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 (e.g. 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    | Emergency medicine incident room | Police Documentation Office |
| Emergency medicine incident room |                              |
| Major incident press office    |                              |

### Local contacts (internal and external)

<table>
<thead>
<tr>
<th>Contact</th>
<th>Name</th>
<th>Extension</th>
<th>Bleep</th>
<th>Mobile/out of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Chief Executive</td>
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<tr>
<td>Trust Senior Nurse Manager</td>
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<tr>
<td>Trust Medical Director</td>
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<tr>
<td>Consultant chemical pathologist</td>
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<tr>
<td>Consultant microbiologist</td>
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<tr>
<td>Consultant haematologist</td>
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<tr>
<td>Consultant infectious disease physician</td>
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<tr>
<td>Infection control lead</td>
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<tr>
<td>Occupational Health lead</td>
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<tr>
<td>Radiation protection/safety officer</td>
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<tr>
<td>Emergency Planning Liaison Officer</td>
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<tr>
<td>Head pharmacist</td>
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<tr>
<td>Emergency admissions/beds manager</td>
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<tr>
<td>Duty manager</td>
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<tr>
<td>Chaplains</td>
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<tr>
<td>Voluntary services organiser</td>
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<tr>
<td>Switchboard supervisor</td>
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<tr>
<td>Duty engineer</td>
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<tr>
<td>Social services emergency duty team</td>
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<tr>
<td>Senior Security Manager</td>
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<tr>
<td>Catering Manager</td>
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<tr>
<td>Contact</td>
<td>Name</td>
<td>Extension</td>
<td>Bleep</td>
<td>Mobile/out of hours</td>
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<tr>
<td>HM Coroner</td>
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<tr>
<td>Consultant CDC/Health Protection</td>
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<tr>
<td>Health Protection Unit</td>
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<tr>
<td>DPH, lead Primary Care Trust</td>
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<tr>
<td>Regional HEPs</td>
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<tr>
<td>Regional Infectious Disease Unit</td>
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<tr>
<td>Regional Chemical Provider Unit</td>
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<tr>
<td>Regional Burns Unit</td>
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<tr>
<td>Police</td>
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<tr>
<td>Fire and Rescue Service</td>
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<tr>
<td>Ambulance control</td>
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<tr>
<td>Pod activation (via ambulance/BTS)</td>
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<tr>
<td>NHS Direct</td>
<td></td>
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<tr>
<td>HPA Chemical Hazards and Poisons Division: 0844 8920555</td>
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<tr>
<td>HPA National Poisons Information Service: 0844 8920111</td>
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<tr>
<td>HPA Centre for Infections: 020 8200 4400</td>
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<tr>
<td>NAR (for incidents involving radioactivity): 0800 834 153</td>
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</tr>
</tbody>
</table>

DO NOT WRITE ON THIS FORM – USE IT AS A MASTER TO MAKE PHOTOCOPIES
Immediate incident management for first responders

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

<table>
<thead>
<tr>
<th>METHANE</th>
<th>'CHALETS'</th>
</tr>
</thead>
<tbody>
<tr>
<td>My call sign/major incident alert</td>
<td>Casualties, number and severity</td>
</tr>
<tr>
<td>Exact location</td>
<td>Hazards, present and potential</td>
</tr>
<tr>
<td>Type of incident</td>
<td>Access and egress</td>
</tr>
<tr>
<td>Hazards at the scene</td>
<td>Location - exact</td>
</tr>
<tr>
<td>Access</td>
<td>Emergency services - present or required</td>
</tr>
<tr>
<td>Number of casualties and severity</td>
<td>Type of incident</td>
</tr>
<tr>
<td>Emergency services present or required</td>
<td>Safety</td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>P1</th>
<th>LIFE THREATENING</th>
<th>Breathe only after airway cleared or RR less than 9 or more than 30bpm or CRT more than 2 secs</th>
<th>IMMEDIATE TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2</td>
<td>URGENT</td>
<td>Unable to walk and RR 10bpm-25bpm and CRT 2 secs or less</td>
<td>URGENT TREATMENT</td>
</tr>
<tr>
<td>P3</td>
<td>MINOR</td>
<td>Walking</td>
<td>DELAYED TREATMENT</td>
</tr>
<tr>
<td>P4</td>
<td>DEAD</td>
<td>Not breathing even after airway cleared</td>
<td>NO TREATMENT</td>
</tr>
</tbody>
</table>

