

[HOSPITAL / HEALTH AUTHORITY NAME]

EMERGENCY DEPARTMENT INFECTION PREVENTION, ISOLATION, AND OUTBREAK RESPONSE

Protocol 54: Standard and Transmission-Based Precautions; Syndromic Screening; Source Control; Patient Placement; Personal Protective Equipment; Environmental Safety; Occupational Exposure; Surveillance; Outbreak Activation; Continuity of Care; and Quality Governance

DRAFT FOR EMERGENCY MEDICINE, NURSING, INFECTION PREVENTION AND CONTROL, MICROBIOLOGY / LABORATORY, OCCUPATIONAL HEALTH, ENVIRONMENTAL SERVICES, FACILITIES / ENGINEERING, AMBULANCE / TRANSFER SERVICES, BED MANAGEMENT, SECURITY, PUBLIC HEALTH, AND CLINICAL GOVERNANCE

STATUS: This is a draft clinical-governance document. It must be reconciled with the hospital infection-prevention manual, national public-health law, current notifiable-disease rules, local isolation and ventilation capacity, approved PPE and respiratory-protection programme, environmental-cleaning procedures, laboratory and specimen pathways, occupational-health arrangements, waste and linen systems, staff immunization policy, and regional referral capability before implementation.

CORE RULE: Use Standard Precautions for every patient, every time. Add Transmission-Based Precautions immediately from the presenting syndrome and epidemiological risk; do not wait for a confirmed diagnosis when delay could expose patients, staff, visitors, ambulance crews, cleaners or the community.

EARLY-SEPARATION RULE: At the first point of contact, contain respiratory secretions, cover draining lesions, perform hand hygiene, and move patients with acute respiratory symptoms, fever with rash, suspected meningococcal disease, infectious vomiting / diarrhoea, unexplained vesicular or pustular lesions, or high-risk travel / exposure out of shared waiting areas as rapidly as clinical safety permits.

OUTBREAK RULE: A single suspected high-consequence infection, unexpected transmission event, unusual organism, or epidemiologically linked cluster requires immediate senior, IPC, laboratory and public-health escalation. Begin control measures, line-listing and exposure management while confirmation is pending.

Document control	Details
Document owner	Emergency Department / Medical Services Directorate / Nursing Services / Infection Prevention and Control Committee / Clinical Governance
Clinical leads	Emergency Medicine; Nursing; IPC; Microbiology / Laboratory; Occupational Health; Environmental Services; Facilities / Engineering; Public Health
Applies to	All patients, accompanying persons, visitors, staff, students, contractors, ambulance crews and other personnel entering or working in the emergency-care environment.
Exclusions	This protocol does not replace pathogen-specific national guidance, laboratory biosafety manuals, sterilization / reprocessing standards, occupational-health protocols, or public-health outbreak command arrangements.
Interfaces	All presentation-specific emergency protocols; Protocol 40 Paediatric Emergency Assessment; Protocol 41 Neonatal Emergencies; Protocol 43 Safeguarding; Protocol 46 Immunocompromised / Oncology Emergencies; Protocol 48 Airway and Ventilatory Support; Protocol 53 Observation Care; Protocol 55 Crowding and Surge; Protocol 56 Disaster Response; Protocol 57 Downtime; Protocol 58 Security and Staff Safety; Protocol 59 Quality Assurance.
Version / status	Draft 1.0 for local multidisciplinary, legal, IPC, public-health, engineering and executive validation.
Approval date / review	Approval: _____ Review: _____ Earlier review after outbreak, occupational transmission, major PPE / ventilation change, new national guidance, serious incident, or identified control failure.
Mandatory local documents	Current isolation matrix; public-health notification list; respiratory-protection programme; donning / doffing procedures; cleaning and room-release SOPs; occupational-exposure pathway; outbreak plan; laboratory specimen guidance; transfer and mortuary arrangements; PPE stock and contingency plan.

1. Purpose

To provide a practical, rapid and auditable emergency-department framework that prevents transmission while preserving timely resuscitation, diagnosis, compassionate care and access. The protocol supports early syndromic recognition, proportionate isolation, correct PPE, safe patient flow, protection of staff and vulnerable patients, prompt public-health communication, and coordinated outbreak response.

2. Core principles

- Infection prevention begins at the entrance, not after laboratory confirmation. Passive signage, active screening and rapid placement must function during routine operations, crowding, outbreaks and disasters.

- Standard Precautions apply to all care because infection or colonization may be unrecognized. Transmission-Based Precautions are additional, syndrome- and route-specific controls.
- Urgent treatment must not be delayed. When infection risk is uncertain, staff should use appropriate PPE, control the source and resuscitate in the safest available location.
- Use the hierarchy of controls: reduce avoidable exposure; separate and route patients; improve ventilation and physical barriers; standardize work systems; then use PPE correctly. PPE alone is not a complete safety system.
- Match precautions to the likely transmission route, severity, procedure and setting. Use combined precautions when more than one route is plausible.
- Use the least restrictive measures that safely prevent transmission. Isolation must not become neglect, delayed analgesia, reduced monitoring, stigma or denial of family communication.
- Apply precautions consistently to staff, visitors and accompanying persons. Provide instructions in accessible language and accommodate disability, age, culture and literacy.
- Protect confidentiality while sharing the minimum necessary information for clinical safety, occupational exposure management and public-health action.
- Report hazards, breaches and exposures promptly without blame. Early reporting enables prophylaxis, containment and system repair.
- Review precautions whenever new clinical, laboratory or epidemiological information becomes available, and document the reason to continue, change or stop them.

