

Guidance for Risk Assessment and Infection Prevention and Control Measures for Measles in Healthcare Settings

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1. Introduction

1.1. Aim and key principles

This guidance is intended to support preparedness for and management of suspected or confirmed measles cases in healthcare settings. This document sets out key infection prevention and control (IPC) principles required to prevent transmission of measles in healthcare settings and provides resources to support patient screening, triage, management (appendices 1 and 2), and assessment of risk applying the hierarchy of controls (HoC) (appendix 3). Further information and resources can be found within the [National IPC Manual for England](#).

To support application of these principles organisations should ensure that:

- **immunisation status/records** are available for all staff (clinical and non-clinical) that may be exposed to a suspected or confirmed case of measles and staff are supported to ensure they are fully immunised. Satisfactory evidence of protection would include documentation of having received two doses of MMR or having had a positive antibody test for measles.
- **patient screening, triaging and testing protocols** are in place for all relevant care settings to ensure prompt isolation of suspected or confirmed cases of measles.
- **a respiratory season/Winter plan** is in place to ensure, for example, appropriate segregation of patient cases depending on the pathogen and management of increasing case numbers where they occur.
- **FFP3 respirator fit testing** is completed for staff who may be required to assess or clinically care for a suspected or confirmed measles case.
- **training in IPC** measures is provided to all staff, including: the correct use of PPE and the correct technique for donning and doffing (putting on and removing) PPE safely.
- **risk assessment(s)** is undertaken for staff who may be at high risk of infection and/or complications from infection with measles.

A glossary of terms associated with the NIPCM can be found here: [NHS England » National infection prevention and control](#)

Additional information can also be found within the [National measles guidelines - GOV.UK \(www.gov.uk\)](#) and the [Green Book of Immunisation - Chapter 21 Measles \(publishing.service.gov.uk\)](#). [Clinical diagnosis | Diagnosis | Measles | CKS | NICE](#)

Other resources:

[Think Measles Poster for A&E, Walk-in and GP Centres - Health Publications](#)

1.2. Measles virus (Rubeola)

Measles is a highly infectious, notifiable, vaccine-preventable, acute viral disease.

Initial symptoms include fever, conjunctivitis, cough, runny nose and sneezing. This may be followed by small grey/white spots, called Koplik's spots, on the inside of the mouth 1 to 2 days before rash onset which may last for 2 to 4 days (although these are often confused with other lesions in the mouth and so their suspected presence is an unreliable marker of measles).

Measles rash appears brown or red and blotchy on white skin but may be harder to detect on black or brown skin. The rash develops 2 to 4 days after the onset of fever, and spreads from the head to the body over the next 3 to 4 days.

Measles is transmitted via airborne respiratory particles, or direct contact with nasal/throat secretions of infected individuals.

It has an incubation period ranging between 7 to 18 days (mean 10 to 12 days) and individuals are typically infectious from 4 days before and up to 4 full days after rash onset.

The exclusion period from healthcare settings, workplaces and educational settings is for the duration of the infectious period which includes a full 4 days after onset of the rash.

Further information can be found at:

<https://www.nhs.uk/conditions/measles/>

[Measles: symptoms, diagnosis, complications and treatment \(factsheet\) - GOV.UK \(www.gov.uk\)](#)

1.3. At risk populations and settings

Anyone who has not had measles infection before or who has not had 2 doses of a measles containing vaccine will be susceptible to measles. Vulnerable groups include immunosuppressed individuals, infants under 1 year of age and pregnant women. These groups are more at risk of developing severe complications including pneumonia/bronchitis, convulsions, diarrhoea, meningitis/encephalitis, immune thrombocytopenic purpura (ITP) and late onset subacute sclerosing panencephalitis (SSPE).

At risk settings include settings where infectious patients may present for care including GP surgeries and emergency care, and settings where vulnerable patient groups may be exposed such as neonatal and paediatric units, antenatal clinics and maternity units, haematology, and oncology units.

