

**Smallpox Emergency Policy:  
Following identification of a suspected, probable or  
possible case within the Trust**

**Effective date:** June 2009

**Review:** June 2012

## 1. Introduction

### 1.1 Clinical Features

#### 1.1.1 Clinical Case Definition

Illness with acute onset of fever  $>38^{\circ}\text{C}$ , which is persistent, followed by a rash without other apparent cause characterised by vesicles or firm papules at the same stage of development and with a predominantly centrifugal distribution .N.B. Atypical presentations (haemorrhagic or malignant) and modified smallpox must also be considered.

#### Typical Presentation of Smallpox

See clinical pictures and Department of Health guidelines for smallpox response and management in the post-eradication era available via the following website:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationPolicyAndGuidance/DH\\_4070830](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationPolicyAndGuidance/DH_4070830)

#### Exposure

- 7-17 days (usually 10-16 days) later develop sudden onset high fever, prostration, back and headache
- 1-3 days later develop macular rash that becomes popular
- 1-4 days after this develop vesicular rash

#### 1.1.3 Case Classification

**Suspected:** a case of fever and rash consistent with the clinical case definition (see section 1.1.1), without laboratory confirmation or an epidemiological link to other cases. Initial cases of smallpox, or unrelated cases in a new geographical area, are likely to present as suspected cases.

**Probable:** a case of fever and rash consistent with the clinical case definition (see section 1.1.1), plus:

- For initial cases of smallpox or unrelated cases in a new geographical area – EM identification of orthopox virus or a case with strongly suspicious clinical features and no other diagnosis
- During an outbreak – an epidemiological link to a confirmed case

**Confirmed:** a case of fever and rash consistent with the clinical case definition (see section 1.1.1), plus

- For initial cases of smallpox or unrelated cases in a new geographical area – laboratory confirmation by PCR or viral isolation.
- During an outbreak – and epidemiological link to a confirmed case and EM identification of orthopox virus or a case with strongly suspicious clinical features and no other diagnosis.

**Possible:** acute onset of fever but no rash in a person with an epidemiological link to a confirmed case. The fever may be accompanied by prodromal symptoms such as prostration, severe headache or backache, rigors and generalised maculopapular rash. Control of an outbreak will depend on the early identification and management of possible cases.

## 1.2 Infectious Period

From 24 hours before onset of fever, until last crusts or scabs have separated

## 1.3 Contacts

### 1.3.1 Primary Contacts

Person who has had contact with a confirmed case of smallpox during the infectious period, or with contaminated fomites (articles). Divided into Category A and Category B contacts.

#### **Category A**

People likely to have been exposed to infection through large droplets or contaminated fomites. They include unvaccinated: household contacts, face-to-face contacts (within 2 meters) and those having fomite contact (ie direct contact with clothing or articles that have recently been used by infectious cases of smallpox).

Other persons thought to have shared a common exposure with cases of smallpox, including the initial release of the virus (i.e., possible co-primary cases) should be managed as Category A contacts.

#### **Category B**

People who have a lower chance of having been exposed to infection via aerosol. They include all unvaccinated persons who have shared rooms or other enclosed spaces with infectious cases of smallpox and who do not fall into the groups of household, face-to-face or fomite contacts above.

Contacts may be symptomatic or asymptomatic. Symptomatic contacts are people who fit the contact definition, and in addition have prodromal

symptoms that may indicate early smallpox infection. These are prolonged high fever (above 38oC) and/or constitutional symptoms such as prostration, severe headache or backache, rigors and generalised maculopapular rash.