3. Scope and definitions

Term	Working definition
Standard Precautions	The minimum IPC practices used for every patient, based on anticipated exposure to blood, body fluids, secretions, excretions, non-intact skin, mucous membranes, contaminated equipment or the care environment.
Transmission-Based Precautions	Additional contact, droplet, airborne or combined measures used for known or suspected infections when Standard Precautions alone may not prevent transmission.
Source control	Actions taken by a potentially infectious person to reduce release of infectious material, including a well-fitting mask when appropriate, respiratory hygiene, covering lesions and containing diarrhoea or drainage.
Airborne infection isolation room (AIIR)	A single room designed and verified to maintain inward directional airflow and the approved air-exchange / exhaust performance for airborne infection isolation.
Aerosol-generating procedure (AGP)	A procedure designated by current national / local guidance as increasing generation of infectious aerosols; the approved local list and pathogen-specific risk assessment govern precautions.
High-consequence infectious disease (HCID)	A severe infection with potential for healthcare or community transmission that requires immediate specialist public-health and IPC coordination, enhanced controls and often regional referral.
Exposure	Unprotected or inadequately protected contact with an infectious source, material or environment that may create a risk requiring assessment, monitoring, prophylaxis or work restriction.
Outbreak / cluster	Cases exceeding the expected baseline or epidemiologically linked in time, place or person; one unusual or high-consequence case may be sufficient to trigger an outbreak response.
Cohorting	Grouping patients with the same confirmed infection and compatible care needs, or dedicating staff / equipment, after IPC approval when single-room isolation is not available.
Room release	The documented process confirming that required cleaning, disinfection, ventilation clearance, equipment decontamination and waste / linen actions are complete before reuse.

4. Governance, readiness and command

- The emergency department must have a named IPC lead, 24-hour escalation route, public-health contact, occupational-health pathway and senior operational decision-maker.
- Maintain current maps of single rooms, AIIRs, ventilation limitations, donning / doffing areas, clean and dirty routes, hand-hygiene points, specimen routes, waste storage and alternative surge zones.
- Maintain fit testing and competency records for respirator users. Staff who cannot achieve an adequate fit require an approved alternative such as a powered air-purifying respirator where available.
- PPE stock levels, expiry dates and outbreak burn rates must be visible. Contingency conservation, extended-use or reuse practices may occur only under a formally approved, evidence-based plan.
- Laboratory, radiology, ambulance, cleaning, security and bed-management services must be included in pathway design and exercises; infection prevention is not solely a nursing task.
- The ED incident lead may activate enhanced IPC controls immediately when delay would create risk, with retrospective IPC / public-health confirmation as soon as possible.

5. Entry screening and syndromic triage

SCREEN WITHOUT DELAY: Screening identifies transmission risk; acuity triage identifies physiological danger. Perform both. A critically ill infectious patient goes directly to resuscitation with source control and appropriate PPE rather than waiting for an isolation room.

1. Use passive screening at entrances and registration points: clear signs, masks, tissues, no-touch waste bins, hand sanitizer and instructions to alert staff before joining a queue.
2. Use active screening at first clinical contact for acute respiratory symptoms; fever with rash; vomiting or diarrhoea; undiagnosed vesicular / pustular rash; draining wounds; meningitis symptoms; known contact; recent healthcare exposure; travel, animal or occupational exposure relevant to current alerts; and any public-health notification.
3. Immediately provide source control that the patient can tolerate: a well-fitting medical mask for appropriate respiratory syndromes, tissues, hand hygiene, a clean covering over lesions or drainage, and prompt toileting / continence support.
4. Move the patient from shared space to the safest available location. Apply the initial precaution sign and notify the receiving nurse / clinician before movement.
5. Record symptom onset, exposure history, initial precautions, room / zone, persons accompanying the patient and any time spent in common areas. Begin an exposure log early when risk is significant.
6. Reassess the syndrome and precautions after examination, test results, treatment response and public-health advice. Do not remove precautions merely because the patient appears well.

6. Immediate isolation and placement

Risk / presentation	Immediate placement and action
Airborne infection possible	Use an AIIR when available. Keep the door closed, limit entrants, use fit-tested respiratory protection, place a mask on the patient for transport if tolerated, and avoid non-essential movement.
Airborne infection possible but no AIIR	Use a single room with the door closed; maximize safe ventilation according to facilities advice; use an approved portable HEPA unit if available and positioned correctly; minimize AGPs and movement; obtain urgent IPC / public-health advice and arrange definitive placement / transfer.
Droplet-spread syndrome	Single room preferred. If unavailable, separate from others and use a designated zone with physical distance and barriers where feasible. Staff wear the locally specified mask and eye protection according to pathogen / task risk.
Contact-spread syndrome	Single room or dedicated cubicle preferred, particularly for uncontrolled diarrhoea, vomiting, drainage, extensive lesions, poor hygiene or high environmental contamination. Use dedicated equipment and enhanced cleaning.
Combined or uncertain route	Apply the highest reasonable combined precautions while urgent assessment and public-health / IPC advice are obtained.
HCID / unusual severe infection	Do not circulate through common areas. Place in the highest-capability single room, restrict to an essential trained team, use a trained doffing observer, contact IPC / public health immediately, and plan specimens, waste, imaging and transfer before proceeding.
Immunocompromised patient needing protection	Separate from symptomatic infectious patients; prioritize a clean room / low-traffic area; ensure staff and visitors with transmissible illness do not enter; use Standard Precautions and disease-specific protective measures rather than unsupported "reverse isolation".