This list is not exhaustive. If vulnerable individuals are exposed to a suspected or confirmed case of measles a risk assessment should be undertaken to urgently consider need for Post Exposure Prophylaxis. Refer to guidance: [National measles guidelines - GOV.UK \(www.gov.uk\)](https://www.gov.uk/guidance/national-measles-guidelines)

2. Infection Prevention and Control

2.1. Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs)

All staff should be familiar with standard infection control precautions (SICPs) and transmission based precautions (TBPs) as set out in Chapters 1 and 2 of the [National Infection Prevention and Control Manual \(NIPCM\) for England](#).

Staff should follow the principles of SICPs as set out in the National Infection Prevention and Control Manual (NICPM) for all patients whether infection is known to be present or not, to ensure the safety of those being cared for, staff and visitors in the care environment. TBPs are applied when SICPs alone may be insufficient to prevent cross transmission of specific infectious agents. TBPs are additional infection control precautions required when caring for patients with known/suspected infection.

This guidance includes specific guidance for patient placement, personal protective equipment (PPE), durations of precautions, advice for visitors, and occupational health (OH) when managing a case of suspected or confirmed measles. Refer to the [NIPCM](#) for guidance on all other elements of SICPs and TBP

2.2. Patient Placement

Patients must be promptly assessed for infection risk on arrival at the care area, e.g. inpatient/outpatient and should be continuously reviewed throughout their stay. The assessment should influence patient placement decisions in line with clinical/care need(s). If a patient is requested to attend secondary care, or requires transfer within a secondary care facility, their infectious status should be communicated to the receiving department.

2.2.1. Patient placement in primary care/outpatient settings

If remote consultation is not possible or if following telephone triage, a patient with suspected or confirmed measles is required/advised to attend primary care or outpatient settings, there should be separation in space and/or time between patients. Patients attending with suspected measles infection should be prioritised for assessment/treatment and isolated at the time of arrival e.g. directed to a side room. Appointments should be scheduled to reduce waiting times in reception areas (where necessary) and avoid cross-over of infectious and non-infectious patients.

If transfer from a primary care facility to hospital is required, ambulance services should be informed of the infectious status of the patient. Patient confidentiality must be maintained.

2.2.2. Patient placement in accident and emergency departments

Patient attending without prior notification should ideally be screened and triaged at reception/entrance.

Patients with suspected measles should not wait in communal areas/reception and should be placed in a segregated area, ideally a single room away from others, as soon as possible.

If patients with suspected measles arrive in A&E by ambulance, the ambulance service should pre-alert the receiving department to ensure they are admitted directly to a side room or segregated area.

This must not compromise or delay patient care.

2.2.3. Patient placement and cohorting in inpatient settings

In the hospital setting patients with suspected or confirmed measles should, whenever possible, be placed in a negative-pressure isolation room with en-suite facilities.

If negative-pressure isolation rooms are limited, infectious patients who have conditions that could increase the risk of transmission of infection to other patients, such as, an excessive cough should be prioritised for placement in a single room, ideally with ensuite facilities. Patients should be moved to a negative-pressure isolation room as soon as one becomes available. If a single room or a negative-pressure isolation room is not available, cohort patients with confirmed measles with other patients confirmed to have the same infectious agent.

In a situation where multiple suspected and confirmed measles cases occur, e.g., during an outbreak, patients with suspected infection can be cohorted together following a risk assessment but should not be cohorted with confirmed measles cases. Risk assessment should consider the vaccination and disease history of suspected cases and individuals who may be exposed.

Infectious patients should only be transferred to other departments if clinically necessary. *See section 2.3.2*

2.2.4. Staff cohorting

Consideration should be given to assigning a dedicated team of care staff to care for patients in isolation/cohort rooms/areas as an additional infection control measure during outbreaks/incidents. This can only be implemented if there are sufficient levels of staff available (so as not to have a negative impact on non-affected patients' care). Only staff whose vaccination status, disease history or immune status is known should be assigned to isolation/cohort rooms/areas.

