Generic incident management

Emergency contacts

Emergency contacts template

- Emergency contact details should be included in your major incident plan, and should be checked and updated regularly (eg every six months and after every drill or exercise, with the task designated to a post – not a person – in the department)
- You may use this list as a template or use it to review and amend your own emergency plans

Useful extension numbers			
Emergency department reception		Chemical pathology laboratory	
Admissions		Microbiology laboratory	
Pharmacy		Haematology laboratory	
Emergency theatres		Blood bank	
Main theatres		Emergency department X-ray	
ITU		Main X-ray	
Coronary care unit		Porters	
PICU		Security	
CSSD/sterile supplies		Mortuary	
		Canteen	
Major incident control room		Ambulance Liaison Officer	
Emergency medicine incident room		Police Documentation Office	
Major incident press office			

Local contacts (Internal and external)				
Contact	**Name**	**Extension**	**Bleep**	**Mobile /out of hours**
Trust Chief Executive				
Trust Senior Nurse Manager				
Trust Medical Director				
Consultant chemical pathologist				
Consultant microbiologist				
Consultant haematologist				
Consultant infectious disease physician				
Infection control lead				
Occupational Health lead				
Radiation protection/safety officer				
Emergency Planning Liaison Officer				
Head pharmacist				
Emergency admissions/beds manager				
Duty manager				
Chaplains				
Voluntary services organiser				
Switchboard supervisor				
Duty engineer				
Social services emergency duty team				
Senior Security Manager				
Catering Manager				
Contact	**Name**	**Daytime contact**		**Mobile/out of hours**
HM Coroner				
Consultant CDC/Health Protection				
Health Protection Unit				
DPH, lead Primary Care Trust				
Regional HEPA				
Regional Infectious Disease Unit				
Regional Chemical Provider Unit				
Regional Burns Unit				
Police				
Fire and Rescue Service				
Ambulance control				
Pod activation (via ambulance/BTS)				
NHS Direct	**0845 46 47**			
HPA Chemical Hazards and Poisons Division: **0870 606 4444**		HPA National Poisons Information Service: **0870 600 6266**		
HPA Centre for Infections: **020 8200 4400**		NAIR (for incidents involving radioactivity): **0800 834 153**		

DO NOT WRITE ON THIS FORM – USE IT AS A MASTER TO MAKE PHOTOCOPIES

Immediate incident management for first responders

STEP 1 2 3

When the cause of an incident is unknown, emergency personnel use these safety triggers

STEP 1	**ONE** CASUALTY	Approach using **normal** procedures
STEP 2	**TWO** CASUALTIES	Approach with **caution**, consider all options Report on arrival, update control
STEP 3	**THREE** CASUALTIES or MORE	Do **NOT** approach Withdraw Contain Report Isolate yourself and SEND for SPECIALIST HELP

Do NOT compromise your own safety or that of your colleagues or the public

Provide a CHALETS or METHANE assessment as soon as possible

Remember that the emergency services have staff trained and equipped to deal with CBRN incidents

Mnemonics for rapid incident assessment

'METHANE'

My call sign/major incident alert
Exact location
Type of incident
Hazards at the scene
Access
Number of casualties and severity
Emergency services present or required

'CHALETS'

Casualties, number and severity
Hazards, present and potential
Access and egress
Location – exact
Emergency services – present or required
Type of incident
Safety

Medical Emergency Response Incident Teams (MERIT)

- MERIT teams carry out the duties formerly undertaken by Mobile Medical Teams or MMTs. They attend an incident at the request of the Ambulance Service and will normally be transported to the site by the Ambulance Service. On arrival at an incident MERITs should report to the Medical Incident Officer (MIO), or in their absence, the Ambulance Incident Officer (AIO) for briefing. At an incident:
- **Always follow instructions from the MIO, AIO, and other emergency service personnel on site**
- **Channel all requests and queries on site through the MIO**
- **Protect yourself – do not put your own life or health at risk to save others:**
  - Ensure that you are wearing appropriate PPE before entering the inner cordon or approaching any casualty
  - Ensure that you are clearly and appropriately identifiable
  - Enter any inner cordon only through the inner cordon access point, where your entry will be logged and you will be briefed about hazards
  - Leave any inner cordon only through the inner cordon access point, so that you can be debriefed and your departure can be logged
- **Initial triage**

  Remember that triage is a dynamic, continuing process (not a 'one off' decision) that aims to 'do the most for the most'

  React to physiological effects (changes in vital signs) rather than anatomical effects (the easily visible)

P1	**LIFE THREATENING**	Breathe only after airway cleared *or* RR less than 9 or more than 30bpm *or* CRT more than 2 secs	**IMMEDIATE TREATMENT**
P2	**URGENT**	Unable to walk *and* RR 10bpm-29bpm *and* CRT 2 secs or less	**URGENT TREATMENT**
P3	**MINOR**	Walking	**DELAYED TREATMENT**
P4	**DEAD**	Not breathing even after airway cleared	**NO TREATMENT**

