Whittington Health NHS

Whittington Hospital

# Meningitis – Prophylaxis for Contacts including Staff

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| **Subject:** | Meningitis prophylaxis for contacts |
| **Policy Number** | N/A |
| **Ratified By:** | Clinical Guidelines Committee |
| **Date Ratified:** | Original (January 2009) minor update August 2013 |
| **Version:** | 2.0 |
| **Policy Executive Owner:** | Clinical lead for Surgery, cancer and diagnostics |
| **Designation of Author:** | Microbiology Department |
| **Name of Assurance Committee:** | Antimicrobial Steering Group reporting to the Drugs & Therapeutics Committee |
| **Date Issued:** | August 2013 |
| **Review Date:** | August 2016 |
| **Target Audience:** | All clinical staff involved in prescribing, dispensing and administering antibiotics. Doctors, nurses and pharmacists. |
| **Key Words:** | Meningitis, prophylaxis, contact, meningococcal, Hib, MenC, immunisation, vaccination, ciprofloxacin, rifampicin, ceftriaxone. |

## Version Control Sheet

| Version | Date | Author | Status | Comment |
|---|---|---|---|---|
| 2.0 | 01/02/13 | Ai-Nee Lim (Lead Pharmacist, Antimicrobial)<br>Dr M Kelsey (Consultant Microbiologist),<br>Dr G Armstrong (Consultant Paediatrician) | Updated. | ▪ Ciprofloxacin is now the recommended 1st choice chemoprophylaxis for meningococcal meningitis and septicaemia.<br>▪ Chemoprophylaxis doses and inclusion criteria updated to reflect national guideline.<br>▪ Immunisation recommendations updated to reflect changes in the Green Book.<br>▪ Rifampicin PIL advice on interactions with oral contraceptives updated.<br>▪ Contact details for Health Protection Unit updated. |
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## *Criteria for use*

- The aim of prophylaxis is to interrupt the transmission of the responsible organism. It is **not a treatment** for early disease.
- Prophylaxis should be given as soon as possible, ideally within 24 hours, after diagnosis of the index case. It may be prescribed for family contacts by hospital doctors, GPs or Public Health doctors.

## *General Management*

### ***Prophylaxis for contacts***

- The hospital staff do not have responsibility for anyone other than household contacts. The Public Health department will advise on whether any other contacts should receive prophylaxis (eg. nursery schools). The Public Health Doctors On-Call Rota, and the Environmental Health / Infectious Diseases Rota, are displayed in the doctors office on Ifor Ward or can be obtained from the microbiology department. If either is not available, please refer to *Sources of Immediate Help* on page 5 of this guideline.
- Staff should advise members of the public who telephone the hospital, to seek advice from their own GPs if they are concerned that the child is unwell. Members of the public should be told that the Public Health Department will advise if any prophylactic antibiotics are required.

### ***Prophylaxis for index case***

- Index case should receive chemoprophylaxis to eradicate throat carriage as soon as he/she is able to take oral medication, before coming out of the cubicle and before going home (**not necessary if been treated with ceftriaxone**). *NB: Those treated with cefotaxime should still receive chemoprophylaxis because it is unknown whether cefotaxime eradicates carriage*.[1]

## *Specific Management*

### 1. Meningococcal Meningitis or Septicaemia

**1.1 Chemoprophylaxis:**

Should be offered to all individuals who have had *prolonged close contact* with the case in a *household type setting* during the 7 days before the onset in the case[1].

Staff only require chemoprophylaxis if they have administered mouth-to-mouth resuscitation or have been directly exposed to large particle droplets/secretions from the respiratory tract of a case[1].

Chemoprophylaxis (see table 1) should be given as soon as possible, ideally within 24 hours, after the diagnosis of the index case[1].

**Table 1: Recommended chemoprophylaxis for Meningococcal meningitis or septicaemia [1, 2]:**

| | |
|---|---|
| ***1st line:***<br><br>(for all age groups and in pregnancy) | **Ciprofloxacin**<br>Adults and children over 12 years: 500mg PO as a single dose<br>Children 5 to 12 years: 250mg PO as a single dose<br>Children < 5 years - 4kg or over: 125mg PO as a single dose<br>- less than 4kg: 30mg/kg PO as a single dose |
| | Pregnancy – short duration of treatment with ciprofloxacin is considered safe.[1, 5] |
| | Breastfeeding – short duration of treatment with ciprofloxacin is considered safe.[1, 5] |
| | **Prescribers:**<br>• Avoid if known ciprofloxacin hypersensitivity (see alternative below).<br>• Refer to counseling points on the 'Patient Information Leaflet for Ciprofloxacin' (Appendix 1).<br>• Prescribe using a separate outpatient prescription form for each individual.<br>**Nurses:**<br>• Obtain ciprofloxacin from ward stock.<br>• Give under supervision and endorse administration on the outpatient prescription form.<br>• Provide patient with 'Patient Information Leaflet for Ciprofloxacin' (see Appendix 1) and a copy of the outpatient prescription form. |