2.3. Personal Protective Equipment (PPE)

Before undertaking any procedure, staff should assess any likely exposure to blood and/or other body fluids, non-intact skin or mucous membranes and wear personal protective equipment (PPE) that protects adequately against the risks associated with the procedure. Refer to the [NIPCM](#) sections 1.4, 2.4 and appendices 5b and 6 for further information of the use of PPE including donning and doffing.

2.3.1. PPE for assessment and management of confirmed and suspected cases of measles

Staff should wear the following PPE when assessing or managing patients with confirmed or suspected measles:

- single-use, disposable gloves
- single-use, disposable apron (or gown if extensive splashing or spraying, or performing an aerosol generating procedure (AGP))
- Respiratory protective equipment (RPE)
- eye/face protection (goggles or visor)

2.3.2. Surgical face masks as source control

If the patient has confirmed or suspected measles, then if possible/tolerated the patient should wear a surgical face mask (type I/II/IIR) in communal areas e.g., during transfer. The request for patients to wear a facemask must never compromise their clinical care.

NB FFP3 respirators or powered respirator hoods must never be worn by an infectious patient(s).

2.3.3. Sessional use of RPE in outpatient and inpatient settings only.

Where patients are cohorted, consideration can be given to sessional use of RPE (including eye/face protection). All other items of PPE (gloves/gown) must be changed between patients and/or after completing a procedure or task.

2.4. Duration of precautions

In general, patients should remain in isolation or cohorted, and TBPs should be applied until resolution of symptoms and/or in accordance with the exclusion period (minimum 9 days (4 days prior to rash onset and 4 full days after rash onset, where day 0 is the date of onset of rash).

The duration of TBPs may require modification as some patients with more severe illness or underlying immune problems may remain infectious for a longer period. TBPs should only be discontinued in consultation with clinicians (including microbiology/IPC team).

2.5. Advice for parents, carers, and visitors

Parents and carers should be supported to attend the care area while minimising the risk of exposure to other patients and themselves. Non-essential visitors should be minimised. Parents, carers, or visitors with symptoms (or who are a known, non-immune contact e.g. siblings) should not be permitted to enter a care area. However, if their presence is considered essential for compassionate (end of life) or other care reasons (for example parent/child) a risk assessment should be undertaken, and mitigations (including source control) put in place to support attendance wherever possible.

Parents, carers, and visitors should be instructed on effective hand hygiene, be made aware of any infection risks, and offered appropriate PPE. Appropriate PPE as per section 2.3.1 should be considered for parents, carers, or visitors who are considered a non-immune contact. Parents, carers, or visitors who are considered a household contact of the infected patient do not require PPE. Powered respirator hoods are an alternative to tight-fitting FFP3 respirators, for example when fit testing cannot be achieved, if there has been no previous exposure to the infected person or the measles virus.

Parents, carers, or visitors should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment.

It may be considered appropriate to restrict visiting in the event of an outbreak of measles within the healthcare setting. This is a local outbreak management team decision.

2.6. Occupational Health (OH)

If staff are uncertain of their immunisation status, they should discuss this with their OH provider.

In relation to childhood illnesses and use of RPE, no vaccine confers 100% protection and a small proportion of individuals acquire/become infected despite vaccination or known IgG immunity (previous infection).

It is recommended that vaccinated individuals wear RPE as detailed in the NIPCM appendix 11a, and within this guidance, to minimise any residual risk, and to promote consistency in practice across all staff groups.

2.6.1. Definition of occupational contacts/exposure

A Health care worker (HCW) is considered to be 'exposed' and/or a contact if they have face to face contact of any length spend more than 15 minutes in a small, confined area or with a confirmed measles patient without wearing appropriate PPE (RPE) (see section 2.3.1). If appropriate PPE (including RPE) is worn the HCW is not considered exposed.

2.6.2. Exclusion of exposed HCWs from work

HCWs who are exposed to a confirmed or suspected case of measles and do not have satisfactory evidence of protection (2 documented doses of measles containing vaccination or measles IgG positive) should be excluded from work from the 5th day after the first exposure to 21 days after the final exposure.