- **Decontaminate** according to protocols for clinical, emergency or mass decontamination
- Decontamination of the injured and emergency decontamination is led and managed by the Ambulance Service
- Mass decontamination is led and managed by the Fire and Rescue Service
- Radiation incidents: if **life-threatening injury, stabilise first** (transfer to hospital if necessary) and **then decontaminate**;
  if **no life-threatening injury, decontaminate at scene** and **then treat**
- Chemical incidents: removing the casualty from the source and prompt decontamination may be life-saving; as may prompt administration of the specific antidotes that are available for some chemicals (eg cyanide, organophosphates)
- Remember that in any CBRN incident, clinical signs may be caused by common, pre-existing conditions (eg ischaemic heart disease, asthma, epilepsy, diabetes), which may be exacerbated by the incident
- **Record** any **treatment given** on the **triage tag** attached to the casualty
- **Feedback relevant information regularly to MIO/Ambulance Control**
- **Ensure that you and your equipment remain in the contaminated area unitl decontaminated, and that you report to the MIO before you leave the site**

See also:

- PPE, decontamination, specific agents, diagnosis & immediate management of chemical incidents, radiation facts, emergency contacts

Personal protective equipment (PPE)

Overview

- PPE will protect you, the patient, and other patients and colleagues from infection and from other hazards, but only if selected, worn, and discarded correctly. The algorithm below is designed to help you select PPE appropriate to the task
- Don and remove PPE as you have been instructed in training.
- For advice on choosing and using PPE contact your infection control team (infection hazards) or for chemical/ radiation, Health Protection Team (HPT), Health Emergency Planning Advisor (HEPA) or HPA Centre for Radiation and Chemical and Environmental Hazards (CRCEH)

Has the patient been **EXPOSED** to a **CHEMICAL and NOT** been **fully decontaminated?**

YES or **MAYBE** →

YOU MUST WEAR FULL NHS PPE for CHEMICAL EXPOSURE

Body, clothes, skin	*Nose, mouth, lungs*	*Eyes*	*Hands*
Chemical-resistant coverall + boots	Chemical respirator (integral to PPE)	Chemical-resistant coverall + integral hood	Chemical-resistant gloves

NO ↓

Could this be **smallpox**, a **viral haemorrhagic fever (VHF)**, or **other infection (eg TB) requiring airborne infection isolation?**

YES or **MAYBE** →

YOU MUST WEAR PPE for AIRBORNE INFECTION ISOLATION

Body, clothes, skin	*Nose, mouth, lungs*	*Eyes*	*Hands*
Full length fluid-impermeable gown + apron + hair + foot cover	Correctly fitting FFP3 mask	Face shield, visor or goggles	Single gloves: disposable, single use, latex/vinyl/nitrile

NO ↓

Will/might you be **exposed** to patient's **respiratory secretions** (eg patient with cough, URTI, 'flu symptoms) or are you about to do a **cough-provoking procedure** (eg suction, intubation, NG tube, bronchoscopy)?

YES or **MAYBE** **(SEEK EXPERT ADVICE)** →

YOU MUST WEAR PPE for RESPIRATORY PRECAUTIONS

Body, clothes, skin	*Nose, mouth, lungs*	*Eyes*	*Hands*
Full-length gown or disposable plastic apron	Surgical mask (FFP3 if SARS is suspected)	Face shield, visor or goggles	Single gloves: disposable, single use, latex/vinyl/nitrile

NO ↓

Will/might you have **contact** with patient's **blood, body fluids, secretions, excretions,** or **a wound, mucosal surface,** or **sterile site?**

YES or **MAYBE** →

YOU MUST WEAR PPE for STANDARD PRECAUTIONS

Body, clothes, skin	*Nose, mouth*	*Eyes*	*Hands*
Disposable plastic apron, or, if risk of extensive contamination, full-length fluid-impermeable gown	Surgical mask if splash or spray possible and you are wearing goggles instead of a full-face shield	If splash or spray possible, wear face shield, visor or goggles	Single gloves: disposable, single use, latex/vinyl/nitrile

NO ↓

Could the patient have been **contaminated** by **radioactive** material **and not** been **fully decontaminated?**

YES →

YOU MUST WEAR PPE for STANDARD PRECAUTIONS (see above) WITH **DOUBLE** GLOVES

NO ↓

AT ALL TIMES AND FOR ALL PATIENTS ALWAYS:

- Hand hygiene ('clean**your**hands')
- Safe sharps use and disposal
- Good basic hygiene
- Safe disposal of clinical waste
- Learn how to don and remove PPE in a way that minimises the risk of cross-contamination

See also

- Decontamination, standard precautions, respiratory precautions, airborne infection isolation, and agent-specific handsheets