### 1.3.2 Secondary Contacts

People with ongoing household contact with category A primary contacts during the formal monitoring period

### 1.3.3 Restriction /monitoring period for contacts

From 9 days after first exposure until 16 days after last exposure to infectious case or contaminated fomites

## 2. Identification of a patient with a suspected, probable or possible smallpox

### 2.1 Notification

- Smallpox Diagnostic Expert (SDE) [Infectious Diseases on-call rota, via switchboard]
- Hospital Infection Prevention and Control Team (IPCT)
- Trust Administrator
- Major Incident Trust Leads i.e., Duty A&E Consultant and Duty Physician RVI
- Medical Director or Deputy
- Ambulance Control

### 2.2 Isolation

2.2.1 Immediately isolate patient in side-room, preferably one with an antechamber, within ward or department. N.B. When deciding where the patient should be isolated pending assessment by the SDE, foremost consideration should be given to minimising further potential exposure of patients, staff and visitors. Urgent advice may be sought from the IPCT. See [Hospital Isolation Policy](#).

2.2.2 If the index case requires medical attention, this should be provided by medical staff who have already been exposed. Urgent advice may be sought from the IPCT, see [Hospital Isolation Policy](#).

2.2.2 Access to the patient should be restricted pending assessment by the SDE

2.2.4 If possible, relevant hospital air conditioning systems should be turned off immediately and should remain off until smallpox has been excluded or decontamination completed (see sections 3.1, 3.28 and [Hospital Isolation Policy](#)). The IPCT will liaise with Estates and advise on the management of

the ventilation system depending on the exact location of the patient and the local ventilation plans. A shut down of the ventilation supplying certain areas of the hospital is intended to help limit potential exposure of other patients, staff and visitors.

- 2.2.5 Potentially contaminated fomites (articles) should be double-bagged in heavy duty clinical waste bags and identified as infected waste. Extreme care must be taken to ensure that contaminated fomites do not leave the ward or department. See [Hospital Isolation Policy](#).

## 2.3 Ambulance

The ambulance used to transfer the patient to the ward or unit should be identified and taken out of service pending further information.

## 2.4 Contacts

### 2.4.1 General Principles

- 2.4.1.1 Contact details must be taken from all patients, staff and visitors before leaving the ward or department, so that they can be traced and vaccinated if required. See Appendix A.
- 2.4.1.2 Details should include: name, date of birth, address, hospital number if applicable, contact telephone number(s), date, duration, type and proximity of exposure to the potential index case. See Appendix A for model smallpox contacts form.
- 2.4.1.3 See below for further details relating to contact identification (sections 2.4.2 to 2.4.4 and 3.2.4) and vaccination (sections 3.2.5 to 3.2.7).
- 2.4.1.4 Contacts should be given the appropriate information leaflet(s) (see Appendix B)

### 2.4.2 Visitors

- 2.4.2.1 Accompanying relatives and friends should be encouraged to wait for advice from the SDE. This is to expedite early health screening and vaccination if required. Those wishing to leave the patient's isolation room before this stage must first provide contact details so that they can be followed up and offered vaccination. Extreme care should be taken to avoid removing potentially contaminated fomites (articles) from the isolation room. This may necessitate a change of clothing. See [Hospital Isolation Policy](#) and Appendix A for model smallpox contact details form.

- 2.4.2.2 Those that remain should be offered refreshments as appropriate and communications with relatives or friends arranged, see [Hospital Isolation Policy](#).
- 2.4.2.3 Other visitors who have had close contact with a suspected case (face-to-face or direct contact with body fluids) should be advised to wait in a separate room. As in 2.4.2.1 should they wish to leave before the advice of the SDE can be obtained, then they must provide contact details and extreme care should be taken to ensure that they do not remove potentially infected fomites (articles) from the area. See [Hospital Isolation Policy](#) and Appendix A for model smallpox contact details form.
- 2.4.2.4 Other visitors to the ward or department (i.e., not category A contacts) must be asked to leave after providing contact details. See Appendix A for model smallpox contact details form.

