

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at [Appendix A](#)
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- UK Health Security Agency (UKHSA) 2024. *Guidance for public health management of meningococcal disease in the UK*
www.gov.uk/government/publications/meningococcal-disease-guidance-on-public-health-management Accessed May 2025
- Department of Health. 2022. *Guidance; meningococcal: the green book chapter 22*.
<https://www.gov.uk/government/publications/meningococcal-the-green-book-chapter-22>
- Accessed May 2025
- NICE., 2024. NG 204 [Overview | Meningitis \(bacterial\) and meningococcal disease: recognition, diagnosis and management | Guidance | NICE](#)
- British Infection Association 2016. The UK joint specialist societies guideline on the diagnosis and management of acute meningitis and meningococcal sepsis in immunocompetent adults [https://www.journalofinfection.com/article/S0163-4453\(16\)00024-4/pdf](https://www.journalofinfection.com/article/S0163-4453(16)00024-4/pdf) Accessed November 2019

Related SFHFT Documents:

- other relevant infection, prevention and control policies/ guidelines as applicable.

11.0 KEYWORDS

Meningococcal, meninges, prevention, management, diagnosis, treatment, infection, control, notifiable, disease

12.0 APPENDICES

[Appendix A](#) – Equality Impact Assessment

Appendix A **EQUALITY IMPACT ASSESSMENT FORM (EQIA)**

Equality Impact Assessment (EIA) Form (Please complete all sections)

EIA Form Stage One:

Name EIA Assessor: Sally Palmer		Date of EIA completion: 21/05/2025	
Department: Infection Prevention and Control		Division: CSTO	
Name of service/policy/procedure being reviewed or created: Meningitis Policy			
Name of person responsible for service/policy/procedure: Sally Palmer			
Brief summary of policy, procedure or service being assessed: This policy covers the management of patients with meningitis.			
Please state who this policy will affect: Patients or Service Users, Staff, Stakeholder organisations, (Please delete as appropriate)			
Protected Characteristic	Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)	Provide a brief summary of what data or supporting information was considered to complete this assessment? This is a review of a current policy and we have consulted with people who are already using the policy to obtain this information. We also use our networks of link professionals.	
Race and Ethnicity	No		
Sex	No		
Age	No		
Religion and Belief	No		
Disability	No		
Sexuality	No		
Pregnancy and Maternity	No		
Gender Reassignment	No		

Marriage and Civil Partnership	No	
Socio-Economic Factors (i.e. living in a poorer neighbour hood / social deprivation)	No	

If you have answered ‘yes’ to any of the above, please complete Stage 2 of the EIA on Page 3 and 4.

What consultation with protected characteristic groups including patient groups have you carried out?

With all members of the Infection Prevention and Control Committee which includes representatives from all Divisions, Occupational Health, Medirest, Health & Safety, Skanska, UKHSA and ICB representatives.

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? No

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)

Positive			Negative			
High	Medium	Low	Nil	Low	Medium	High

If you identified positive impact, please outline the details here:

EIA Form Stage Two:

Protected Characterist Signature: <i>S Palmer</i> *I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form*	Examples of at the impact or Service/Clinical Guideline will be on the protected characteristic group.	What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening.	Please outline any further actions to be taken to address and mitigate or remove any in barriers that have been identified.
Date:			
Race and			
Ethnicity			
Gender			
Age			
Religion			
Disability			
Sexuality			
Pregnancy and			
Maternity			
Gender			
Reassignment			
Marriage and			
Civil Partnership			
Socio-Economic			
Factors (i.e.			
living in a poorer			
neighbour hood			
/ social			
deprivation)			
Please send the complete EIA form to the People EDI Team for review. Please send the form to: sfh-tr.edisupport@nhs.net			