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|---|---|
| ***Alternative:***<br><br>(if ciprofloxacin is contra-indicated e.g. known ciprofloxacin allergy) | **Rifampicin**<br>Adults and children over 12 years: 600mg PO 12 hourly for 2 days<br>Children - 1 to 12 year: 10mg/kg (max. 600mg) PO 12 hourly for 2 days<br>- less than 1 year: 5mg/kg PO 12 hourly for 2 days |

| ***If weight not known*** | ***Doses based on average weight for age[1]*** | | |
|---|---|---|---|
| 0 – 2 months: | 20mg | = 1ml x 100mg/5ml syrup | BD for 2 days |
| 3 – 11 months: | 40mg | = 2ml x 100mg/5ml syrup | BD for 2 days |
| 1 – 2 years: | 100mg | = 5ml x 100mg/5ml syrup | BD for 2 days |
| 3 – 4 years: | 150mg | = 7.5ml x 100mg/5ml syrup | BD for 2 days |
| 5 – 6 years: | 200mg | = 10ml x 100mg/5ml syrup | BD for 2 days |
| 7 – 12 years: | 300mg | (as capsule or syrup) | BD for 2 days |

| | |
|---|---|
| | Pregnancy – NOT recommended.[1, 5] |
| | Breastfeeding – considered safe.[1, 5] |
| | **Prescribers:**<br>• Avoid if jaundice, known rifampicin allergy or pregnant (seek pharmacist advice for alternatives such as Ceftriaxone IM stat or Azithromycin PO stat).[1]<br>• Interaction with anticoagulants, antiepileptics, antiretrovirals and oral contraceptives – counsel patient and refer to GP or clinic as appropriate.<br>• Refer to counseling points on the 'Patient Information Leaflet for Rifampicin' (Appendix 2).<br>• Prescribe using a separate outpatient prescription form for each individual.<br>**Nurses:**<br>• Obtain supply of rifampicin from pharmacy or the on-call pharmacist if out-of-hours.<br>• Endorse supply on the outpatient prescription form.<br>• Provide patient with 'Patient Information Leaflet for Rifampicin' (see Appendix 1) and a copy of the outpatient prescription form. |

### 1.2 Immunisation:

Household and kissing contacts of confirmed cases of **Group A, C, W135 or Y** meningococcal disease should be given **meningococcal vaccine** (see table 2) in addition to **chemoprophylaxis** (see table 1)**.** The Public Health department will advise whether others should be offered vaccination.

Chemoprophylaxis should be given first and the decision to offer vaccine should be made when the results of typing are available. Appropriate vaccine should be given within 4 weeks after illness onset [1].

**Table 2: Recommended vaccination for index cases and contacts of Meningococcal meningitis or septicaemia: [1, 2]**

| Patient status | Vaccine schedule |
|---|---|
| **Confirmed serogroup C infections** | |
| **INDEX CASE** | |
| Not immunised with MenC vaccination AND under 25 years | Give **MenC** vaccination according to recommended UK schedule - see The Green Book |
| **CLOSE CONTACT OR IMMEDIATE FAMILY OF CASES** | |
| Not previously immunised with MenC vaccination | Give **MenC** vaccination according to recommended UK schedule - see The Green Book |
| Partially immunised with MenC vaccination | Complete the course of **MenC** vaccination according to UK schedule - see The Green Book |
| Immunised with MenC vaccination only in infancy<br>Completed the recommended immunisation course of MenC vaccination (including the 12-month booster) more than 1 year prior | Give **MenC** vaccine:<br>- single dose of 0.5ml IM |

| Patient status | Vaccine schedule |
|---|---|
| **Confirmed serogroup A, W135 or Y infections** | |
| **INDEX CASE** | |
| Not immunised with MenC vaccination AND under 25 years | Give **MenC** vaccination according to recommended UK schedule - see The Green Book |
| **CLOSE CONTACT OR IMMEDIATE FAMILY OF CASES** | |
| All close contacts | Give **MenACWY conjugate** vaccine:<br>*Children < 1 year*:<br>- two doses of 0.5ml IM given one month apart<br>*Children ≥ 1 year and Adults*:<br>- single dose of 0.5ml IM |