Decontamination of non-ambulant patients at the hospital

Overview

- Decontamination after exposure to a chemical, biological or radiation hazard is intended to reduce the risk of harm to the patient, to others, or to the wider environment
- If a CBRN/Hazmat incident occurs, casualties should be decontaminated at the scene, but, contaminated casualties may also self present to the emergency department
- The first indication of an incident may be the arrival of contaminated or symptomatic patients at your department
- Casualties of industrial accidents, road accidents, bombs or incendiary devices may be contaminated
- Prompt decontamination after chemical exposure may be life-saving; in a radiation incident, first treat life-threatening injury, then decontaminate
- Be alert to the unusual, the unexpected, and the unexplained – and if in doubt, seek expert advice

Equipment for decontamination

Scissors
Buckets (5-10 litres size)
Sponges/soft brushes/washcloths
Liquid soap/washing up liquid/shampoo without conditioner
Disposable towels/drying cloths
Large plastic bags (for clothing and double bagging)
Small clear plastic bags (for jewellery, watches, other valuables)
ID labels/tags
Sturdy containers for used decontamination equipment
Warm water source; 0.9% saline; topical anaesthetic drops for eyes

RINSE – WIPE – RINSE technique

Step 1: Gently wash affected areas with soapy water (0.9% saline for open wounds and eyes): this dilutes the contaminant and removes particles and water based chemicals

Step 2: Wipe affected areas gently but thoroughly with sponge or soft brush or washcloth: this removes organic chemicals and petrochemicals

Step 3: Gently rinse affected areas

"Remove it from others, keep it off yourself, and don't spread it around"

- Work in teams of 2-4 people
- **Protect yourself:** ensure that you are wearing appropriate PPE; do NOT perform mouth to mouth/nose resuscitation
- **Protect others:** ensure that contaminated patients are decontaminated outside your department, in the NHS decontamination unit, and that contaminated patients do not enter the department. Ensure that the decontamination area is cordoned off, secured, and that patients (and staff) have privacy. Only personnel wearing appropriate PPE should enter the decontamination area
- Emergency resuscitation, antidote administration, and decontamination may have to be done at the same time
- Avoid or minimise hand – mouth/eye/face/mask contact. NEVER eat, drink or smoke in the decontamination area
- Make up a solution of **liquid soap and water** (5ml soap/litre of water = 3-4 squirts of liquid soap to a 5-10 litre bucket of water)
- **Use warm or tepid water** (hot water may increase absorption of contaminant; cold water increases risk of hypothermia)
- **Do NOT use bleach**
- Establish patient's name (if possible), and use name and/or hospital number (ideally both) on water-impermeable wrist band for patient and on labels for bags containing patient's clothing and effects
- **Explain what you are going to do** before you start and as you go along. Remember that, for most, this will be a frightening, unpleasant experience
- **Remove/cut off clothing gently and speedily** (this may reduce contamination by 80%-90%). Do NOT pull clothing off over the head
- If clothing is adherent, do not rip, pull or tear: soak gently and thoroughly with water until clothing can be separated from underlying tissue
- Fold clothing outsides to middle to contain contamination. Place clothing in large plastic bag and put ID label in the bag
- Remove jewellery, watches, rings, and other personal effects (eg wallet, passport), place in small clear plastic bag, add ID label
- Place small clear plastic bag inside larger bag, then place both bags inside a further large plastic bag. Seal/tie, ID-label, and store securely
- Glasses/spectacles needed for vision can usually be washed-wiped-rinsed-dried and returned to, or kept with, the patient
- Hearing aids should be removed, but should not be immersed in water. Either wipe thoroughly with saline-moistened gauze, place in clear plastic specimen bag and keep with patient if patient cannot hear without them, or place with other personal effects
- **Decontaminate using RINSE – WIPE – RINSE technique. Do NOT rub hard or abrade skin**, as this may increase absorption
- Airway and face first (protect airway, prevent aspiration); sites needed urgently for IV access and any open wounds next (gently and thoroughly irrigate wounds with copious 0.9% saline, then cover with dressing), then work from hair/head downwards to toes. Pay special attention to skin folds, skin creases (axillae, perineum, back of neck, behind knees), nails, ears, and hair. Roll patient gently onto side (ensure neck stability if cervical spine injury) to reach back, buttocks, back of head, and legs
- **Eyes:** if contact lenses present, remove if possible without harm; use topical anaesthetic if needed; flush eyes copiously with 0.9% saline
- If contaminated with **radioactive material**, survey for residual contamination and if more than 2 x background, repeat decontamination process
- **Dry, and cover** or clothe patient, transfer to clean trolley or backboard, transfer to 'clean' area for further assessment and care
- Used sponges, towels, brushes and other contaminated equipment should remain in the decon area for evidential use or safe disposal
- Contain waste water where possible: if not possible, seek advice, and inform EA/SEPA/local sewage and water companies
- Protect yourself and others: rest and rotate staff as needed; make sure all staff self-decontaminate before leaving the decon area