If HCWs are tested rapidly after exposure, they can continue to work if found to be measles IgG positive within 7 days of exposure (as this is too early to be due to infection from the recent exposure). Where MMR vaccine is given post-exposure, it is unlikely to prevent the development of measles but if the HCW remains symptom-free for at least 14 days after MMR was given, they can return at that stage.

HCWs with satisfactory evidence of protection can continue to work normally but should be advised to report to OH if they develop prodromal symptoms or a fever between 7 days after the first exposure and 21 days after the last exposure. Exposed HCWs that develop fever or rash should be excluded from all work until 4 full days after onset of the rash.

Refer to [National measles guidelines - GOV.UK \(www.gov.uk\)](https://www.gov.uk/guidance/national-measles-guidelines) for further information.

Appendix 1: Practical Steps towards completing a local risk assessment for Measles in Healthcare Settings

19 March 2024, Version 1.1

Purpose:

To support organisations, practices and employers to undertake a local risk assessment in the context of managing cases of suspected or diagnosed measles based on the measures as prioritised in the hierarchy of controls.

This includes:

- A set of risk mitigation measures prioritised in the order: elimination, substitution, engineering, administrative controls, and PPE (including respiratory protective equipment [RPE]).
- Risk assessments must be carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise what must be done to control the risk from the hazards associated with measles: this can be the employer, or a person specifically appointed to complete the risk assessment. Communication and consultation should take place with employees during this process and on completion of the risk assessment. [Risk assessment: Steps needed to manage risk - HSE](#)
[Managing for health and safety \(hse.gov.uk\)](https://www.hse.gov.uk)

- The completed risk assessment can be used to populate local risk management systems.
- If there is a change in circumstances for whatever reason that invalidates the risk assessment and its' findings, a new risk assessment must be carried out.
- Additionally, there is a need to regularly monitor the effectiveness of the identified control measures implemented and periodically review the assessment document. Triggers that may indicate the need for a review include increases in bed occupancy, increased rates of nosocomial infection and outbreaks in risk assessed areas.

Trust/organisation/practice name	Date of initial assessment	Assessor's name	Date of review

<p>What are the hazards?</p> <p>What are the risks of harm associated with the hazard?</p>	<p>Who might be harmed and how?</p>	<p>Standard required</p>	<p>What further action do you need to take to control risks?</p>
<p>Contracting or spreading Measles</p>	<ul style="list-style-type: none"> • Patients • Staff • Contractors • Visitors/Other accompanying person/carer 	<p>Regularly Monitor and Review:</p> <ul style="list-style-type: none"> • community prevalence of Measles • number of outbreaks • Staff immunity to measles • UKHSA Guidance National measles guidelines - GOV.UK (www.gov.uk) and NICPM NHS England » National infection prevention and control manual (NIPCM) for England <p>Regularly Monitor and Review:</p> <ul style="list-style-type: none"> • Organisational operational capacity, for example: <ul style="list-style-type: none"> ○ staff absence ○ Bed occupancy and operational matrixes that report on patient flow 	
<p>Contracting or spreading Measles</p>	<ul style="list-style-type: none"> • Patients • Staff • Contractors • Visitors/Other accompanying person/carer 	<p>Elimination (physically remove the hazard)</p> <p>Redesign the activity such that the risk of encountering the infection is removed or eliminated</p> <p>Key mitigations</p> <p>Patients: – check systems are in place to ensure that:</p> <ul style="list-style-type: none"> • where possible and appropriate virtual alternatives are available to support consultations, diagnosis and treatment (telephone or online modes of access). The decision to offer virtual alternatives or delay appointments must never compromise the patient’s clinical care. • screening, triaging and where appropriate testing is in place to enable early recognition and to clinically assess patients prior to face-to-face attendance to identify whether the patient has: <ul style="list-style-type: none"> ○ had exposure to measles virus. ○ been fully vaccinated with documented evidence of two MMR vaccine or a positive antibody tests for measles and rubella, in keeping with national guidance . 	