Abbreviations: **MenC** = Meningitis C conjugate vaccine; **MenACWY** = quadrivalent ACWY conjugate vaccine

**Refer to Public Health England - Immunisation against Infectious Disease: The Green Book for up-to-date information and changes to the immunisation schedule.**

## 2. Haemophilus Influenza Disease (Meningitis, Septicaemia, Epiglottitis etc)

Since the introduction of Hib vaccine, invasive *Haemophilus Influenzae* type b (Hib) disease is now rare.

### 2.1 Chemoprophylaxis:

Chemoprophylaxis (see table 3) should be given to all members of the household contacts *only when one or more family members are at risk*. At risk individuals include those who are immunocompromised, asplenic or children under 10 years of age.[3, 4]

Index case should also be given chemoprophylaxis if they are under 10 years of age [4] or if they are in contact with at risk household contacts.[3] Not all children have been shown to mount an antibody response following an invasive Hib disease.[6]

**Table 3: Recommended chemoprophylaxis for *Haemophilus Influenzae* Disease [3, 4] :**

| | |
|---|---|
| ***1st line:*** | **Rifampicin**<br>Adults and children > 12 years: 600mg PO once daily for **four** days<br>Children > 3 months – 12 years: 20mg/kg (max. 600mg) PO once a day for **four** days<br>Children 1 month – 3 months: 10mg/kg PO once a day for **four** days |
| | Pregnancy – NOT recommended. [1, 5] |
| | Breastfeeding – considered safe. [1, 5] |
| | **Prescribers:**<br>• Avoid if jaundice, known rifampicin allergy or pregnant (see alternative below).<br>• Interaction with anticoagulants, antiepileptics, antiretrovirals and oral contraceptives – counsel patient and refer to GP or clinic as appropriate.<br>• Refer to counseling points on the 'Patient Information Leaflet for Rifampicin' (Appendix 2).<br>• Prescribe using a separate outpatient prescription form for each individual.<br>**Nurses:**<br>• Obtain supply of rifampicin from pharmacy or contact on-call pharmacist if out-of-hours.<br>• Endorse supply on the outpatient prescription form.<br>• Provide patient with 'Patient Information Leaflet for Rifampicin' (see Appendix 1) and a copy of the outpatient prescription form. |

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| ***Alternative:***<br>(if rifampicin is contra-indicated) | **Ceftriaxone**<br>Adults and children > 12 years: 1g IM or IV once a day for 2 days<br>Children 1 month – 12 years: 50mg/kg (max.1g) IV infusion once a day for 2 days |
| | Pregnancy – considered safe. [1, 5] |
| | Breastfeeding – considered safe. [1, 5] |
| | **Prescribers:**<br>• Avoid if known beta-lactam allergy (seek Microbiology advice).<br>• Interaction with anticoagulants – counsel patient and refer to GP or clinic as appropriate.<br>• Prescribe using a separate outpatient prescription form for each individual.<br>**Nurses:**<br>• Obtain ceftriaxone from ward stock. For IV bolus (adult), reconstitute 1g vial with 10ml WFI and give over 2 – 4minutes. For IM (adult), reconstitute 1g vial with 3.5ml of lidocaine 1%. For IV infusion (children), reconstitute 1g vial with 10ml WFI (resultant solution of approx. 100mg/ml) then draw up the required dose and add to 50ml N/S. Infuse over 30 minutes.[4, 7]<br>• Endorse administration on the outpatient prescription form.<br>• Advise when the next dose is due and make arrangements to give the outstanding dose.<br>• Provide patient with a copy of the completed outpatient prescription form. |

## 2.2 Immunisation:

Any unimmunised index cases and household contacts from 2 months up to 10 years of age should be immunised as appropriate (see Table 4).[3]

The Public Health department should take the opportunity to immunise any unimmunised child contacts <10 years of age, eg. at nursery, playgroup, crèche or school.

