



Policy for patients with possible or confirmed High Consequence Infectious Diseases (HCID)

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DOCUMENT CONTROL		POLICY NO.	160
Policy Group:	Corporate		
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Lead Executive:	Director of Public Health		
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Last review date:	March 2026	Next review date	May 2028
Approved by:	Board Management Team	Approval date:	May 2026
Equality Impact Assessed:	Yes	Equality Impact Assessment date:	March 2026
Data Protection Impact Assessed:	No – Not required	Data Protection Impact Assessment Date:	Not applicable

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Summary & Aim	Key Requirements
The purpose of this policy is to ensure that NHS Dumfries and Galloway have processes in place and that these are fully embedded into our everyday activities to protect people, whether they are patients, carers, or staff from being exposed to a case of high consequence infectious disease	<ul style="list-style-type: none"> • Staff to undertake training as determined necessary • Staff need to be aware of this policy and any actions required in event of a patient with HCID presenting
Target Audience	Previous Names
<p>This policy is relevant to all NHS Dumfries and Galloway staff, but in particular:</p> <ul style="list-style-type: none"> • Clinical staff, most notably Emergency Department (ED), Acute Medical Unit (AMU), Primary Care and Out of Hours Primary Care Service • Members of Site Management, Emergency Planning, Duty General Managers, Duty Executive Directors, Infection Prevention and Control, Microbiology, Labs and Health Protection Staff • Other support services including those from Estates/ SERCO and Facilities 	<ul style="list-style-type: none"> • Not applicable as this is a new policy

Equality and Diversity Statement
<p>NHS Dumfries and Galloway recognise that some communities within society are more likely than others to experience discrimination, prejudice and inequalities. The Equality Act 2010 specifically recognises the protected characteristics of age, disability, sex, race, religion or belief, sexual orientation, gender reassignment, pregnancy and maternity, and marriage and civil partnership. The Fairer Scotland Duty also requires NHS Dumfries and Galloway to actively consider how socio-economic disadvantage can be reduced when making strategic decisions.</p> <p>NHS Dumfries and Galloway are committed to promoting and advancing equality, removing and reducing discrimination and harassment and fostering good relations between people that hold a protected characteristic and those who do not. This applies both in the provision of services and as our role as a major employer. NHS Dumfries and Galloway believe that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discrimination practice.</p>

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1. PURPOSE AND RATIONALE

- 1.1 Trends are changing in infectious disease patterns with High Consequence Infectious Disease (HCIDs) outbreaks occurring with greater frequency across the world. This combined with an increasingly interconnected world mean that healthcare providers need to be aware of and prepared for managing a situation where an individual has a suspected or confirmed HCID. HCIDs are rare in the UK, when cases occur, they tend to be sporadic and are usually associated with travel to an area where the infection is known to be endemic or where an outbreak is occurring.
- 1.2 To outline the response of NHS Dumfries and Galloway (NHS D&G) in managing a suspected or confirmed case of HCID

2. POLICY AIMS

- 2.1 To ensure:
- Any patient with possible or confirmed HCID should receive care that is safe and secure for them and for those around them.
 - Staff involved in care provision will be aware of their responsibilities and risk to them will be minimised enabling them to complete their duties in a calm and controlled manner.
 - Anxiety amongst staff and other patients will be minimised.
 - The recovery and restoration of disrupted services is managed carefully, safely and efficiently.

3. POLICY SCOPE

- 3.1 This policy applies to all staff but in particular:
- Clinical staff involved in the assessment of patients on arrival, most notably Emergency Department (ED), Acute Medical Unit (AMU), Primary Care and Out of Hours Primary Care service.
 - Members of Site Management, Emergency Planning, Duty General Manager and Duty Executive Directors, Infection Prevention and Control staff, Microbiology, Laboratory staff and Health Protection staff.
 - Other support staff, including those from Estates/ SERCO and Facilities.

This policy applies to the care of patients that have been assessed as suspected or confirmed as having a HCID.

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4. DEFINITIONS

4.1 A HCID is defined according to the following criteria:

- Acute infectious disease.
- Typically has a high case fatality rate.
- May not have an effective prophylaxis or treatment.
- Often difficult to recognise and detect rapidly.
- Ability to spread in the community and within healthcare settings.
- Requires an enhanced individual, population and system response to ensure it is managed effectively, efficiently and safely.