<p>What are the hazards?</p> <p>What are the risks of harm associated with the hazard?</p>	<p>Who might be harmed and how?</p>	<p>Standard required</p>	<p>What further action do you need to take to control risks?</p>
		<ul style="list-style-type: none"> ○ has symptoms e.g., maculopapular rash, fever, cough, coryza, conjunctivitis <p>Staff – check systems are in place to ensure:</p> <ul style="list-style-type: none"> • Patients with known or suspected measles should be cared for by those staff known to be immune to measles • staff who are immunocompromised/pregnant should have a risk assessment undertaken to identify who may be at high risk of complications from infectious agents - this could be via occupational health/GP. • consider restriction of non-essential staff and visitors in triage/care areas • ensure staff working in clinical areas: <ul style="list-style-type: none"> ○ have had the required health checks, immunisations (MMR) and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs)); (Criteria 10, Health and Social Care Act Code of Practice Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)) <p>Visitors/Contractors:</p> <ul style="list-style-type: none"> • Restriction of visiting may be appropriate in outbreak situations. 	



<p>What are the hazards?</p> <p>What are the risks of harm associated with the hazard?</p>	<p>Who might be harmed and how?</p>	<p>Standard required</p>	<p>What further action do you need to take to control risks?</p>
<p>Contracting or spreading measles</p>	<ul style="list-style-type: none"> • Patients • Staff • Contractors • Visitors/Other accompanying person/carer 	<p>Substitution (replace the hazard)</p> <p>Replace the hazard with one that reduces the risk</p> <p>Key mitigations:</p> <p>This is not directly applicable for healthcare to achieve as treatment needs to be carried out, so emphasis needs to be on the mitigating risks via other controls.</p>	



<p>What are the hazards?</p> <p>What are the risks of harm associated with the hazard?</p>	<p>Who might be harmed and how?</p>	<p>Standard required</p>	<p>What further action do you need to take to control risks?</p>
<p>Contracting or spreading measles</p>	<ul style="list-style-type: none"> • Patients • Staff • Contractors • Visitors/Other accompanying person/carer 	<p>Engineering Controls (Control, mitigate or isolate people from the hazard)</p> <p>Design measures that help control or mitigate risks, such as ventilation, barriers, and screens.</p> <p>Key mitigations:</p> <ul style="list-style-type: none"> • Ensure adequate ventilation systems are in place, ie mechanical/or natural national recommendations for minimum air changes are met as defined for the care area. This should be carried out in conjunction with organisational estates teams/specialist advice from ventilation group and/or authorised engineer on how best to achieve the recommended number of air changes as appropriate. See HTM 03-01 Specialised ventilation for healthcare buildings and section 2.5 of the NIPCM. • Maintenance and monitoring of ventilation systems should be in place to ensure that they remain effective and continue to provide the expected performance. Ventilation in the workplace (hse.gov.uk) • action is taken to mitigate the risk for areas (clinical and non-clinical) which are poorly ventilated or where existing ventilation systems are inadequate. (Considering size and number of people in the room). • if considering screens/partitions in reception/waiting areas ensure air flow is not affected and cleaning schedules are in place, consult with appropriate professional advice/facilities teams. • where a clinical space has very low air changes and it is not practical to increase dilution effectively then consider alternative technologies with appropriate professional advice/facilities team. 	