**Table 4: Recommended vaccination for index cases and contact of *Haemophilus Influenzae* Disease: [3, 4]**

| Patient's status | Vaccine |
|---|---|
| **INDEX CASE – 2 month to ≤ 10 years of age** | |
| Not immunised<br>Partially immunised | Should complete their age-specific course of immunisation after recovery from infection. |
| Previously vaccinated against Hib | Should have convalescent antibody levels measured and booster vaccination may be advised.<br>*If antibody testing is not possible:*<br>An additional dose of Hib-containing vaccine should be given after recovery from infection. |
| **HOUSEHOLD CONTACTS – 2 month to ≤ 10 years of age** | |
| Never received any immunisation | **DTaP/IPV/Hib vaccine (Pediacel®)**<br>- 3 doses of 0.5ml IM given one month apart. |
| Immunisation interrupted or incomplete | Complete the UK recommended immunisation schedule - this should be resumed but not repeated. |
| If never received Hib-containing vaccine<br>BUT completed primary course of diphtheria, tetanus, pertussis and polio | *Children < 1 year:*<br>**Hib / MenC vaccine (Menitorix®)**<br>- 3 doses of 0.5ml IM given one month apart.<br>*Children 1 to 10 years:*<br>**Hib / MenC vaccine (Menitorix®)**<br>- single dose of 0.5ml IM. |
| Received Hib vaccine in infancy<br>BUT did not receive a booster dose of Hib-containing vaccine after the age of 12 months | **Hib / MenC vaccine (Menitorix®)**<br>- single dose of 0.5ml IM. |

**Refer to Public Health England - Immunisation against Infectious Disease: The Green Book for up-to-date information and changes to the immunisation schedule.**

## 3. Pneumococcal Disease

**No Chemoprophylaxis is required.**
Close contacts of pneumococcal meningitis or other invasive pneumococcal disease are not normally at an increased risk of pneumococcal infection and therefore antibiotic prophylaxis is not indicated.[3]

Any case of invasive pneumococcal infection or lobar pneumonia believed to be due to *Streptococcus pneumoniae* should prompt a review of the patient's medical history to establish whether they are in a recognised risk group and whether they have been vaccinated.[3]

## *Source of Immediate Help*

The hospital staff do not have responsibility for anyone other than household contacts. The Health Protection Agency will advise on whether any other contacts should receive prophylaxis (eg. nursery schools).

**Contact numbers within Whittington Hospital:**

*During working hours:*

| | | |
|---|---|---|
| Paediatric SHO / SpR | *(Monday to Friday, 08:30 – 17:00)* | ext. 5442 / 3677 (Ifor ward) |
| SpR in Microbiology | *(Monday to Friday, 09:00 – 17:00)* | ext. 5085 / 5780 or bleep 3069 |
| Pharmacy Medicines Information | *(Monday to Friday, 09:00 – 17:30)* | ext. 5021 |

*Out of hours:*

| | |
|---|---|
| On-call Paediatric SHO / SpR | bleep via Whittington switchboard |
| On-call SpR in Microbiology | aircall via Whittington switchboard |
| On-call pharmacist | aircall via Whittington switchboard |

**Contact number for public health doctor at Public Health England (PHE) London:**

North East and North Central London Health Protection Unit (HPU)

*- includes London borough of Barnet, Camden, Enfield, Hackney, Haringey and Islington.*

| | |
|---|---|
| During office hours (*Monday to Friday, 09:00 – 17:00*): | 020 7811 7100 |
| Out-of-hours – via pager system | 07623 541 417 |

## *References*


1. Health Protection Agency (HPA). Guidance for public health management of meningococcal disease in the UK. Meningococcus and Haemophilus Forum (Updated March 2012) Accessed online: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1194947389261
2. Public Health England. Immunisation against infectious disease: The Green Book. Chapter 22. Meningococcal. 7th May 2013. Accessed online: https://www.gov.uk/government/organisations/public-health-england/series/immunisation-against-infectious-disease-the-green-book
3. Public Health England. Immunisation against infectious disease: The Green Book. Chapter 16. Haemophilus influenzae type b (Hib). 19th April 2013. Accessed online: https://www.gov.uk/government/organisations/public-health-england/series/immunisation-against-infectious-disease-the-green-book
4. BNF 65 (March 2013) London: BMJ Group and RPSGB.
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6. Johnson, P. D., Hanlon, M., Isaacs, D. and Gilbert, G. L. (1996) Differing antibody responses to Haemophilus influenzae type b after meningitis or epiglottitis. *Epidemiology and Infection*, vol 116 (1) pp 21-6.
7. UCL Hospitals Injectable Medicines Administration Guide. 3rd Edition. Wiley-Blackwell. Accessed online: www.uclhguide.com
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**Appendix 1**

## PATIENT INFORMATION LEAFLET

## CIPROFLOXACIN FOR PREVENTION OF MENINGITIS

Because you have been in close contact with someone with meningitis, we advise that you or your child should take a short course of antibiotics just in case you are carrying the germ. The antibiotic reduces the chances of you or your family developing meningitis or a serious infection. However it may not be 100% effective and if you or your family becomes unwell you should seek medical advice quickly.