Further information on HCIDs can be found here <https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid>)

It is important to note HCID in the UK is rare, cases are generally sporadic and most are associated with travel to an endemic area or an avian influenza exposure. Dumfries and Galloway, along with the rest of Scotland, have seen an increase in exposures to avian influenza through wild bird migration. In line with UK Health & Security Agency (UKHSA) guidance, the Health Protection Team in Dumfries and Galloway provides support and follow up to ensure appropriate public health measures are implemented to mitigate risk and prevent further transmission.

5. DUTIES / RESPONSIBILITIES

5.1 It is the duty of **NHS Dumfries and Galloway** to:

- Have an HCID policy in place
- Ensure annual planned exercises to test the response are undertaken.
- Provide correct Personal Protective Equipment (PPE) for staff
- Ensure staff have access to appropriate training

5.2 It is the duty of the **receiving service/ clinical area and relevant staff** to:

- Be familiar with this policy and relevant Action Cards
- Be familiar with the list of HCID's and current outbreaks
- Be able to recognise a potential HCID
- To enact the HCID processes as soon as possible
- To take up appropriate training opportunities and FIT testing

5.3 It is the duty of the **Infectious Disease (ID) Specialist (or relevant senior clinician)** to:

- Provide expert clinical advice, guidance and support to the initial notifier and other relevant people
- Ensure receiving laboratories and Health Protection Team are informed of the HCID status of the patient

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- Be key person who liaises with reference laboratories, HCID units and other relevant partners
 - Actively participate in an Incident Management Team and provide expert clinical advice
- 5.4 It is the duty of the **Microbiology Team** to:
- Provide expert microbiological advice and oversight during the identification, investigation and management of suspected or confirmed HCID cases
 - Liaise with clinical teams, HPT and designated laboratories to ensure safe and effective response
 - Provide laboratory testing where applicable
- 5.5 It is the duty of the **Health Protection Team (HPT)** to:
- Ensure that persons who are part of a returning worker scheme or have known exposure to an HCID are followed up as per guidance and are provided with escalation advice should they become unwell
 - Determine the requirement for, convene and chair a Problem Assessment Group (PAG)/ Incident Management Team (IMT)
 - Provide expert advice on most recent guidance
 - Carry out contact tracing and assess any contacts for post-exposure prophylaxis or other control measures
- 5.6 It is the duty of **Infection Prevention and Control Team (IPCT)** to:
- Provide accurate and expert advice, guidance and support to the clinical teams.
 - Liaise with clinical teams, relevant other colleagues and designated specialist laboratories as required
 - Actively participate in IMT's and provide expert advice
- 5.7 It is the duty of **General Managers (GM)** to:
- Provide senior management support
 - Liaise with relevant teams (supporting teams mentioned above) as subject matter experts for involvement in IMT
 - Ensure Executive Director on duty is aware of situation
- 5.8 It is the duty of **Executive Directors** to:
- Ensure core functions of NHS Dumfries and Galloway continue to be delivered safely and efficiently
 - Liaise with the Chief Executive if required
 - Support Incident Management Team (IMT) if required
 - Ensure effective communication with the Chairman, Scottish Government MPs & MSPs, Local Council, Emergency Services and other NHS Boards, as required

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6. PROCESS / PROCEDURES

- 6.1 The operational process for NHS Dumfries and Galloway in the event of a person being identified as having suspected or confirmed HCID is outlined in the Operational Protocol for HCID (Appendix 1)

7 CONSULTATION

- 7.1 The creation of the HCID policy was managed by a short-term working group within NHS Dumfries and Galloway chaired by the Nurse Consultant in Health Protection. There was representation on the group from the following teams:

- Acute Medicine
- Communications
- Emergency Planning and Resilience
- Emergency Department
- Family Support Services (formerly Women's and Children's Services)
- Paediatrics
- Health Protection Team (Public Health)
- Infectious Diseases
- Infection Prevention and Control Team
- Microbiology
- Occupational Health Services
- Primary Care
- Sexual Health

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this the policy:

- Unscheduled Care Leadership Group
- Health & Social Care Leadership Team
- Area Partnership Forum
- Infection Control Committee
- Tactical Health and Safety
- Area Clinical Forum

8 TRAINING AND SUPPORT

- 8.1 The Health and Safety Executive guidelines 282/28 require that any staff member who wears respiratory equipment i.e. FFP3 respirators must be fit tested. Staff members are responsible for making sure they are fit tested, and this is renewed every 3 years. A fit test is required on FFP3 face masks to

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ensure a mask is a good fit and seal for an individual. Contact Occupational Health (01387 244626) if your last test was over 3 years ago or you have never had a fit test. Do not wear an FFP3 mask if you have a beard.