7. Standard Precautions for every patient

Domain	Minimum ED standard
Hand hygiene	Perform at the recognized clinical moments, before aseptic tasks, after body-fluid exposure risk, after touching the patient or environment, and after glove removal. Gloves never replace hand hygiene.
Exposure-risk assessment	Before each task, anticipate contact with blood, body fluids, secretions, excretions, mucosa, non-intact skin, contaminated equipment, splashes, sprays or aerosols and select PPE accordingly.
Aseptic technique	Use approved aseptic non-touch technique for vascular access, urinary catheterization, medication preparation, wound care and other invasive procedures.
Injection and medication safety	Use a new sterile needle and syringe for every injection and every entry into a medication container; prepare medications in a clean area; never reuse single-dose products between patients.
Sharps safety	Use safety devices where available; do not recap by hand; dispose immediately at point of use in an accessible approved container; report injuries without delay.
Respiratory hygiene	Provide source-control supplies and separate symptomatic persons rapidly. Staff and visitors follow cough etiquette and hand hygiene.
Equipment	Assign dedicated equipment when possible. Clean and disinfect reusable equipment between patients with an approved product, contact time and responsibility.
Environment	Clean spills promptly; clean high-touch surfaces at defined frequency; terminally clean isolation rooms using pathogen-appropriate products and documented release criteria.
Linen, waste and specimens	Handle with minimum agitation, prevent leakage, use correct bags / containers and labels, and follow local transport and biosafety pathways.
Care of devices	Insert only when indicated, use aseptic technique, maintain closed systems and remove unnecessary devices promptly to reduce healthcare-associated infection.

8. Transmission-Based Precautions

Precaution	Core controls
Contact	Single room / designated space; gloves and gown / apron according to anticipated contact and local policy; dedicated equipment; enhanced environmental cleaning; contain drainage, stool and secretions; minimize shared items.
Droplet	Source-control mask for the patient if tolerated; single room or designated separated area; staff use a medical mask on entry and eye protection when indicated by the pathogen, procedure or splash risk; limit movement and mask the patient during transport.
Airborne	AIIR preferred; keep door closed; staff use a fit-tested N95 / FFP2 / FFP3 or higher approved respirator; limit susceptible personnel; minimize movement; patient wears a medical mask during necessary transport if tolerated.
Combined	Apply all relevant contact, droplet and / or airborne measures. Clearly display combined requirements to prevent partial compliance.
Protective placement	Reduce exposure of highly vulnerable patients to infectious persons and environmental hazards; this is not a substitute for Standard Precautions or disease-specific controls.

- Isolation signs must state required actions without displaying stigmatizing diagnoses in public view.
- Cohort only after IPC approval, preferably after laboratory confirmation, and do not mix pathogens, uncertain diagnoses or incompatible vulnerabilities.
- Children should remain with a parent / caregiver whenever safe. Assess the caregiver for symptoms, provide PPE instruction and document who may enter.
- Visitors are restricted only to the degree necessary. Essential caregivers may often remain after instruction, PPE and risk assessment.

9. Respiratory hygiene, source control and ventilation

- Keep masks, tissues, waste bins and hand-hygiene supplies at entrances, registration, triage, waiting areas and clinical zones. Replace depleted supplies immediately.
- Advise symptomatic patients and visitors older than two years to wear a well-fitting mask when tolerated and clinically appropriate; use age- and condition-sensitive alternatives when masking is unsafe.
- During high community respiratory-virus activity or an ED outbreak, consider broader source-control masking through a documented facility risk assessment.
- Reduce crowding and time in shared air: rapid streaming, remote registration, outdoor or well-ventilated waiting areas where safe, spacing, barriers and early discharge / transfer decisions.
- Facilities / engineering must verify air-handling performance, room pressure and approved portable air-cleaning devices. Staff must not assume a room is negative pressure without confirmation.
- After an AGP or care of an airborne infection, room re-entry and cleaning timing must follow the room's verified air changes and the approved engineering clearance table rather than a fixed universal interval.

10. PPE selection, donning and doffing

PPE RULE: Select PPE from the exposure and transmission risk, not from job title. PPE must fit, be available before entry, be removed in the correct place and sequence, and be followed by hand hygiene.