#### 2.4.3 Patients

- 2.4.3.1 Ambulant patients (in the A&E, Minor Injuries Unit and Walk In Centre setting) who have had close contact with a suspected case (face-to-face or direct contact with body fluids) should be advised to wait in a separate room. As in 2.4.2.1 should they wish to leave before the advice of the SDE can be obtained, then they must provide contact details and extreme care should be taken to ensure that they do not remove potentially infected fomites (articles) from the area. See [Hospital Isolation Policy](#) and Appendix A for model smallpox contact details form.
- 2.4.3.2 Inpatients who have had contact with the patient should be vaccinated and should remain on the ward or unit for 16 days after last exposure for monitoring, unless the conditions in section 3.2.6.1 are satisfied. Patient contacts in the A&E, Minor Injuries Unit and Walk In Centre setting who require hospital admission should be vaccinated and transferred to a dedicated ward for care and monitoring for a minimum of 16 days following last exposure. It may be possible for these patients to be discharged before the 16-day monitoring period is completed, if the conditions set out in section 3.2.6.1 are satisfied.

#### 2.4.4 Staff

- 2.4.4.1 Staff who have been directly involved in caring for the patient should remain in the ward or department. As in 2.4.2.1 if it is necessary for them to leave before the advice of the SDE can be

obtained, then they must first provide contact details. Extreme care must be taken to ensure that they do not remove potentially infected fomites (articles) from the area. See [Hospital Isolation Policy](#) and Appendix A for model smallpox contact details form.

- 2.4.4.2 Other staff may leave the ward or department as normal after leaving contact details. See Appendix A for model smallpox contact details form.

## 2.5 Restricted Access / Ward Closure

Additional potential contacts should be minimised by restricting access to the affected ward or unit:-

- 2.5.1 No further patients or visitors should be admitted to the ward or unit
- 2.5.2 Ambulance Control should be informed to redirect emergencies to other units
- 2.5.3 Access of staff should be restricted to those who have already been exposed during previous shifts
- 2.5.3 The Trust's Major Incident Lead personnel will decide whether cancellation of elective admissions, operations and procedures is required. Alternative emergency healthcare provision may need to be arranged.
- 2.5.5 The following additional restrictions apply to A & E , the Minor Injuries Unit, the Walk In Centre, RVI ward 41 and the Emergency Admissions Unit, FH (See also 2.4.3, 2.5.1, 2.5.2 and [Trust Major Incident Plan](#)):-
  - 2.5.5.1 Patients with minor ailments should be sent home or to alternative healthcare providers.
  - 2.5.5.2 Those with more serious disorders should be transferred to a ward for cohort nursing
  - 2.5.5.3 The department should be cleared of all unnecessary people
  - 2.5.5.4 The department must remain closed and traffic through it strictly controlled until smallpox has been excluded or decontamination has been carried out (See sections 3.1 and 3.2.8)

## 3. Actions following Assessment by the SDE

Smallpox Excluded

- 3.1.1 Stand down all action
- 3.1.2 Inform all those notified (see 2.1)
- 3.1.3 Refer patient to appropriate local services
- 3.2 Suspected Case of Smallpox
  - 3.2.1 See section 2
  - 3.2.2 The SDE will contact the Regional Smallpox Management and Response Team (SMART). After they have arrived, they will assume overall responsibility for the further management of the patient's care and outbreak control, working closely with Trust personnel.
  - 3.2.3 Index Case

The SDE/SMART will arrange for diagnostic testing and the transfer of the patient to appropriate isolation facilities
  - 3.2.4 Contact Tracing

Initiate identification and tracing of further contacts including patients, discharged patients, visitors, healthcare workers and others (see sections 1.3 and 2.4). This will be the responsibility of the Ward Manager and the Matron in association with the IPCT. Strenuous attempts should be made to compile an exhaustive list of contacts. To facilitate this, careful consideration must be given to the individual case including the following factors: details of the index patient's movements from 24 hours before the onset of fever, including ward transfers, investigations, procedures and visits to other departments; all visitors and healthcare workers coming into contact with the index case; other patients, visitors and staff on the ward or unit during the infectious period of the index case. Discharged patients and out-patients visiting the ward or unit during the risk period must also be considered. It is recognised that it may be difficult to be certain that all potential contacts have been identified, but every effort should be made including inspection of ward or departmental records of patients and visitors, and liaison with colleagues working in the area. In the long term, it is intended that contact tracing would be facilitated by the Electronic Patient Record system. If appropriate, the Regional Smallpox Diagnosis and Response Group (RSDRG) or Regional or National Smallpox Outbreak Control Centre (SOCC) may initiate other methods of contact tracing such as a media campaigns and telephone information lines.