No nationally accredited training on Personal Protective Equipment training has been made available for Health Boards; therefore, NHS D&G have provided front line staff with local training based on the most up to date national guidance and evidence. This training has occurred throughout both Dumfries & Galloway Royal Infirmary and Galloway Community Hospitals, being delivered by the Infection Prevention and Control Team. All staff are reminded of their personal responsibility to ensure training and competence/ confidence in donning and doffing is kept up to date.

Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland published a HCID addendum to the National Infection Prevention and Control Manual which contains guidance on the use of new UK HCID assessment PPE ensemble. NHS Boards have until 25 August 2026 to implement this new ensemble. Training will be offered by IPCT on a Train the Trainer basis for appropriate departments to roll out training within their teams. Staff are responsible for ensuring their training and competence is kept up to date.

9 MONITORING

9.1 The monitoring arrangements for this Policy are set out in the table below.

Element to be monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
Whole policy	Review by HCID group	F. McKinnon	Board Management Team	Every 2 years
Exercise of policy		F. McKinnon K. Fergusson	Board Management Team as part of Emergency Planning Update	Every year
Training requirements being met		Teams service manager	HCID Review Group	Every year

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10 EQUALITY IMPACT ASSESSMENT

10.1 As part of the process for reviewing and developing this policy an Equality Impact Assessment was undertaken. The assessment identified the following areas with appropriate mitigations put in place.

Please summarise any identified negative impacts and associated mitigations/actions:		
Negative Impact	Mitigation/Action	Responsibility/ Timescale
Potential for vulnerable adults and children to be emotionally affected if separated from family or support mechanisms when being managed in isolation	Documented within the Policy/Plan, that any vulnerable person involved in hospital isolation situation must receive a dynamic risk assessment and must be treated with dignity and respect,	Doctor and Nurse in Charge of incident
Potential cultural or language barriers could impact on a person's perception of processes	There is telephone translation service available. All staff identified within this guidance, irrespective of religion or belief have equal access to advice and support	Doctor and Nurse in Charge of incident
Patients may refuse to be managed in isolation within NHS D&G	The most appropriate legislation is used to protect and empower those at risk of harm. Public Health (Scotland) Act 2008 may be invoked to provide protection of the public from notifiable diseases.	Health Protection Team

All Equality Impact Assessments are published on our external website, which can be accessed by clicking [here](#).

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11 DATA PROTECTION AND CONFIDENTIALITY IMPACT ASSESSMENT

- 11.1 A Data Protection Impact Assessment was not undertaken when reviewing this policy as the document did not review or handle confidential or personal information.

12. DOCUMENT CONTROL SHEET

12.1 Document Amendment History

Version	Section(s)	Reason for update

12.2 Distribution

Name	Responsibility	Version number
Corporate Business Support Team	Cascade to Exec Directors and General Managers	V2.0
General Managers and Exec Directors	Directorate dissemination to all staff through line management	V2.0
Corporate Business Support team	Issue EQIA to Comms team for publication and place policy on Board facing website and policy and appendices on beacon	

12.3 Associated documents

Operational Plan for the management of HCID
Equality and Diversity Impact Assessment Policy

12.4 Action Plan for Implementation

Action	Lead Officer	Timeframe
SLA to be shared with appropriate clinicians	Assistant General Manager Acute	July 2026
Annual exercise to be carried out	Head of Resilience	May 2027
Development of bespoke operational protocols if identified	Acute nursing/ clinical teams	



**Operational Protocol for the management of
patients with possible or confirmed
High Consequence Infectious Diseases (HCID)**

If you suspect that you have a patient or client with possible HCID you must immediately follow the **Initial Notifier Action Card in Action Card 1**