See also

- For Home Office guidance (The decontamination of people exposed to chemical, biological, radiological or nuclear (CBRN) substances or material. Strategic National Guidance. [2nd edition, revised 2004]), see www.ukresilience.info/cbrn, and PPE, emergency contacts, CERF, radiation facts, specific agents, incident management record form

Infection control: standard precautions and hand hygiene

Overview

- 'Infection control' is intended to prevent transmission of infection between patients, from patients to health care workers, and from health care workers to patients. Training in basic infection control and local policies should be provided as part of your orientation or induction. If you are in doubt about any aspect of infection control, or need training, seek help from your infection control team
- Infection control includes adopting safe behaviours and working practices (eg hand hygiene) that reduce transmission of infection; choice and use of personal protective equipment (PPE: gloves, gowns, eye/mouth/face protection, masks); patient placement (eg protective isolation for immunosuppressed patients, isolation rooms, cohort nursing); pre and post exposure prophylaxis (eg HBV immunisation); environmental measures (eg cleaning, laundering, safe disposal of clinical waste); design and engineering controls (eg auto-destruct syringes, laminar air flow), and organisational culture – working in an organisation where patient and worker safety is highly valued.
- **'STANDARD'** precautions are applied by **ALL STAFF** in **ALL HEALTH CARE SETTINGS** to **ALL PATIENTS**, regardless of the patient's diagnosis or presumed infection status, **ALL THE TIME**

Standard precautions

- Practice good basic hygiene with regular hand cleaning (see below)
- Cover wounds or skin lesions with waterproof dressings
- Never touch your eyes, nose, mouth or face, or adjust PPE, with contaminated hands or gloves: you risk infecting yourself
- Limit your contact with items in the patient's immediate environment to the minimum necessary for patient care
- Select PPE for a task according to the anticipated risks (splash, spray, splatter, touch, infection, chemical, radiation)
- Wear gloves (single use disposable latex, vinyl or nitrile) for: all invasive procedures; contact with sterile sites (including wound care and dressing changes); contact with mucous membranes, and all tasks assessed as carrying a risk of exposure to patients' blood or body fluids
- Don gloves immediately before starting the task, remove and discard them safely on completion, and clean your hands before moving to another patient
- Work from 'clean' to 'dirty'; change gloves during a procedure if you have to move from a 'dirty' body site to a 'clean' one
- If your gloves get torn or become heavily soiled during a procedure, remove them, discard them safely, clean your hands, and don a new pair
- Wear a disposable single use plastic apron for any task where there is a risk that your clothing or uniform may be exposed to the patient's body fluids or become wet; discard the apron safely when you complete the task and clean your hands before moving to another patient
- Wear a full-body, fluid-impermeable, gown for tasks where there is a risk of extensive splashing of body fluids or contamination of your skin
- Wear eye and face protection for tasks where there is a risk of splashes or spray to your face, eyes, nose or mouth
- Avoid using sharps if possible, and know how to use and discard sharps safely
- Do not re-sheathe needles; discard used needles and syringes as a single unit into a sharps bin placed at point of use; do not overfill sharps bins
- Know what to do if there is a sharps injury or blood splash incident
- Always clear up blood spillages promptly and safely
- Never re-use single use disposable equipment (including single use ambu bags, laryngoscope blades/handles, suction equipment), and ensure that re-usable equipment is correctly decontaminated (eg by being sent to CSSD) after use and before being used on another patient
- Always dispose of contaminated waste safely, and know how to deal with soiled linen
- Clean, disinfect and sterilise equipment, and decontaminate the environment as appropriate
- If you are in doubt, or unsure about any aspect of infection control, ask your infection control team for advice

Hand hygiene: cleanyourhands

- If **ALL** health care workers **ALWAYS** cleaned their hands before **ANY** direct patient contact, health care associated infections could be halved
- If your hands are visibly dirty, or contaminated with blood or body fluids, use soap and water to clean your hands
- If your hands are not visibly dirty, use an alcohol-based hand rub, or soap and water
- **Always** clean**your**hands:
  - Before any patient contact (even if you are 'only' going to examine them)
  - Before any clinical procedure
  - Before you eat
  - After any patient contact
  - After completing a clinical procedure
  - After handling or touching any contaminated item or equipment (eg bed pan, suction apparatus, toilet flush-button)
  - After removing your gloves
  - After leaving an isolation room
  - After using the lavatory
- Never try to clean visibly soiled disposable gloves by cleaning your gloved hands: it doesn't work. Remove gloves, clean your hands, and reglove

See also

- Emergency contacts, personal protective equipment, respiratory precautions, airborne infection isolation, specific agents