- **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 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 until 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
## 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).

### Algorithm for Selecting PPE

1. **Has the patient been exposed to a chemical and not been fully decontaminated?**
   - **YES** or **MAYBE**

2. **Could this be smallpox, a viral haemorrhagic fever (VHF), or other infection (e.g., TB) requiring airborne infection isolation?**
   - **NO**

3. **Will/might you be exposed to patient’s respiratory secretions (e.g., patient with cough, URTI, ‘flu symptoms) or are you about to do a cough-provoking procedure (e.g., suction, intubation, NG tube, bronchoscopy)?**
   - **YES** or **MAYBE** (SEEK EXPERT ADVICE)

4. **Will/might you have contact with patient’s blood, body fluids, secretions, excretions, or a wound, mucosal surface, or sterile site?**
   - **NO**

5. **Could the patient have been contaminated by radioactive material and not been fully decontaminated?**
   - **YES**

### 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

### YOU MUST WEAR PPE for CHEMICAL EXPOSURE

<table>
<thead>
<tr>
<th>Body, clothes, skin</th>
<th>Nose, mouth, lungs</th>
<th>Eyes</th>
<th>Hands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical-resistant coverall + boots</td>
<td>Chemical respirator (integral to PPE)</td>
<td>Chemical-resistant coverall + integral hood</td>
<td>Chemical-resistant gloves</td>
</tr>
</tbody>
</table>

### YOU MUST WEAR PPE for AIRBORNE INFECTION ISOLATION

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

### YOU MUST WEAR PPE for RESPIRATORY PRECAUTIONS

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

### YOU MUST WEAR PPE for STANDARD PRECAUTIONS

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

### YOU MUST WEAR PPE for STANDARD PRECAUTIONS (see above)

WITH DOUBLE GLOVES
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

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

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 outwards 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.
- 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.
- 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](http://www.ukresilience.info/cbrn), and PPE, emergency contacts, CERF, radiation facts, specific agents, incident management record form.
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 reusable 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
Droplet spread

- Droplets are particles (> 5 micrometers) generated when a patient coughs, sneezes or talks, and during cough-provoking procedures (e.g. 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 (e.g. 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 (e.g. 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 (e.g. 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.
  - 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 has to be moved from the room (e.g. 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.
  - If the patient has to be moved from the room (e.g. 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.
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

- 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**

1. **Suspect package or material identified**
   - Do not open the package, move it, or handle it further
   - Do not attempt to clean up any spilled material
   - Do not brush powder/material off clothes – better to gently remove clothing during decontamination
   - If in a room, leave package/material in the room, close windows, leave the room, close door and prevent entry; switch off room air conditioning
   - If outside, stay away from material and warn others

2. **Isolate package/material and notify building manager**
   - Keep persons exposed to the material away from material, separate from others and available for medical attention
   - Building manager will switch off building air conditioning system, close fire doors in building, and close windows

3. **Call police immediately on 999**

4. **Police conduct risk assessment**

   - ‘No credible threat’
     - Inform and reassure all involved
     - Handle package/material as usual
     - Return to normal

   - ‘Credible threat exists’
     - Inform CCDC at local HPU

5. **Police**
   - Manage incident
   - Take environmental samples
   - Send samples to national laboratory
   - Identify potentially exposed persons
   - Advise on further building use
   - Maintain isolation of room/area