- Perform a point-of-care risk assessment before entry and before any procedure. Include splash, spray, aerosol, duration, proximity, patient behaviour and environmental contamination.
- Use gloves for anticipated contact with blood, body fluids, mucosa, non-intact skin or contaminated items; change between dirty and clean tasks and between patients.
- Use gown or apron according to expected contamination of skin or clothing. Fluid-resistant protection is required when splash or heavy contamination is likely.
- Use eye protection when splash / spray is possible and for respiratory pathogens when required by current guidance. Prescription glasses are not adequate eye protection.
- Use a medical mask for droplet protection and source control; use a fit-tested respirator for airborne precautions and designated aerosol-risk care.
- Do not touch the face, adjust contaminated PPE unnecessarily or move between patients wearing the same gloves or gown.
- Doff slowly in the designated area, avoiding contact between contaminated surfaces and clothing / skin. Use a trained observer for HCID, complex PPE or staff unfamiliarity.
- Any breach, torn PPE, facial contamination, unprotected AGP or incorrect respirator use requires immediate first aid, exit, hand hygiene and exposure assessment.

11. Aerosol-generating procedures and airway care

- Use the current locally approved AGP list and pathogen-specific guidance; evidence and classifications may change.
- When an AGP is necessary for suspected airborne infection, use an AIIR if available, the minimum essential experienced team, fit-tested respirators, eye protection, gown and gloves, and closed doors.
- Prepare all equipment before entry, use checklists, minimize circuit disconnections and avoid repeated attempts. Follow Protocol 48 for airway planning and post-intubation care.
- Use viral / bacterial filters and closed suction systems when clinically appropriate and compatible with equipment.

- Clean and disinfect all equipment and surfaces; document room air-clearance and release before reuse. Do not send unprotected staff into the room during the clearance period.

12. Patient movement, diagnostics, transport and transfer

1. Limit movement to clinically necessary care. Use bedside tests and portable imaging when safe and diagnostically adequate.
2. Before transport, notify the destination and transport team of precautions; plan the route and timing to minimize exposure; cover lesions and contain secretions / excretions.
3. The patient uses source control appropriate to the syndrome if tolerated. Transport staff wear PPE based on expected contact and whether they enter the patient space.
4. Clean the trolley, wheelchair, ambulance and shared equipment after use. Record any breach or exposure during movement.
5. Inter-facility transfer requires clinical stabilization, explicit acceptance, pathogen / precaution handover, PPE and waste plan, documentation, and public-health approval when required.
6. Do not transfer solely to displace infection risk. The receiving facility must have the capability and information to continue safe care.

13. Environment, equipment, specimens, linen and waste

Area	Required controls
Room and high-touch surfaces	Use an approved cleaning schedule, product, dilution and contact time matched to the organism. Clean visible soil before disinfection. Record enhanced and terminal cleaning.
Reusable equipment	Use dedicated equipment where possible. If shared, clean and disinfect before leaving the room or before another patient. Clarify responsibility for monitors, ultrasound probes, keyboards, phones and transport devices.
Spills	Restrict access, wear task-appropriate PPE, remove organic material safely and use the approved spill kit / disinfectant. Report large or unusual spills.
Specimens	Agree tests with the laboratory when risk is unusual. Use leak-proof primary containers, secondary containment, correct labelling and hand-delivery / transport rules. Never use pneumatic tubes when prohibited.
Linen	Do not shake. Bag at point of use in the approved water-soluble / leak-resistant system. Treat heavily contaminated or HCID linen according to pathogen-specific policy.
Waste	Segregate at point of use, close bags / sharps containers safely, and follow current infectious / HCID waste rules. Do not overfill or manually compress waste.
Dead bodies	Use Standard and pathogen-specific precautions, minimize leakage and unnecessary manipulation, label discreetly, and coordinate with mortuary, public health and funeral services according to Protocol 52 and local law.
Room release	Confirm cleaning, disinfection, waste and linen removal, equipment decontamination, required air clearance, and documentation before the space returns to service.

14. Occupational exposure, staff illness and immunization

- After needlestick, sharps injury, bite or mucosal / skin splash: stop the task safely; wash skin with soap and water; irrigate eyes or mucosa with water / saline; do not scrub, squeeze or use caustic agents; report immediately.
- Assess the source, exposure route, PPE, timing, staff susceptibility and pathogen. Begin time-critical prophylaxis, baseline testing and vaccination according to the approved occupational-health pathway.
- For respiratory, contact or HCID exposure, identify duration, proximity, procedure, room ventilation and PPE. Public health / occupational health determines monitoring, testing, prophylaxis and work restriction.
- Staff with fever, vomiting / diarrhoea, acute respiratory illness, unexplained rash or other potentially transmissible illness must report before work or immediately if symptoms begin on shift.
- Maintain confidential records of staff immunization, fit testing, exposure, prophylaxis and clearance. Use these records for safety, not punitive performance management.
- Offer recommended healthcare-worker immunizations and ensure rapid access to post-exposure advice at all hours, including weekends and nights.