Infection control: respiratory precautions

Droplet spread

- Droplets are particles (> 5 micrometers) generated when a patient coughs, sneezes or talks, and during cough-provoking procedures (eg bronchoscopy, chest physiotherapy, suctioning, intubation, nasogastric tube insertion, nebuliser therapy, non-invasive ventilation, CPAP)
- Droplets expelled by an infected patient can travel for short distances through the air and, if deposited on the mucosal surfaces of the eyes, nose or mouth (or subsequently transferred there by hand-face contact) can infect anyone nearby (traditionally, within 1 metre, but possibly, at greater distances)
- Diseases that are transmissible by droplet spread include: SARS, influenza, pneumonic plague, monkeypox, smallpox, *Mycoplasma pneumoniae,* adenovirus, RSV, whooping cough, group A streptococcal infections and meningococcal meningitis (*Neisseria meningitidis*)
- Smallpox and SARS may also be transmissible from person to person by airborne spread: airborne isolation infection precautions are required
- Basic hygiene measures, applied as part of standard infection control, will help to prevent transmission of these infections. You should:
  - Encourage all staff, patients and visitors with URTI symptoms (cough, sneezing, runny nose) to cover their nose and mouth when coughing or sneezing, and to use single-use disposable paper tissues, discard them safely into a lidded bin, and clean their hands afterwards
  - Ensure that patients (and others) in waiting areas who have URTI symptoms maintain a distance of at least 1 metre from others in the area, and are offered a surgical mask to wear and/or disposable tissues to use while waiting
  - Make sure that if you have symptoms of an URTI, you avoid patient contact until your symptoms have resolved
  - Practice scrupulous hand hygiene ('clean**your**hands')
  - Avoid touching your eyes, nose, mouth or face or adjusting your PPE with contaminated, unclean, or gloved hands
  - Ensure that single use disposable equipment (eg peak flow meter mouthpiece) is always safely discarded after a single use
  - Ensure that surfaces and equipment are regularly cleaned and decontaminated, paying particular attention to surfaces and items likely to be touched frequently or likely to be contaminated with blood/body fluids (eg bedrails, doorknobs, bedside tables, equipment near patient, toilet and surrounding area)

Respiratory precautions

- Use **RESPIRATORY PRECAUTIONS** in **addition** to **STANDARD** precautions when you **know** or **suspect** that a patient has an **infection transmissible by droplet spread** or when the patient has syndromic signs and symptoms of an infection transmissible by droplet spread (eg URTI or flu-like illness; meningitis with petechial or ecchymotic rash; bronchiolitis in children)
  - Examine the patient in a single room or cubicle
  - Wear a surgical mask (in addition to any other necessary PPE) for all close contact with the patient (within 1-2 metres, or when in room)
  - Change your mask if it becomes soiled or wet, or before leaving the room: discard it safely, and immediately clean your hands
  - If the patient needs admission and a single room is not available, discuss patient placement with your infection control team
  - Encourage the patient to wear a surgical mask, provided that they can tolerate this medically
  - Encourage anyone accompanying or visiting the patient to wear a surgical mask
  - Limit patient movement outside the room to what is medically necessary
  - If the patient has to be moved from the room (eg to go to X-ray), they should wear a surgical mask until they return to the room; those transporting or accompanying the patient do not need to wear a mask
  - Maintain respiratory precautions until the suspected diagnosis has been excluded or, for bacterial infections, until 24 hours (meningococcal infection) or 72 hours (pneumonic plague) after the start of antibiotic therapy or, for viral infections, until symptoms resolve – but discuss discontinuation with your infection control team

Masks

- Wear a mask:
  - As part of PPE for standard precautions, to protect your nose and mouth during tasks that might produce splash/spray of blood or body fluids
  - As part of PPE for respiratory precautions, to protect your nose, mouth and upper respiratory tract from droplet infection
  - During surgical procedures or other 'sterile' procedures, to protect the patient
- Don PPE in this order: gown, mask, face shield or goggles, gloves
- Remove PPE in order determined by local protocol
- When you remove your mask, assume that both the inside and the outside of the facepiece are contaminated: do NOT handle the facepiece. Remove the mask touching only the tapes or ties, discard it safely into a waste container, and then immediately clean**your**hands
- Surgical masks do not protect against the infection following the inhalation of small (< 5 micrometers) particles. If you know or suspect that the patient has smallpox, a viral haemorrhagic fever, or other serious infection that may be transmissible by airborne infectious particles, you should wear a correctly fitted FFP3 mask. You should also use a FFP3 mask if the patient fulfils the case definition for SARS or for avian influenza until these diagnoses have been excluded.