Depending upon the advice of the RSDRG and SOCC and according to the individual circumstances, which include the extent of the patient's movements, duration of exposure and area(s) involved, consideration may be given to the vaccination of large numbers of staff, patients and visitors. This may even involve vaccination of the entire staff and patient population present in the building with an infectious case.

### 3.2.5 Vaccination of Contacts

(See also sections 1.3, 2.4 and 3.2.4)

3.2.5.1 Prioritise those with the closest and most prolonged contact

3.2.5.2 Aim to vaccinate as quickly as possible, within three days of exposure

3.2.5.3 Check for symptoms consistent with smallpox prior to vaccination, in order to identify contacts that are actually co-primary cases. This may be more difficult in hospital patients as the early signs of smallpox may be masked by underlying disease

3.2.5.4 Consider potential exclusion criteria before vaccination. An individual risk assessment should be made, according to the degree of exposure and the type of relative contraindication. The views of the patient should be taken into account and the advice of SMART sought. However, in general, it is considered that there are no contraindications for vaccination of Category A contacts, who should therefore be vaccinated, while Category B contacts should be vaccinated unless the risks of the relative contraindications are deemed to outweigh the potential risks of disease. Secondary contacts should be vaccinated if possible. If this is contraindicated, then they should avoid contact with the primary contact until the primary contact's vaccination site is completely healed.

3.2.5.5 People who have been vaccinated within the previous six months do not require revaccination

3.2.5.6 The management of vaccinated staff who may have had close contact with a case should be guided as follows:

- If vaccinated within the previous 6 months – no action required
- If vaccinated > 6 months but < 3 years before exposure – revaccinate
- If never vaccinated or vaccinated > 3 years before exposure –vaccinate. These staff will require formal monitoring and

will not be able to work during the restriction period (See sections 3.2.6.2 and 3.2.6.3)

3.2.5.7 Ideally, the vaccinations will be carried out by trained, immunised vaccinators. The Occupational Health Service will aim to act as a resource initially. Depending on the nature of the incident, it may be necessary to recruit additional staff to perform vaccinations.

3.2.5.7 Vaccination of visitors who have left the Trust premises and discharged patients will be the responsibility of the SMART/RSOCC and will probably be carried out at a local Smallpox Vaccination Centre. It is important that there are good communications between the different agencies to ensure that such contacts are not lost to follow up.

3.2.5.9 Vaccination of secondary contacts must also be addressed. These will include staff caring for Category A contacts during the monitoring period (see sections 1 and 3.2.6.1), and the close contacts and family members of staff, visitors and patients who are identified as Category A contacts. This may be carried out either in the Trust, or in a Smallpox Vaccination Centre in the community as appropriate (See Sections 3.2.5.7 and 3.2.5.8).

3.2.5.10 Under certain circumstances, consideration may be given to the use of Vaccinia Immunoglobulin (VIG) or cidofovir in individual cases.

3.2.5.11 Vaccinated contacts should be advised about the procedure and follow-up and given the appropriate information leaflet(s). See Appendix B

3.2.5.12 Vaccination programmes may need to be extended, according to national advice or if secondary cases occur.

### 3.2.6 Post-Vaccination

3.2.6.1 Vaccinated inpatient contacts must be cohort nursed using standard isolation precautions for 16 days after last exposure to the index case, see [Hospital Isolation Policy](#). If they are medically fit, then it may be possible for them to be discharged before the 16 day period has elapsed. In order for this to be considered, such patients must be afebrile and have no symptoms suggestive of smallpox. In the case of Category A contacts, then all their household contacts should have been vaccinated at least 3 days prior to the planned discharge date, and the vaccination 'take' established. Early discharge of such patients should be

agreed with the SMART or SOCC and should be by ambulance, manned by vaccinated ambulance staff.