15. High-risk syndromes and pathogen-specific triggers

Presentation / trigger	Initial ED response pending expert advice
Acute respiratory infection	Source control, rapid separation and syndrome-based droplet / contact / airborne precautions according to current pathogen guidance, procedure and community activity.
Fever with generalized rash; possible measles	Airborne precautions immediately; mask and separate before registration where possible; use immune staff when feasible; notify IPC / public health urgently; identify persons exposed in shared air.
Vesicular rash; possible varicella or disseminated zoster	Airborne plus contact precautions; cover lesions; use immune staff when feasible; assess susceptible exposed persons.
Possible pulmonary / laryngeal tuberculosis	Airborne precautions, AIIR if available, mask patient for transport, minimize cough-inducing procedures and notify TB / public-health services.
Possible meningococcal disease	Droplet precautions in addition to urgent sepsis treatment; notify IPC / public health; identify close unprotected exposures for chemoprophylaxis assessment.
Vomiting / diarrhoea cluster or suspected <i>C. difficile</i> / norovirus	Contact precautions, rapid containment, dedicated toilet / commode, soap-and-water handwashing when specifically indicated, and pathogen-appropriate enhanced environmental disinfection.

Presentation / trigger	Initial ED response pending expert advice
Possible mpox	Cover lesions, place in a single room, use current national / WHO / CDC PPE and environmental guidance, notify IPC, and assess staff / household exposures.
Severe unusual febrile illness with travel, animal or laboratory exposure	Activate HCID pathway; isolate, restrict staff, avoid unnecessary AGPs and invasive procedures, obtain immediate public-health advice, and plan specimens / transfer before collection.
Known MDRO or resistant organism alert	Use organism- and site-specific contact / enhanced precautions, dedicated equipment and antimicrobial stewardship; do not delay emergency treatment.
Suspected healthcare-associated transmission	Preserve relevant cultures / isolates, identify contacts, notify IPC and laboratory, and begin a line list even if the source is uncertain.

16. Outbreak recognition and activation

ACTIVATION TEST: “Could these cases be linked, could transmission be occurring here, or would delay in control create disproportionate harm?” If yes or uncertain, escalate and begin preliminary controls.

- A single suspected HCID, novel pathogen, unusual severe infection or legally urgent notifiable disease.
- Two or more epidemiologically linked patients, staff or visitors with a compatible syndrome or organism, or an increase above expected baseline.
- A laboratory alert for an unusual organism, resistance pattern, contamination pattern or possible cross-transmission.
- Unprotected exposure involving multiple persons, an AGP, shared waiting area, delayed recognition or an infectious patient who left before isolation.
- A cluster of staff illness, environmental contamination, failure of ventilation / water / waste systems, or repeated PPE breaches.
- Any concern from frontline staff, cleaners, laboratory, ambulance or public health that routine precautions are insufficient.

17. Outbreak operational response

Action	Minimum requirement
Command	Name an incident lead, IPC lead, clinical lead, nursing lead and communications / public-health link. Define meeting frequency and decision authority.
Verify and define	Confirm diagnoses where possible; create a practical case definition; establish time, place and person; start a line list and exposure map.
Immediate controls	Isolate or cohort, strengthen source control and PPE, limit non-essential movement, dedicate staff / equipment where possible, increase cleaning and protect vulnerable patients.
Laboratory	Agree specimen priority, collection, packaging, testing and result communication. Preserve isolates and request typing / sequencing when available and useful.
Exposure management	Identify patients, visitors and staff who may have been exposed; risk-stratify; provide testing, prophylaxis, monitoring, work restrictions and contact instructions.
Capacity and flow	Create clean and affected zones; adjust entrances, waiting areas and staffing; maintain urgent care; activate surge and transfer plans without unsafe mixing.
Communication	Provide brief, accurate, role-specific updates to staff, patients and public. Protect confidentiality, address uncertainty and counter misinformation.
Supplies and infrastructure	Track PPE, disinfectant, oxygen, isolation-room, ventilation, waste, linen and staffing capacity. Escalate shortages before failure.
Daily review	Review new cases, exposures, compliance, staffing, bed use, laboratory status, environmental findings and control effectiveness; revise the plan explicitly.
Stand-down and recovery	Use public-health / IPC-agreed criteria, complete terminal cleaning, close exposure follow-up, restore services safely, debrief and publish corrective actions.

18. Surge, zoning and continuity of essential emergency care

- Separate entry, waiting, assessment and treatment streams according to syndrome and risk while maintaining immediate access to resuscitation.
- Define clean, transition and contaminated zones with clear signage, physical layout, PPE stations, waste routes and staff movement rules.
- Use dedicated teams when feasible; prevent staff from moving repeatedly between affected and high-risk patient groups without changing PPE and performing hand hygiene.
- When isolation capacity is exceeded, prioritize AIIRs and single rooms using risk: airborne / HCID first, uncontrolled secretions or diarrhoea, high environmental shedding, inability to follow source control, and presence of highly vulnerable contacts.
- Cohort only compatible confirmed cases or, during an approved emergency plan, tightly defined syndromic groups with safeguards and frequent review.
- Maintain essential non-outbreak care, medication access, emergency surgery, maternity, paediatrics and chronic disease treatment. Infection control must not create avoidable indirect harm.
- Escalate to Protocol 55, Protocol 56 or Protocol 57 when crowding, mass casualty, utilities failure, oxygen limitation, laboratory downtime or equipment failure threatens safe separation.