See also

- Emergency contacts, personal protective equipment, standard precautions, airborne infection isolation, specific agents

Infection control: airborne infection isolation

Airborne spread of infection

- Airborne spread follows the inhalation of small (< 5 micrometers) particles containing an infectious agent
- These small particles may be formed after evaporation of droplets expelled from the respiratory tract (droplet nuclei) of an infected patient, or from dust particles containing microorganisms
- Small particles less than 5 micrometers can remain suspended in air, travel for longer distances in air than larger particles, and may be dispersed widely in air currents and through shared ventilation systems, so close contact (within 1-2 metres) with an infected person is not required for transmission of infection, although close contact may make transmission more likely
- Infections that may be transmissible from person to person by the airborne route include TB, chickenpox, measles, smallpox and, possibly, SARS, and viral haemorrhagic fevers (VHFs)
- Smallpox is most often transmitted by droplet spread or by contact, but airborne transmission from person to person has been documented
- Airborne spread of haemorrhagic fever viruses is thought to be an uncommon route of transmission in humans, but research on VHF infections in non-human primates has suggested that airborne spread in these species may be possible
- Airborne transmission of SARS from person to person has been reported, but not conclusively proven
- Surgical masks protect mucosal surfaces of the upper respiratory tract against contamination by large particles (droplets) and, therefore, protect personnel against infections transmissible by droplet spread, but they do not protect the respiratory tract against inhaled infectious small particles
- Basic hygiene measures, applied as part of standard infection control, also help to prevent transmission of these infections. See the handsheets on 'standard infection control precautions', 'respiratory precautions', and 'personal protective equipment' for more information

Airborne infection isolation

- Use **AIRBORNE INFECTION ISOLATION** (sometimes called 'STRICT RESPIRATORY PRECAUTIONS') in addition to **STANDARD** precautions when you know or suspect that a patient has **smallpox, SARS, a viral haemorrhagic fever,** or **other infection that may be transmissible by airborne spread** or when the patient has syndromic signs and symptoms of an infection transmissible by airborne spread (eg fever + generalised vesicular rash; fever and repetitive dry cough)
- Develop triage systems that allow early identification and segregation of patients who may have an infection transmissible by airborne spread
- In the emergency department:
  - **Immediately put a surgical mask on the patient** and maintain this until patient has either been admitted to a negative pressure isolation room or assessed and the diagnosis of an infection transmissible by the airborne route excluded
  - **Immediately place patient in single room/side room, close the door, and restrict entry to essential personnel:** admitting doctor (wearing surgical mask or FFP3 mask, gown and gloves) to remain with patient to provide reassurance and any immediately necessary supportive care
  - All persons entering the room to don gown, face shield or goggles, and surgical mask or FFP3 mask before entry, and to remove and safely discard all PPE, and clean their hands immediately before leaving the room
  - Senior EM clinician (wearing surgical mask or FFP3 mask, eye protection, gown, gloves) to assess patient. If the diagnosis cannot be excluded, arrange urgent further assessment and management by Smallpox Diagnostic Expert, or ID physician or consultant microbiologist, as appropriate
- If the patient requires admission:
  - Immediately alert infection control team, occupational health, and local Health Protection Team
  - Admit to 'negative pressure' isolation room with more than 6 air changes/hour (or, for VHFs, as directed by ID physician)
  - If negative pressure isolation room is not available, agree patient placement with infection control doctor and consultant ID physician
  - Restrict entry to essential personnel and visitors; all entering room to wear correctly fitting FFP3 mask, eye protection, and other PPE as appropriate, and to have been instructed in infection control precautions before entry
  - Keep the door closed except to allow entry and exit of essential personnel and visitors
  - Limit patient movement outside the room to what is medically necessary
  - If the patient has to be moved from the room (eg to go to X-ray), they should wear a surgical mask until they return to the room. Those transporting or accompanying the patient should wear a correctly fitting FFP3 mask and other PPE as appropriate
  - Keep aerosol-provoking procedures to the minimum necessary for effective patient care
  - Don PPE in this order: gown, FFP3 mask, face shield and/or goggles, gloves
  - Remove PPE in order determined by local protocol
  - When you remove your FFP3 mask, assume that both the inside and the outside of the facepiece are contaminated: do NOT handle the facepiece. Remove the mask touching only the tapes or ties, discard it safely into a waste container, and then immediately **clean your hands**
  - Maintain airborne infection isolation until the suspected diagnosis has been excluded, or, for smallpox, until the scabs have separated; for VHFs for the duration of illness; for SARS for 10 days after resolution of fever, provided that respiratory symptoms have resolved or are improving – but always discuss discontinuation of airborne infection isolation with the infection control team

See also

For detailed guidance on the management of smallpox, SARS, and VHFs, see agent specific section. More detailed information available at: www.hpa.org.uk