<p>Contracting or spreading measles</p>	<ul style="list-style-type: none"> • Patients • Staff • Contractors • Visitors/Other accompanying person/carer 	<p>Administrative controls (change the way people work)</p> <p>Administrative controls are implemented at an organisational level (eg the design and use of appropriate processes, systems and provision and use of suitable work equipment and material) to help prevent the introduction of infection; and to control and limit the transmission of infection in healthcare.</p> <p>Key mitigations – check systems in place to ensure that:</p> <ul style="list-style-type: none"> • services operate in a way which minimises the risk of spread of the virus to other patients. • triaging and testing is undertaken to enable early recognition of measles. • appropriate patient placement systems are in place for those who continue to be at higher risk of serious illness eg. Most at risk of complication are immunosuppressed, infants and pregnant women. • separation is maintained in space and/or time between patients with or without suspected measles, by appropriate: <ul style="list-style-type: none"> ○ appointment and clinic scheduling ○ patient placement for infectious patients in isolation. • for patients who are known or suspected to be positive for measles, and treatment cannot be deferred, care should be provided via services that can operate in a way that minimises the risk of spread of the virus to other patients/staff/ individuals. • there is provision of appropriate infection prevention & control education and compliance for staff, patients and visitors, and contractors who work in clinical areas. • the provision of additional hand hygiene stations (alcohol-based hand rub) and signage, to ensure good hygiene practices in staff, contractors who work in clinical areas patients and visitors. • regular cleaning regimes are followed, and compliance monitored, including shared equipment. • an increase in cleaning frequency is considered beyond specified local and national schedules to mitigate risks, particularly when bed occupancy or face to face appointments rates are high. • staff, contractors who work in clinical areas and patients comply with current public health measures. Staff or contractors who decline MMR are redeployed from clinical areas with vulnerable individuals i.e. children under 1, pregnant women and immunosuppressed individuals 	
<p>Contracting or spreading measles</p>	<ul style="list-style-type: none"> • Patients • Staff 	<p>Personal protective equipment (PPE)/respiratory protective equipment (RPE) (Protect the worker with personal protective clothing)</p>	

<p>What are the hazards?</p> <p>What are the risks of harm associated with the hazard?</p>	<p>Who might be harmed and how?</p>	<p>Standard required</p>	<p>What further action do you need to take to control risks?</p>
	<ul style="list-style-type: none"> Contractors Visitors/Other accompanying person/carer 	<p>Employers are under a legal obligation – under the Control of Substances Hazardous to Health Regulations (COSHH) 2002 Control of substances hazardous to health (Sixth edition) - L5 (hse.gov.uk) to adequately control the risk of exposure to hazardous substances where exposure cannot be prevented. PPE must be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with NHS England » Chapter 1: Standard infection control precautions (SICPs) and NHS England » Chapter 2: Transmission based precautions (TBPs).</p> <p>PPE is required for protection of individuals when, after working through the risk assessment, adequate control of exposure to the hazard cannot be achieved after applying the other Hierarchy of controls.</p> <p>Key mitigations:</p> <p>Systems in place to ensure that:</p> <ul style="list-style-type: none"> there is adequate supply and availability of PPE to protect staff, contractors who work in clinical areas, patients and visitors as indicated by PPE guidance. all staff who are required to wear an FFP3 (RPE) mask have been fit-tested (this is a legal requirement) Respiratory protective equipment at work: A practical guide HSG53 (hse.gov.uk). all staff (clinical and non-clinical) are trained in putting on, removing and disposing of PPE and there are adequate facilities for them to do this, reducing the risk of contamination and spread. for reusable PPE, there are adequate facilities for cleaning and decontamination, and PPE is kept in good working order. PPE ensembles, including type IIR masks and RPE should be used in accordance with current official guidance and / or guided by local risk assessment. Please check latest version of official guidance. visual reminders are displayed communicating the importance of compliance with Public Health measures specific to PPE. Every action counts (england.nhs.uk) 	



Appendix 2: Think Measles - Primary Care Actions for Screening, Triage and Management

Measles cases are most likely to contact primary care first including general practice, community pharmacy, dental, and optometry (eye health) services

Receptionists / counter staff should know that any patients with fever and rash are potentially infectious
A patient reporting fever AND rash AND one of coryza OR cough OR conjunctivitis

Triage

- Unvaccinated or partially vaccinated with MMR
- Recent travel to area where measles is circulating
- Contact with confirmed or suspected case of measles

If an in-person review is needed, reception staff should be alerted. The person should be directed straight to a consultation room on arrival

Assessment Focus:
Severe disease (Oxygen sats/PEWS/NEWS2/GCS)
Risk factors – immunocompromised, <12 mths, pregnancy
(ask re patient and household contacts)