### *Before taking ciprofloxacin*

If any of the following apply you should seek advice before taking this medicine:

- You are pregnant or breast-feeding.
- You have previously had a reaction to ciprofloxacin.
- You are glucose-6-phosphate dehydrogenase (G6PD) deficient.
- You are an epileptic or have a history of epilepsy.
- You are currently taking blood-thinning medication such as warfarin.

### *Taking ciprofloxacin*

You only need to take one dose of ciprofloxacin.

Ciprofloxacin comes in tablet or liquid form. The tablet should be swallowed whole with a glass of water. It is important that you drink plenty of fluid for the rest of the day after having this antibiotic.

Do not take indigestion remedies, multivitamins, or supplements containing calcium, zinc or iron at least 4 hours before and after taking ciprofloxacin. Dairy products (such as milk or yogurt) or drinks with added calcium should not be taken at the same time as ciprofloxacin. It is important that you take this antibiotic as instructed to ensure that it works effectively.

### *About ciprofloxacin*

Side effects are unusual but occasionally some people may experience diarrhoea, feeling sick, vomiting, and dizziness. If you feel dizzy or drowsy after taking the tablet you should not drive or operate machinery for a few hours. Avoid skin exposure to strong sunlight and do not use a sunbed on the day of treatment.

*If you are unclear or would like further information, please contact:*
Medicines Information 0207 288 5021 (Monday to Friday 09:00 – 17:30)

*Further information is also available from:*

| | | |
|---|---|---|
| NHS Choices/NHS Direct | www.nhs.uk | 111 |
| Meningitis Research Foundation | www.meningitis.org | 0808 800 3344 |
| Meningitis Trust | www.meningitis-trust.org | 0808 80 10 388 |
| Meningitis UK | www.meningitisuk.org | 0117 947 6320 |

**Appendix 2**

## PATIENT INFORMATION LEAFLET

## RIFAMPICIN FOR PREVENTION OF MENINGITIS

Because you have been in close contact with someone with meningitis, we advise that you or your child should take a short course of antibiotics just in case you are carrying the germ. The antibiotic reduces the chances of you or your family developing meningitis or a serious infection. However it may not be 100% effective and if you or your family becomes unwell you should seek medical advice quickly.

### *Before taking rifampicin*

If any of the following apply you should seek advice before taking this medicine:

- You suffer from an acute porphyria.
- You have previously had a reaction to rifampicin
- You are currently taking warfarin, phenytoin, lamotrigine, oral antidiabetic drugs, cyclosporin, theophylline, antiretrovirals or oral contraceptives.

### *Taking rifampicin*

Rifampicin is usually taken twice a day (morning and evening) for two days. For some rare types of meningitis, it is taken once a day for four days. Your doctor will advise you on the correct dose to take. It is important that you take the full course as instructed to ensure that the antibiotics work effectively.

Rifampicin should be taken on an empty stomach either 30 minutes before a meal or 2 hours after a meal.

### *About rifampicin*

You are unlikely to notice any side effects from this treatment. However, occasionally nausea, vomiting and diarrhoea may be troublesome. If so, take the medicine with food. In addition, for a short while urine, saliva and tears may have a slight orange or red discolouration. This is harmless and will disappear after the course is finished. However, soft-contact lenses may be stained and therefore should not be worn whilst taking rifampicin and for a few days after as the red colour in tears may last for some time after stopping treatment.

Rifampicin can significantly reduce the effectiveness of oral contraceptives. Hence, it is important to use an alternative method of contraception (such as injectable progestogen-only contraceptives or intrauterine devices) when taking rifampicin and for 4 weeks after stopping rifampicin.