3.2.6.2 Category A contacts should be monitored following vaccination and asked to report their temperatures on a daily basis to the Smallpox Contacts telephone number (this will be provided by the Regional SOCC). Healthcare workers, previous visitors and discharged patients will be advised how to do these themselves, while hospital inpatients will be assessed by the staff caring for them. Evidence of pyrexia (temperature must be measured at least daily), constitutional symptoms or other symptoms consistent with smallpox from 9 days after the first exposure, to 16 days after their last exposure (the monitoring or restriction period) must be notified immediately by telephoning the Smallpox Contact telephone number (this will be provided by the Regional SOCC).

3.2.6.3 During this restriction period Category A contacts will be advised to stay away from work or school, to avoid contact with unvaccinated persons, stay away from crowded areas/gatherings and not to travel outside of the local area.

3.2.6.4 Category B contacts do not require formal monitoring but should be advised to contact the Smallpox Contact telephone number (this will be provided by the Regional SOCC) if they develop fever or other constitutional symptoms during the 16 days following their last exposure to infection. They must not travel abroad until they have been free of symptoms during this same 16 day period and until their vaccination site has completely healed.

3.2.6.5 Follow-up checks to ascertain the efficacy of the immunisation (assess the 'take') will be arranged and a register will be kept of vaccinees in accordance with DH guidelines.

### 3.2.7 Isolation of Contacts

Inpatient contacts must be cohort nursed under standard isolation conditions. See section 3.2.6.1 and Trust Isolation Policy. Visits to other wards and departments should only be undertaken after a careful individual risk assessment carried out between the consultant in charge of the patient (or their deputy) and a member of the IPCT or Infectious Diseases Team. Access to this unit should be restricted to the minimum number of essential personnel until all inpatient contacts have been free from disease for 16 days after their last exposure to infection. Unless already vaccinated, these staff, and any visitors should be vaccinated as secondary contacts.

### 3.2.8 Decontamination

- 3.2.8.1 Thorough decontamination of the isolation room and all other areas exposed to an infectious case of smallpox, contaminated fomites (articles) or patient contacts of an infectious smallpox patient must be carried out in accordance with [Hospital Isolation Policy](#).
- 3.2.8.2 Once the A&E, Minor Injuries Unit, Walk In Centre, RVI ward 43 and the Emergency Admissions Unit, FH have been evacuated these units, and any other units that have been emptied following exposure to infectious smallpox cases, should be sealed until they have been decontaminated.
- 3.2.8.3 Other units should be decontaminated once the index case and all monitored contacts have left (see sections 1, 3.2.6.1 and 3.2.6.2).
- 3.2.8.4 This may necessitate closure of large areas of the Trust for prolonged periods.
- 3.2.8.5 Alternative facilities for the provision of healthcare may be required.
- 3.2.8.6 See [Hospital Isolation Policy](#) for decontamination procedures.
- 3.2.8.7 Additional advice may be sought from the SMART and the ICT.

### 3.2.9 Major Incident and Major Outbreak Plans

These will be brought into action in the event of a suspected, probable, confirmed or possible case of smallpox. See [Trust Major Incident Plan and Policy](#) for the [Investigation and Control of Major Outbreaks of Infection](#).

### 3.2.10 Public Relations

All communications with the media should be coordinated, via the Chief Executive's Office, with the Regional or National Smallpox Outbreak Co-ordination Centres (SOCC)

## 4 Monitoring

Compliance with this Policy will be monitored by the Infection Prevention and Control Team in conjunction with the Infectious Disease Consultant, Smallpox Diagnostic Expert and the Regional Smallpox Management and Response Team who will inform the Health Protection Agency of any cases.