Suspect packages and parcels

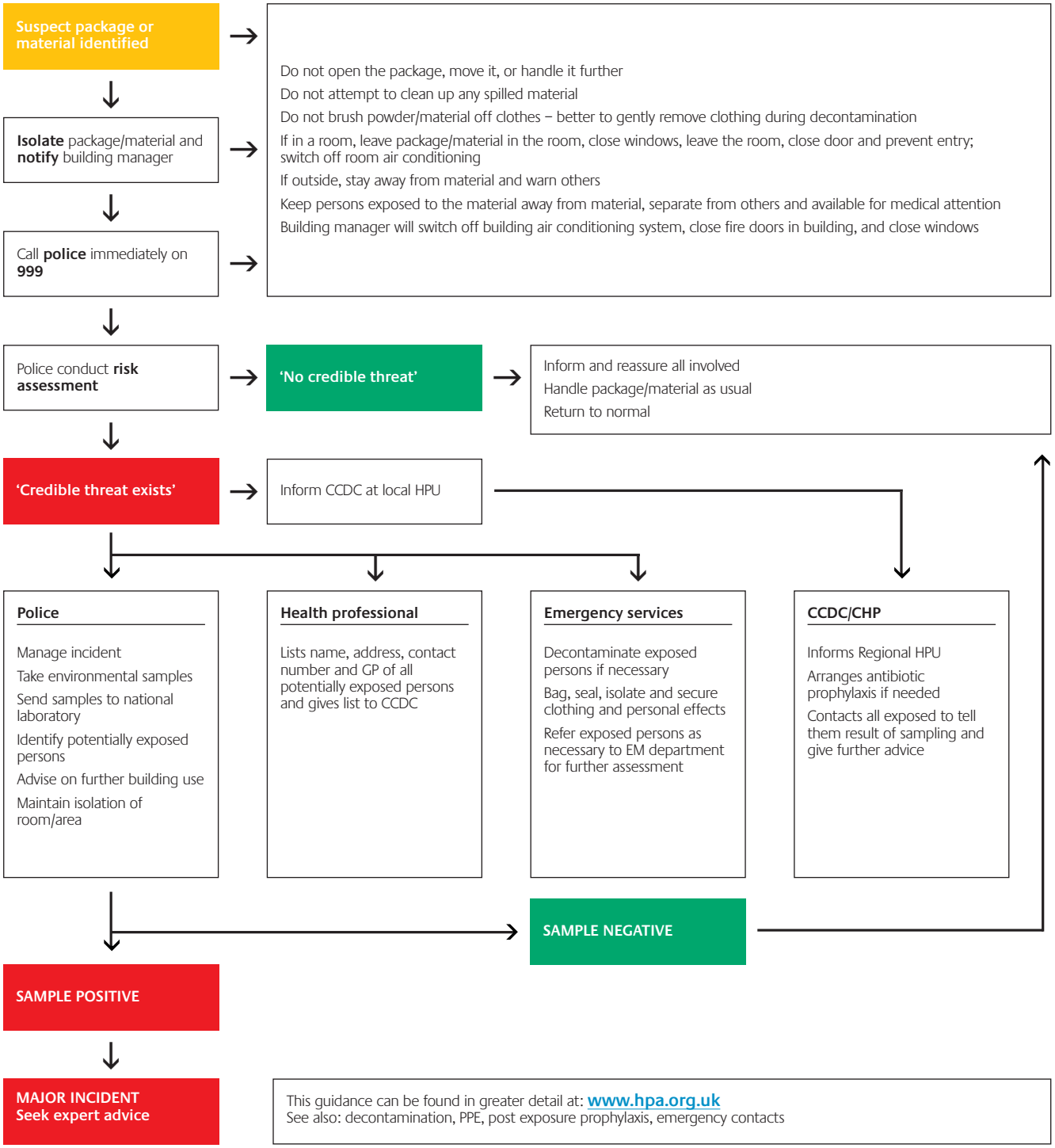
Remember

If you are EVER in ANY doubt about a package, letter or parcel
DO NOT OPEN IT, HANDLE IT, OR MOVE IT
CALL THE POLICE ON 999

Signs that might trigger suspicion include

- Any envelope or package with a suspicious or threatening message written on it or contained inside
- Oily stains, strange odours
- Envelopes that are lopsided, rigid, bulky, discoloured, or feel as though they contain powder
- Unexpected envelopes or packages from foreign countries
- No postage stamp, no franking, no cancellation of the postage stamp, excessive postage
- Incorrect spelling of common names, places or titles
- Handwritten envelopes/packages from an unknown source particularly if addressed to an individual and marked 'personal' or 'addressee only'
- Symptoms (runny nose, streaming eyes, cough, skin irritation) in exposed persons

Suspect package management algorithm



This guidance can be found in greater detail at: www.hpa.org.uk
See also: decontamination, PPE, post exposure prophylaxis, emergency contacts

Incident management records

Overview

- Many, if not all, major incidents, accidents or outbreaks will be followed by an investigation
- It is therefore very important that your records are comprehensive, contemporary, and legible
- Incident management records should include the details of **ALL** advice given or received, and **ALL** actions taken to protect yourself, staff, patients or the public, or to inform others. Time, date and sign them all.
- You may find the form below, which may be freely copied, helpful – it may not cover everything, so amend it as necessary