*If you are unclear or would like further information, please contact:*
Medicines Information 0207 288 5021 (Monday to Friday 09:00 – 17:30)

*Further information is also available from:*

| | | |
|---|---|---|
| NHS Choices/NHS Direct | www.nhs.uk | 111 |
| Meningitis Research Foundation | www.meningitis.org | 0808 800 3344 |
| Meningitis Trust | www.meningitis-trust.org | 0808 80 10 388 |
| Meningitis UK | www.meningitisuk.org | 0117 947 6320 |

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval

| | | Yes/No | Comments |
|---|---|---|---|
| **1.** | **Does the procedural document affect one group less or more favourably than another on the basis of:** | | |
| | • 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 disabilities, 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.** | **Is the impact of the procedural document likely to be negative?** | No | |
| **5.** | **If so can the impact be avoided?** | N/A | |
| **6.** | **What alternatives are there to achieving the procedural document without the impact?** | N/A | |
| **7.** | **Can we reduce the impact by taking different action?** | N/A | |

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Director of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

**For advice in respect of answering the above questions, please contact the Director of Human Resources.**

## Checklist for the Review and Approval of Procedural Document

To be completed and attached to any procedural document when submitted to the relevant committee for consideration and approval.

| | Title of document being reviewed: | Yes/No | Comments |
|---|---|---|---|
| **1.** | **Title** | | |
| | Is the title clear and unambiguous? | Yes | |
| | Is it clear whether the document is a guideline, policy, protocol or standard? | Yes | |
| **2.** | **Rationale** | | |
| | Are reasons for development of the document stated? | Yes | |
| **3.** | **Development Process** | | |
| | Is it clear that the relevant people/groups have been involved in the development of the document? | Yes | |
| | Are people involved in the development? | Yes | |
| | Is there evidence of consultation with stakeholders and users? | Yes | |
| **4.** | **Content** | | |
| | Is the objective of the document clear? | Yes | |
| | Is the target population clear and unambiguous? | Yes | |
| | Are the intended outcomes described? | Yes | |
| **5.** | **Evidence Base** | | |
| | Are key references cited in full? | N/A | |
| | Are supporting documents referenced? | N/A | |
| **6.** | **Approval** | | |
| | Does the document identify which committee/ group will approve it? | Yes | |
| **7.** | **Dissemination and Implementation** | | |
| | Is there an outline/plan to identify how this will be done? | Yes | |
| **8.** | **Document Control** | | |
| | Does the document identify where it will be held? | Yes | |
| **9.** | **Process to Monitor Compliance and Effectiveness** | | |

| | Title of document being reviewed: | Yes/No | Comments |
|---|---|---|---|
| | Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document? | Yes | |
| | Is there a plan to review or audit compliance with the document? | Yes | |
| **10.** | **Review Date** | | |
| | Is the review date identified? | Yes | |
| | Is the frequency of review identified? If so is it acceptable? | Yes | |
| **11.** | **Overall Responsibility for the Document** | | |
| | Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document? | Yes | |

| **Executive Sponsor Approval** | | | |
|---|---|---|---|
| If you approve the document, please sign and date it and forward to the author. Procedural documents will not be forwarded for ratification without Executive Sponsor Approval | | | |
| Name | | Date | |
| Signature | | | |
| **Relevant Committee Approval** | | | |
| The Director of Nursing and Patient Experience's signature below confirms that this procedural document was ratified by the appropriate Governance Committee. | | | |
| Name | | Date | |
| Signature | | | |
| **Responsible Committee Approval – only applies to reviewed procedural documents with minor changes** | | | |
| The Committee Chair's signature below confirms that this procedural document was ratified by the responsible Committee | | | |
| Name | | Date | |
| Name of Committee | | Name & role of Committee Chair | |
| Signature | | | |

## Tool to Develop Monitoring Arrangements for Policies and guidelines

| What key element(s) need(s) monitoring as per local approved policy or guidance? | Who will lead on this aspect of monitoring?<br><br>Name the lead and what is the role of the multidisciplinary team or others if any. | What tool will be used to monitor/check/observe/Assess /inspect/ authenticate that everything is working according to this key element from the approved policy? | How often is the need to monitor each element?<br><br>How often is the need complete a report ?<br><br>How often is the need to share the report? | What committee will the completed report go to? |
|---|---|---|---|---|
| **Element to be monitored** | **Lead** | **Tool** | **Frequency** | **Reporting arrangements** |
| Compliance with choice of meningitis prophylaxis for contacts | Respective speciality team supported by the Microbiology & Pharmacy Department | In house audit tools. | Annual audit and report. | • Respective departmental meeting<br>• Antimicrobial Steering Group |