## 5 References

Department of Health guidelines for smallpox response and management in the post-eradication era (version 2) Dec 2003

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4070830](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4070830)

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**APPENDIX A****Contact Monitoring Form**

To be drafted by the RSOCC. Until this has been produced, use the following, taken from the Guidelines for smallpox response and management in the post-eradication era Version 2 (Dec 2003)

<b>Contact reference number:</b>		
Case reference number (or reference number of primary contact if secondary contact):		
Possible case:	Probable case:	Confirmed case:

<b>Contact's details</b>		
Name:		
Address:		
Postcode:		
Telephone:		
DoB:	Age:	Gender:
Relevant medical history:		

Type of contact (indicate and specify dates and location)
Category A (indicate if household, face-to-face, fomite or shared exposure with case):
Category B:
Secondary:

<b>Status and management of contact at identification</b>
Symptomatic (S) /asymptomatic (A):
Date of last contact with case (d):
Any active rashes / skin conditions or other medical complaints:
Vaccination done (Y/N; date):
Vaccination site assessed ('take'/'No-take'; date):
Monitoring arranged (formal/informal/none):

<b>Formal monitoring of category A contacts</b>							
Day	Date	Contact phoned	Contact visited	Temp.	Other symptoms	Overall status (S/A)	Signed (print name)
d+1							
d+2							
d+3							
d+4							
d+5							
d+6							
d+7							
d+8							
d+9							
d+10							
d+11							
d+12							
d+13							
d+14							
d+15							
d+16							

**Information Leaflets****Information for smallpox contacts****What is smallpox?**

Smallpox is a viral infection caused by the variola virus. It was previously declared eradicated in 1980. It now appears that further cases have emerged, which suggests that the virus has been released deliberately.

**What are the symptoms?**

Symptoms tend to begin suddenly with high fever, tiredness and an aching head and back. Patients are very unwell and usually bedridden. A distinctive rash then develops: fluid filled lumps appear all over the body, particularly on the face, arms and legs, and also in the mouth and throat. After a couple of weeks, these form scabs, which eventually fall away after 3 - 4 weeks. When smallpox occurs in people who have no immunity it is a serious illness, and is often fatal.

**How do you catch smallpox?**

Smallpox is spread by inhaling virus particles breathed out by infectious patients or by direct contact with virus particles on their clothes and belongings. Patients do not become infectious until they are unwell.

It usually requires long periods in close contact with infectious patients to catch smallpox. Contacts of smallpox patients can be divided into two categories:

Category A (highest risk of infection): have spent substantial periods of time in very close contact with infectious patients or their belongings.

Category B (lower risk of infection): have spent shorter periods at a greater distance in contact with infectious patients.

**How long does it take for the illness to develop?**

It usually takes 10 to 16 days for the fever to develop, and the rash appears about 4 to 7 days later.

**Can smallpox be prevented?**

There is an effective vaccine against smallpox, worldwide use of which led to the eradication of the virus. The vaccine contains vaccinia, a virus related to variola. Successful vaccination before contact with the virus provides almost complete protection from infection. Vaccination in the early days after contact is not guaranteed to prevent infection but any illness is likely to be much less severe. People who were vaccinated years ago may no longer be protected, and should be re-vaccinated if they have close contact with an infectious patient. The vaccine has a number of side effects, which is why it has not been used routinely since the virus was eradicated.

## Category A Contacts

### Why do I need to take action?

You have been in contact with a patient who appears to have infectious smallpox. There are therefore a number of actions that need to be taken immediately to protect you from infection. If the patient turns out not to have smallpox, you will be advised.

### Should I be vaccinated against smallpox?

You will be offered vaccination at a designated centre. You will be assessed at the centre 3 days after vaccination to see whether it has been successful. Vaccination is most effective if given within 3 days of exposure. That is why it is not always possible to wait for the patient's diagnosis to be confirmed before vaccinating contacts.

### Are there any special precautions for vaccination?

There are some medical conditions that put people at a greater risk of side effects from vaccination. These will be discussed with you. It is always necessary to weigh up the risk from side effects against the risk from disease.

### What else do I need to do?

You should monitor yourself carefully for the next 16 days for symptoms of smallpox so that infection can be detected early and you can then be transferred to a specialist centre for observation or treatment. You will be given a thermometer, temperature chart and instructions on how to use them.