19. Discontinuing or changing precautions

1. Review the working diagnosis, symptom course, treatment, test results, immune status, shedding risk and current pathogen-specific guidance.
2. Consult IPC / public health when the disease is high consequence, notifiable, outbreak-associated, resistant, unusual or when uncertainty remains.
3. Do not stop precautions solely because of bed pressure, a single negative test of limited sensitivity, symptom improvement without meeting criteria, or patient / visitor preference.
4. Document the decision, date, time, evidence, remaining instructions and person authorizing the change.
5. Remove signs and PPE supplies only after room release; communicate the change to nursing, medical, cleaning, laboratory, transport and the next care area.

20. Disposition, discharge and community protection

- Provide diagnosis or suspected syndrome, duration of home precautions, mask / hygiene / lesion / laundry / waste advice, medication, warning signs and follow-up in language the patient can understand.
- Verify that home isolation is feasible and safe, including food, water, sanitation, caregiving, medication and ability to seek help. Escalate social or safeguarding concerns.
- Notify public health and arrange contact tracing, testing, prophylaxis or transport when required. Do not rely on the patient alone to transmit urgent public-health information.
- For admission or transfer, use structured handover of syndrome, confirmed organism, precautions, exposures, tests, treatment and outstanding public-health actions.
- For patients leaving before completion, follow Protocol 51 and urgently manage any public-health risk, outstanding critical result and exposure notification within law and policy.

21. Documentation standard

- Presenting syndrome, epidemiological risk, symptom onset, relevant travel / contact / healthcare / animal / occupational exposure and vaccination or susceptibility information.
- Time of recognition, source-control measures, initial and revised precautions, room / zone, PPE and reasons for any deviation.
- Names / categories of persons potentially exposed and locations / procedures relevant to risk assessment.
- IPC, occupational-health, laboratory, public-health and receiving-service communications, including advice and time.
- Specimens, transport method, cleaning / room release, equipment, waste and linen arrangements.
- Outbreak case definition, line list, decisions, control measures, daily review and stand-down criteria when activated.
- Discharge / transfer advice, public-health notification, pending results, contact details and responsibility for follow-up.
- Any breach, delay, PPE shortage, ventilation failure, exposure, complaint or serious incident and the immediate corrective action.

22. Staff roles

Role	Responsibilities
Reception / registration / security	Maintain entry signs and supplies, identify visible syndromes, alert clinical staff, redirect safely and avoid prolonged questioning in public areas.
Triage nurse	Perform active syndromic screen and acuity triage, initiate source control and precautions, select placement, document common-area exposure and escalate immediately.
ED clinician	Stabilize and diagnose without delay, refine precautions, minimize risky procedures, order appropriate specimens, notify IPC / public health and document decisions.
Nurse in charge	Coordinate rooms, zoning, staffing, PPE, visitor instruction, exposure log, cleaning, handover and escalation during capacity pressure.
IPC lead / team	Advise precautions, placement, outbreak activation, exposure management, surveillance, training, audit, room release and liaison with public health.
Laboratory / microbiology	Provide specimen advice, safe transport, rapid alerts, organism interpretation, isolate preservation and outbreak testing support.
Occupational health	Maintain immunization / fit testing, assess exposures and illness, provide prophylaxis / testing, confidential monitoring and work-clearance decisions.
Environmental services	Use approved products and contact times, complete routine / enhanced / terminal cleaning, manage spills and document room release.
Facilities / engineering	Verify ventilation, pressure and water / sanitation systems; support HEPA placement and air-clearance calculations; escalate failures.
Ambulance / transport	Use pre-alerts, source control, route planning, PPE, vehicle / equipment decontamination and exposure reporting.
Public-health authority	Confirm notification, case definition, testing, contact tracing, prophylaxis, community measures, outbreak command and stand-down criteria.
All staff	Perform hand hygiene, follow precautions, challenge unsafe practice respectfully, report illness / exposure / shortages and protect patient dignity.

23. Quality and safety indicators

Measure	Suggested local standard / review
Early recognition	Median time from arrival to syndrome identification, source control and appropriate placement for respiratory, rash, diarrhoeal and HCID alerts.
Hand hygiene	Compliance by clinical moment and area; product availability; feedback by team and shift.
Precaution accuracy	Percentage of audited cases with correct initial, revised and discontinued precautions; over-isolation and under-isolation reviewed.
PPE competency	Fit-testing coverage; donning / doffing competency; observed breach rate; availability and stock-out hours.
Isolation capacity	AIIR / single-room utilization, verified ventilation failures, time waiting for appropriate placement and number cohorted under contingency.
Environmental safety	Completion and audit of high-touch, enhanced and terminal cleaning; room-release documentation; equipment decontamination failures.
Occupational exposure	Number, type, time to reporting, time to prophylaxis, preventability and completion of follow-up.
Outbreak performance	Time from trigger to escalation, line list and controls; secondary cases; staff absence; service disruption; completion of debrief actions.
Patient experience and equity	Communication, access, dignity, interpreter use, family support, delays and complaints associated with isolation.
Governance	Annual review of local isolation matrix, public-health contacts, outbreak plan, PPE stock, ventilation inventory, training and simulation.