Incident advice record form

Hospital/Trust:	Department:	Date:	
Type of incident:	Place of incident:	Number of casualties:	
Task/query	Advice received and action taken (Details of the advice/action, your name and signature)	Source of advice (Name, date, time)	Telephone number
Staff protection/PPE			
Operational lockdown			
Turning off air-conditioning			
Patient containment			
Decontamination			
Patient investigation			
Patient treatment			
Post exposure prophylaxis			
Environmental sampling			
Who to inform			
Other			
Other			
Other			
Other			
Other			
Other			
Other			
Other			
Other			

DO NOT WRITE ON THIS FORM – USE IT AS A MASTER TO MAKE PHOTOCOPIES

Chain of evidence documentation

Overview

- If a deliberate release is suspected or there are other forensic considerations, chain of evidence (sometimes called 'chain of custody') documentation will be needed for samples
- Chain of evidence forms are intended to provide a complete record of the 'life' of a sample – from obtaining the sample, through testing (perhaps in two or three different laboratories), to storage
- Any break in the chain of documentation may compromise the evidential value of the sample
- Samples from a single patient to a single destination (eg microbiology, toxicology laboratory) can be grouped together on the same form
- Every transfer of a sample must be documented. If you use the form below, which may be freely copied or used as a template for your own form, you will need to complete a new form for each transfer (eg from the person who took the sample to the porter who will take the sample to the laboratory; from porter to scientist; from laboratory to courier service; from courier service to scientist in reference laboratory). All the forms in this chain must be numbered in sequence
- Keep all the forms for one set of samples together – and keep the originals carefully: photocopies cannot usually be used as evidence.
- The consultant in charge of the case should authorise the transfer of the sample(s) to the laboratory. To prevent delay, particularly for specimens critical to patient care (eg group and save, cross match, ABGs), authorisation may be given verbally – but the consultant must sign the form as soon as practicable thereafter

Chain of evidence form

HOSPITAL/TRUST				
PATIENT DETAILS	Patient name:		Sex:	Date of birth:
	Hospital number:		Postcode:	Ward:
Requesting doctor:			Bleep number:	Consultant:

SAMPLE DETAILS			
Sample type/description	Sample date	Sample time	Laboratory/specimen number

HANDOVER DETAILS			
Person handing the sample(s) over		**Person receiving the sample(s)**	
Name:	Grade:	Name:	Grade:
Signature:	Date & time:	Signature:	Date & time:
Person authorising the transfer			
Name:	Signature:		Date:
Address:			Form number:

Chain of evidence form

HOSPITAL/TRUST				
PATIENT DETAILS	Patient name:		Sex:	Date of birth:
	Hospital number:		Postcode:	Ward:
Requesting doctor:			Bleep number:	Consultant:

SAMPLE DETAILS			
Sample type/description	Sample date	Sample time	Laboratory/specimen number

HANDOVER DETAILS			
Person handing the sample(s) over		**Person receiving the sample(s)**	
Name:	Grade:	Name:	Grade:
Signature:	Date & time:	Signature:	Date & time:
Person authorising the transfer			
Name:	Signature:		Date:
Address:			Form number:

DO NOT WRITE ON THIS FORM – USE IT AS A MASTER TO MAKE PHOTOCOPIES

Further reading and other resources

Important UK national sources of advice include:

Health Protection Agency www.hpa.org.uk
Department of Health www.dh.gov.uk
Home Office www.homeoffice.gov.uk/terrorism
UK Resilience www.ukresilience.info

UK toxicology & pharmacology resources:

TOXBASE www.spib.axl.co.uk (registration required)
British National Formulary www.bnf.org (registration required)
Chemical Incident Management Handbook, The Stationery Office, 2000, ISBN 0113222521

UK professional organisations for emergency and immediate care providers include:

BASICS (British Association for Immediate Care) www.basics.org.uk
British Association for Accident and Emergency Medicine www.baem.org.uk
Faculty of Accident and Emergency Medicine www.faem.org.uk
Advanced Life Support Group www.alsg.org.uk

Other useful UK organisations include:

PRODIGY www.prodigy.nhs.uk
Doctors.Net www.doctors.net.uk

Important international sources of advice include:

World Health Organisation www.who.int/csr/en from which 'Public health response to biological and chemical weapons. WHO guidance 2004' may be downloaded
Centers for Disease Control and Prevention, Atlanta, Emergency Preparedness and Response website www.bt.cdc.gov
International Atomic Energy Authority www.ieae.org
International Programme on Chemical Safety www.inchem.org
International Commission on Radiological Protection www.icrp.org

Sources of expert telephone advice

HPA Chemical Hazards and Poisons Division 0870 606 4444
HPA Centre for Emergency Preparedness and Response 01980 612 100
HPA Centre for Infections 020 8200 4400
HPA National Poisons Information Service 0870 600 6266
HPA Radiation Protection Division, office hours 01235 831600 *or* non office hours 01235 834590
NAIR (National Arrangements for Incidents involving Radioactivity) RADSAFE 0800 834 153
Institute of Naval Medicine (for advice on the clinical management of radiation injury; ask for duty RMS) 02392 768 020