Think Measles

Prodrome 2-4 days fever, coryza, cough, conjunctivitis
Rash spreads from face to rest of body
Differential Diagnosis:
Other viral exanthems
Group A Streptococcus
Kawasaki Disease
Complications:
Pneumonia, Otitis media
Diarrhoea
Rare – encephalitis
Secondary bacterial infections

Discharge Home

Exclude from nursery, educational setting, or work until full 4 days after onset of rash.
Advice re red flags/when to seek medical attention. Details passed to HPT.
Health professionals must inform local health protection teams of suspected cases. Urgently by telephone [Find your local health protection team in England - GOV.UK \(www.gov.uk\)](http://www.gov.uk) to facilitate prompt risk assessment and public health action for vulnerable contacts

Referral to secondary care:

When referring a suspected measles case to A&E/hospital, inform hospital staff beforehand so that the person can be appropriately signposted to mitigate against onward transmission
Inform local HPT of the suspected case [Find your local health protection team in England - GOV.UK \(www.gov.uk\)](http://www.gov.uk)
Urgently by telephone to facilitate prompt risk assessment and public health action for vulnerable contacts

HPT will follow up patient about oral Fluid sample for PCR/IgG & IgM
<https://www.gov.uk/government/publications/measles-mumps-and-rubella-mmr-letter-for-parents-and-form-for-oral-fluid-swab>

Make Every Contact Count

Check the immunisation history of every patient, especially for children, new registrations, new migrants, refugees, and asylum seekers: offer vaccination to prevent the spread in the community. For further information see [National Measles Guidance and the National Infection Prevention & Control Manual](#)

Appendix 3: Think Measles - Urgent & Emergency Care Actions

Patient-facing staff should have documented evidence of 2 doses of the MMR vaccine or have positive antibody tests for measles and rubella, according to [national guidance](#)

Staff should know that any patients with fever and rash are potentially infectious and take appropriate action to stop onward transmission without delay, including PPE. Face-to-face contact of any length or more than 15 minutes in a small, confined area is considered as exposure and will require follow-up.

A patient reporting fever AND rash AND one of coryza OR cough OR conjunctivitis

Triage

- Unvaccinated or partially vaccinated with MMR
- Recent travel to area where measles is circulating
- Contact with confirmed or suspected case of measles

Transmission Based Precautions (TBPs)

Assessment Focus:

Severe disease (Oxygen sats/PEWS/NEWS2/GCS)

Risk factors – immunocompromised, <12 mths, pregnancy

(ask re patient and household contacts)

Admission :

When admitting a suspected or confirmed measles case to hospital ensure:

Risk assessment of contacts

Receiving area aware of the diagnosis

TBPs when caring for a confirmed or suspected case of measles

Inform local HPT of the suspected case

[Find your local health protection team in](#)

[England - GOV.UK \(www.gov.uk\)](#) Urgently by telephone to facilitate prompt risk assessment and public health action for vulnerable contacts

Discharge Home

Exclude from nursery, educational setting, or work until full 4 days after onset of rash.

Advice re red flags/when to seek medical attention. Advice re post-exposure

prophylaxis (vaccination) for household

Health professionals must inform local health protection teams of suspected cases.

Urgently by telephone [Find your local health protection team in England - GOV.UK](#)

[\(www.gov.uk\)](#) to facilitate prompt risk assessment and public health action for vulnerable contacts

Think Measles

Prodrome 2-4 days fever, coryza, cough, conjunctivitis

Rash spreads from face to rest of body

Differential Diagnosis:

Other viral exanthems

Group A Streptococcus

Kawasaki Disease

Complications:

Pneumonia, Otitis media

Diarrhoea

Rare – encephalitis

Secondary bacterial infections

Make Every Contact Count

Where appropriate, and particularly for individuals who do not engage with primary care, check if they are up to date with their MMR and vaccinate (or signpost to GP) if not. For further information see [National Measles Guidance and the National Infection Prevention & Control Manual](#)