24. Training and simulation

- Induction and annual competency must include hand hygiene, Standard and Transmission-Based Precautions, PPE selection, respirator use, donning / doffing, sharps / splash first aid, source control, specimen handling and room release.
- Front-door staff, security, cleaners, porters, ambulance crews and students require role-specific training, not abbreviated assumptions.
- Run multidisciplinary simulations for: measles in a crowded waiting room; undifferentiated HCID; respiratory AGP; infectious diarrhoea cluster; staff needlestick / splash; ventilation failure; and PPE shortage.
- Each exercise should test notification, patient flow, lab and public-health communication, exposure line-listing, cleaning, transport, documentation and continuity of non-outbreak care.
- Use incidents and near misses for learning. Correct system weaknesses in supplies, design, staffing, training and communication rather than relying on reminders alone.

25. Evidence base and source guidance

Source	Key use in this protocol
World Health Organization. Framework and toolkit for infection prevention and control outbreak preparedness, readiness and response: implementation manual. 2025.	Outbreak preparedness, implementation, readiness, response, command, assessment and continuous improvement.
World Health Organization. Syndromic screening for infection prevention and control measures during public health emergencies. 2025.	Active and passive front-door screening for acute respiratory infection, infectious rash and diarrhoeal syndromes.
World Health Organization. Framework and toolkit for IPC in outbreak preparedness, readiness and response at health-care facility level. 2022.	Facility outbreak planning, case finding, control actions and linkage with public health.
US CDC. Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings. Current web guidance.	Standard Precautions, respiratory hygiene, early syndrome-based precautions, education, occupational safety and monitoring.
US CDC. Transmission-Based Precautions and Appendix A: Type and Duration of Precautions. Updated 2024-2025.	Contact, droplet and airborne precautions and pathogen-specific duration references.
US CDC. Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings. 2025.	Entrance supplies, source control, triage, masking risk assessment, distancing and ventilation.
US CDC. Infection Control in Healthcare Personnel: Epidemiology and Control of Selected Infections. 2025.	Occupational exposure, staff monitoring, prophylaxis and work-restriction principles.
NHS England. National Infection Prevention and Control Manual, version 2.12, 2025.	Standard and transmission-based precautions, placement, PPE, AGPs, equipment, environment and care of the deceased.
NHS England. National Standards of Healthcare Cleanliness 2025.	Governance, functional risk, cleaning responsibilities, audit, spill response and outbreak cleaning.
Saint Christopher and Nevis. Public Health Act, revised edition 2020 and subsequent amendments / regulations.	Local legal framework for infectious-disease control, notification and public-health action; current consolidated requirements must be verified before approval.

Annex A. Rapid syndromic screen and immediate action

Screen at first contact	Yes / No / immediate action
Acute cough, breathing symptoms, sore throat or new respiratory illness?	<input type="checkbox"/> No <input type="checkbox"/> Yes Mask / source control <input type="checkbox"/> Separate <input type="checkbox"/> Precautions: _____
Fever with generalized, vesicular, pustular or unexplained rash?	<input type="checkbox"/> No <input type="checkbox"/> Yes Cover lesions <input type="checkbox"/> Separate <input type="checkbox"/> Airborne / contact considered <input type="checkbox"/>
Vomiting or diarrhoea, especially multiple cases or healthcare exposure?	<input type="checkbox"/> No <input type="checkbox"/> Yes Dedicated toilet / commode <input type="checkbox"/> Contact precautions <input type="checkbox"/>
Severe headache / meningism with fever or purpuric rash?	<input type="checkbox"/> No <input type="checkbox"/> Yes Droplet precautions <input type="checkbox"/> Sepsis pathway <input type="checkbox"/> Public health / IPC <input type="checkbox"/>

Screen at first contact	Yes / No / immediate action
Known exposure to communicable disease or outbreak?	<input type="checkbox"/> No <input type="checkbox"/> Yes Disease / date / place: _____
Recent travel, animal, laboratory, occupational or healthcare exposure relevant to alerts?	<input type="checkbox"/> No <input type="checkbox"/> Yes Details: _____
Known MDRO, TB, mpox, measles, varicella or other infection alert?	<input type="checkbox"/> No <input type="checkbox"/> Yes Alert / prior records checked <input type="checkbox"/> Precautions initiated <input type="checkbox"/>
Critically ill?	<input type="checkbox"/> No <input type="checkbox"/> Yes Direct to resuscitation with source control and PPE; do not delay care.
Initial location / time	Room / zone _____ Arrival _____ Recognized _____ Isolated _____
Escalation	Senior clinician _____ Nurse in charge _____ IPC _____ Public health _____