### How do I monitor myself for symptoms?

You should take your temperature daily, at the same time each day, with the thermometer provided. You should record your daily temperature measurement on the chart that you have been given, and then report it to the **Smallpox Contacts Telephone Number**, which is given below. If your temperature rises above 38 °C at any time (the red line on the chart), or if you feel unwell, you should immediately call the Smallpox Contacts Telephone Number.

### Do I need to restrict my activities in any way?

If you have a temperature above 38 °C or feel unwell you should stay at home.

During the **restriction period** indicated below, you should:

- Not attend your normal place of work.
- Avoid contact with unvaccinated individuals.
- Remain within your local area.

Outside the restriction period you may continue your normal activities, although you should not travel abroad and should avoid travelling long distances within the UK for the next 16 days.

Dates of restriction period:

This is 9 days after first exposure until 16 days after last exposure to an infectious case

Smallpox Contacts Telephone Number:

This number is staffed 24 hours a day

## **Advice for Category B Contacts**

### **Why do I need to take action?**

You have been in contact with a patient who appears to have infectious smallpox. However, you have not been in close contact with the patient and your risk of infection is low. However, as a precaution, there are a number of actions that need to be taken to protect you from infection. If the patient turns out not to have smallpox, you will be advised.

### **Should I be vaccinated against smallpox?**

You will be offered vaccination at a designated centre. You will be given instructions on how to check your vaccination has been effective – if you are concerned, you may return to the vaccination centre to have the site checked by a professional.

Vaccination is most effective if given within 3 days of exposure. That is why it is not always possible to wait for the patient's diagnosis to be confirmed before vaccinating contacts.

### **Are there any special precautions for vaccination?**

There are some medical conditions that put people at a greater risk of side effects from vaccination. These will be discussed with you. It is always necessary to weigh up the risk from side effects against the risk from disease.

### **What else do I need to do?**

Over the next 16 days, if you develop a high temperature (above 38 °C) or if you feel unwell, you should immediately call the smallpox hotline (telephone number given below). This is so that smallpox infection can be detected early and you can then be transferred to a specialist centre for observation or treatment.

### **Do I need to restrict my activities in any way?**

If you have high temperature or feel unwell you should stay at home. Otherwise, you may continue your normal activities, although you should not travel abroad for the next 16 days.

Smallpox Contacts Telephone Number:  
This number is staffed 24 hours a day

## **Advice for Secondary Contacts**

### **Why do I need to take action?**

You may be spending time with a person who has themselves had close contact with a patient who appears to have infectious smallpox. This person will be monitored for the development of symptoms of smallpox over the next 16 days. There are a number of actions that you need to take in case they develop symptoms. If the patient turns out not to have smallpox, you will be advised.

### **Should I be vaccinated against smallpox?**

You will be offered vaccination at a designated centre. You will be given instructions on how to check your vaccination has been effective – if you are concerned, you may return to the vaccination centre to have the site checked by a professional.

Vaccination is most effective if given within 3 days of exposure. That is why it is not always possible to wait for the patient's diagnosis to be confirmed before vaccinating contacts.

### **Are there any special precautions for vaccination?**

There are some medical conditions that put people at a greater risk of side effects from vaccination. These will be discussed with you. If you have any of these conditions, it would be preferable to avoid vaccination, and avoid spending time with the contact of the smallpox patient for the next 16 days.

### **What else do I need to do?**

You do not need to take any special precautions, and need take no further action unless the contact of the smallpox patient develops symptoms, in which case you will be advised further. Over the next 16 days, if you have any concerns you may call the smallpox advice line (telephone number given below) for help.

### **Do I need to restrict my activities in any way?**

No, you may carry on your normal activities, although if you have been vaccinated, you should not travel abroad for the next 16 days.

Smallpox Contacts Telephone Number:

This number is staffed 24 hours a day

## Information about smallpox vaccination

### What happens after vaccination?

Successful vaccination causes a mild infection: within 3 days a patch of small pimples appears, which develop into blisters by 6 to 7 days. The blisters become scabbed, and heal by 10 to 12 days after vaccination in most people to produce a scar. The spots are sometimes itchy or a little sore.