6. **Health professional**
   - Lists name, address, contact number and GP of all potentially exposed persons and gives list to CCDC

7. **Emergency services**
   - Decontaminate exposed persons if necessary
   - Bag, seal, isolate and secure clothing and personal effects
   - Refer exposed persons as necessary to EM department for further assessment

8. **CCDC/CHP**
   - Informs Regional HPU
   - Arranges antibiotic prophylaxis if needed
   - Contacts all exposed to tell them result of sampling and give further advice

9. **SAMPLE NEGATIVE**

   - This guidance can be found in greater detail at: [www.hpa.org.uk](http://www.hpa.org.uk)
   - See also: decontamination, PPE, post exposure prophylaxis, emergency contacts

10. **SAMPLE POSITIVE**

    - MAJOR INCIDENT
      - Seek expert advice

11. **SAMPLE POSITIVE**

    - This guidance can be found in greater detail at: [www.hpa.org.uk](http://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

<table>
<thead>
<tr>
<th>Incident advice record form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital/Trust:</strong></td>
</tr>
<tr>
<td><strong>Type of incident:</strong></td>
</tr>
<tr>
<td><strong>Task/query</strong></td>
</tr>
<tr>
<td>Staff protection/PPE</td>
</tr>
<tr>
<td>Operational lockdown</td>
</tr>
<tr>
<td>Turning off air-conditioning</td>
</tr>
<tr>
<td>Patient containment</td>
</tr>
<tr>
<td>Decontamination</td>
</tr>
<tr>
<td>Patient investigation</td>
</tr>
<tr>
<td>Patient treatment</td>
</tr>
<tr>
<td>Post exposure prophylaxis</td>
</tr>
<tr>
<td>Environmental sampling</td>
</tr>
<tr>
<td>Who to inform</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Other</td>
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<td>Other</td>
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<td>Other</td>
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<td>Other</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>HOSPITAL/TRUST</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT DETAILS</td>
<td></td>
</tr>
<tr>
<td>Patient name:</td>
<td>Sex:</td>
</tr>
<tr>
<td>Hospital number:</td>
<td>Postcode:</td>
</tr>
<tr>
<td>Requesting doctor:</td>
<td>Bleep number:</td>
</tr>
<tr>
<td>Consultant:</td>
<td></td>
</tr>
</tbody>
</table>

| 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: | Form number: |  |
| Address: | Form number: |  |
Further reading and other resources

Important UK national sources of advice include:

- Health Protection Agency [www.hpa.org.uk](http://www.hpa.org.uk)
- Department of Health [www.dh.gov.uk](http://www.dh.gov.uk)
- Home Office [www.homeoffice.gov.uk/terrorism](http://www.homeoffice.gov.uk/terrorism)
- UK Resilience [www.ukresilience.info](http://www.ukresilience.info)

UK toxicology & pharmacology resources:

- TOXBASE [www.spib.axl.co.uk](http://www.spib.axl.co.uk) (registration required)
- British National Formulary [www.bnf.org](http://www.bnf.org) (registration required)

UK professional organisations for emergency and immediate care providers include:

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

Other useful UK organisations include:

- PRODIGY [www.prodigy.nhs.uk](http://www.prodigy.nhs.uk)

Important international sources of advice include:

- World Health Organisation [www.who.int/csr/en](http://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](http://www.bt.cdc.gov)
- International Atomic Energy Authority [www.ieae.org](http://www.ieae.org)
- International Programme on Chemical Safety [www.inchem.org](http://www.inchem.org)
- International Commission on Radiological Protection [www.icrp.org](http://www.icrp.org)

Sources of expert telephone advice

- HPA Chemical Hazards and Poisons Division 0844 8920555
- HPA Centre for Emergency Preparedness and Response 01980 612 100
- HPA Centre for Infections 020 8200 4400
- HPA National Poisons Information Service 0844 8920111
- 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