Annex B. Initial isolation matrix

Syndrome / risk	Initial precautions	Placement / key notes
Undifferentiated acute respiratory infection	Standard + current respiratory pathogen precautions; source control; eye protection / respirator according to task and guidance.	Rapid separation; single room preferred; airborne controls for AGP or specific airborne suspicion.
Fever + generalized rash / suspected measles	Airborne.	AIIR preferred; mask patient; immune staff where feasible; urgent IPC / public health; exposure map.
Vesicular rash / varicella / disseminated zoster	Airborne + contact.	AIIR preferred; cover lesions; susceptible staff / visitors excluded where feasible.
Possible pulmonary TB	Airborne.	AIIR preferred; minimize cough-inducing procedures; TB / public-health referral.
Meningococcal syndrome	Droplet + Standard.	Single room; urgent treatment; identify unprotected close contacts.
Vomiting / diarrhoea	Contact + Standard.	Single room / dedicated toilet; enhanced environmental disinfection; outbreak screen.
Draining wound / extensive skin infection / uncontrolled secretions	Contact + Standard.	Contain drainage; dedicated equipment; single room if contamination cannot be controlled.
Suspected mpox	Current pathogen-specific precautions + Standard.	Single room; cover lesions; notify IPC; follow current PPE, waste and exposure guidance.
Possible HCID / VHF / novel zoonosis	Enhanced combined precautions under HCID plan.	Highest-capability room; essential trained team; observer; immediate public-health coordination.
Highly immunocompromised patient without infectious syndrome	Standard + protective placement as locally indicated.	Clean low-traffic area; separate from symptomatic persons; avoid unnecessary exposure.

Annex C. PPE and safe donning / doffing prompt

Before entry	During care	Before leaving / after exit
<input type="checkbox"/> Read sign and perform task risk assessment <input type="checkbox"/> Gather all equipment <input type="checkbox"/> Hand hygiene <input type="checkbox"/> Gown / apron if indicated <input type="checkbox"/> Mask or fit-tested respirator <input type="checkbox"/> Eye protection <input type="checkbox"/> Gloves last <input type="checkbox"/> Buddy / observer for HCID or complex PPE	<input type="checkbox"/> Keep hands away from face <input type="checkbox"/> Avoid unnecessary adjustment <input type="checkbox"/> Change torn / heavily contaminated gloves <input type="checkbox"/> Change gloves between dirty and clean tasks <input type="checkbox"/> Keep clean equipment separate <input type="checkbox"/> Limit surfaces touched <input type="checkbox"/> Stop and seek help after a breach	<input type="checkbox"/> Remove contaminated PPE slowly in approved sequence / zone <input type="checkbox"/> Avoid contact with skin / clothing <input type="checkbox"/> Dispose or place reusable items correctly <input type="checkbox"/> Hand hygiene at required steps and at end <input type="checkbox"/> Report breach / exposure immediately <input type="checkbox"/> Clean equipment <input type="checkbox"/> Document entry if exposure log active

Annex D. Outbreak activation checklist and line-list fields

Activation checklist	Completed / details
Incident and IPC leads named; public health and laboratory notified	<input type="checkbox"/> Time _____ Names / contacts _____
Preliminary case definition and trigger documented	<input type="checkbox"/> Definition _____
Line list opened; cases and exposed persons identified	<input type="checkbox"/> File / location _____ Owner _____
Immediate isolation / cohort / zoning controls implemented	<input type="checkbox"/> Areas _____
PPE, respirator, hand-hygiene, cleaning and waste capacity checked	<input type="checkbox"/> Gaps / escalation _____
Staff cohorting, sickness reporting and occupational-health plan activated	<input type="checkbox"/> Details _____
Patient movement, visitors, ambulance and transfer arrangements revised	<input type="checkbox"/> Details _____
Daily situation report and review time set	<input type="checkbox"/> Frequency _____ Next review _____ Stand-down authority _____

Line-list field	Record
Person / identifier / role	_____

Line-list field	Record
Case / contact classification	_____
Symptoms and onset	_____
Date / time / location in ED	_____
Exposure source / procedure / PPE	_____
Specimens / results	_____
Isolation / treatment / prophylaxis	_____
Public-health / occupational-health actions	_____
Follow-up status / outcome	_____

Annex E. Occupational exposure record

Field	Record
Exposed person / role / contact	_____
Date / time / location	_____
Exposure type	<input type="checkbox"/> Sharps <input type="checkbox"/> Splash <input type="checkbox"/> Respiratory <input type="checkbox"/> Contact <input type="checkbox"/> AGP <input type="checkbox"/> Other _____
Source / syndrome / known organism	_____
Task, distance and duration	_____
PPE worn and any breach	_____
Immediate first aid	_____
Risk assessment and tests	_____
PEP / vaccine / work restriction	_____
Monitoring plan and responsible service	_____
Follow-up dates / outcome	_____
Incident report / corrective action	_____

Annex F. Mandatory local configuration before approval

Item	Approved local rule / contact / document location
IPC 24-hour contact and escalation	_____
Public-health / Chief Medical Officer notification contacts	_____
Current notifiable-disease list and legal timeframes	_____
AIIR locations, verified performance and backup plan	_____
Single-room prioritization and cohort / surge zones	_____
Approved AGP list and air-clearance table by room	_____
Respirator models, fit testing and PAPR availability	_____
PPE matrix and shortage / conservation plan	_____
Donning / doffing locations and observer process	_____
Cleaning products, contact times and room-release SOP	_____
Specimen packaging, high-risk lab contact and courier route	_____
Sharps / splash / respiratory exposure pathway and 24-hour PEP	_____
Healthcare-worker immunization and sickness policy	_____
Waste, linen, mortuary and deceased-person procedures	_____
Ambulance / inter-facility / regional HCID transfer pathway	_____
Outbreak incident-command structure and line-list location	_____
PPE / disinfectant stock thresholds and responsible officer	_____
Training, simulation, audit and review schedule	_____