### What are the side effects of smallpox vaccination?

Vaccinia virus is mildly infectious. It can be transferred from the blisters to other parts of your skin, or to others, by contact. Vaccinia blisters can then occur in inconvenient or dangerous locations, such as the eye, mouth or private parts. You are therefore advised to avoid contact sports and to be careful when holding babies and young children. Many people also prefer to avoid sexual contact until the blisters have healed. The position of the blisters on the upper arm makes accidental contact less likely.

The vaccinia virus multiplies very well in skin affected by eczema: several new blisters can occur in different skin areas in people with eczema, even when care has been taken to avoid contact spread. This is usually more inconvenient than dangerous, but in severe eczema cases it can be a problem.

Rarely, vaccinia infection may spread in the blood or into the underlying tissues if the skin fails to heal. Inflammation of the brain may occur rarely.

### How do I take care of my vaccination?

- The site should be covered at all times with one of the dressings provided.
- When a dressing falls off, it should be placed and sealed inside one of the small yellow bags provided, **and taken back to the vaccination centre for disposal.**[DN: Discuss]
- Do not apply antiseptics, or wash with antiseptic soap or skin gels; these could kill the viruses and invalidate the vaccination.
- Do not go swimming, or soak the skin in the bath, until the skin has healed.
- Do not take part in contact sports, such as rugby, wrestling, boxing or self-defence, as this may spread the vaccinia virus on your own skin, or the skin of others.
- It is advisable to avoid sexual contact until the skin has healed.
- Unvaccinated household members with eczema or severely impaired immunity should avoid contact with a vaccinated person; it may be a good idea for them to stay with friends until the vaccinated person's skin has healed.

### It is sensible to consult the doctor or NHS Direct if:

- The vaccinated site becomes very painful (pain not controlled by paracetamol, ibuprofen or similar painkillers).
- The vaccinated skin becomes very swollen and red (over an area more than 5-6 cm. (2 - 2½ inches) in diameter).
- Swellings or blisters appear in skin areas away from the vaccination area.
- A high temperature develops (not controlled by paracetamol).
- Persistent drowsiness or confusion occurs.

**Advice for Concerned Individuals**

You have not had close contact with a smallpox patient, and therefore you do not have a significant risk of infection.

**Should I be vaccinated against smallpox?**

You do not require vaccination. Smallpox vaccine can have unpleasant and sometimes fatal side effects and therefore it is not normally recommended for people who are not at significant risk of infection.

**What else do I need to do?**

You do not need to take any special precautions. Over the next 16 days, if you feel unwell or have any concerns you may call the smallpox advice line (telephone number given below) for help.

**Do I need to restrict my activities in any way?**

No, you may carry on your normal activities.

Smallpox Contacts Telephone Number:

This number is staffed 24 hours a day

**THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST**  
**IMPACT ASSESSMENT – SCREENING FORM A**

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	<b>Management Plan for Severe Acute Respiratory Syndrome (SARS)</b>	Policy Author:	Dr S Waugh
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		There is no evidence that SARS affects any one group more than any other.
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4(a).	Is the impact of the policy/guidance likely to be negative? <i>(If “yes”, please answer sections 4(b) to 4(d)).</i>	No	
4(b).	If so can the impact be avoided?		
4(c).	What alternatives are there to achieving the policy/guidance without the impact?		
4(d)	Can we reduce the impact by taking different action?		

<b>Comments:</b>	<b>Action Plan due (or Not Applicable):</b>  <b>Not Applicable</b>
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Name and Designation of Person responsible for completion of this form: **Sheila Waugh. Consultant Virologist** ..... Date: **20/05/09** .....

Names & Designations of those involved in the impact assessment screening process: Infection Control Committee .....

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

*For advice on answering the above questions please contact Helen Lamont, Deputy Director Nursing & Patient Services, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) [steven.stoker@nuth.nhs.uk](mailto:steven.stoker@nuth.nhs.uk) together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.*