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Glossary

AMU	Acute Medical Unit
CPH(M)	Consultant in Public Health (Medicine)
DGRI	Dumfries and Galloway Royal Infirmary
GCH	Galloway Community Hospital
ECC	Emergency Care Centre
ECG	Electrocardiogram
ED	Emergency Department
HCID	High Consequence Infectious Disease
HPT	Health Protection Team
ID	Infectious Diseases
IFS	Imported Fever Service
IMT	Incident Management Team
IPC	Infection Prevention and Control
NHSDG	NHS Dumfries and Galloway
NIC	Nurse In Charge
PAG	Problem Assessment Group
PH	Public Health
SARS	Severe Acute Respiratory Syndrome
SAS	Scottish Ambulance Service
SNVTS	Scottish National Viral Haemorrhagic Fever Test Service
SOM	Scottish Ambulance Service Strategic Operations Manager
SVC	Specialist Virology Centre
VHF	Viral Haemorrhagic Fevers
WoSSVC	West of Scotland Specialist Virology Centre

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1. PURPOSE AND RATIONALE

Trends are changing in infectious disease patterns with High Consequence Infectious Disease (HCIDs) outbreaks occurring with greater frequency across the world. This combined with an increasingly interconnected world mean that healthcare providers need to be aware of and prepared for managing a situation where an individual has a suspected or confirmed HCID.

HCIDs are rare in the UK, when cases occur, they tend to be sporadic and are usually associated with travel to an area where the infection is known to be endemic or where an outbreak is occurring.

The purpose of this protocol is to outline the response of NHS Dumfries and Galloway (NHS D&G) in managing a suspected or confirmed case of HCID.

2. DEFINITION OF A HCID

An HCID is defined according to the following criteria:

- Acute infectious disease.
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- May not have an effective prophylaxis or treatment.
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Further information on HCIDs can be found here <https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid>)

It is important to note HCID in the UK is rare, cases are generally sporadic and most are associated with travel to an endemic area or an avian influenza exposure. Dumfries and Galloway, along with the rest of Scotland, have seen an increase in exposures to avian influenza through wild bird migration. In line with UK Health & Security Agency (UKHSA) guidance, the HPT in Dumfries and Galloway provides support and follow up to ensure appropriate public health measures are implemented to mitigate risk and prevent further transmission.

3. PROCESS / PROCEDURES

3.1 Initial Assessment

A patient with possible HCID could present in the community, at an Emergency Department (ED), or less likely as a patient already in hospital in Dumfries and Galloway.

It is important that ED Reception staff are aware of HCID and always have the screening tool (**Appendix 2**) available.

Whoever identifies the initial suspicion of HCID should follow the **Initial Notifier Action Card (Action card 1)**. This directs the person with initial suspicion, whether a primary care or secondary care clinician, a community healthcare provider, or a member of the HPT or IPCT, to seek urgent assessment of the patient from the Infectious Disease (ID) Specialist. During the day, this would be via Dumfries and Galloway Royal Infirmary (DGRI). On the rare occasion, that there is no ID specialist available, further advice on who to contact should be discussed with the operational manager.

Out of hours the receiving clinician responsible for care should collaborate with other NHS Boards for advice and support, seeking support from GM or Executive Director as required.

Note - In the early stages of illness there may be no specific clinical features, staff should consider malaria as a differential diagnosis. Malaria remains the most likely diagnosis in febrile returning travellers. Delays in diagnosis and treatment are associated with poor outcomes.

HCID should be considered in any patient who develops an unexplained fever within three weeks of returning from one of the areas which are known to be endemic, these include Africa, parts of South America, rural parts of the Middle East and Eastern Europe.

Clinicians at first point of contact, whether remotely (e.g. NHS 111, Out of Hours, Primary Care) or in person (e.g. ED self-presenter), must make an explicit clinical decision on whether the patient requires inpatient care at Dumfries and Galloway Royal Infirmary.

This decision should balance:

- The clinical condition and physiological stability of the patient
- The risk of cross-contamination to patients, staff, and volunteers
- The availability of safe alternatives to hospital attendance
- Where clinically appropriate, assessment should be undertaken:
- Remotely via telephone or video consultation

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- With augmentation by objective physiological measurements (e.g. oxygen saturation and heart rate monitoring in the patient's location)
- This assessment may be dynamic, with repeated review at an interval appropriate to the severity of illness.
- Only patients with a clear clinical need for inpatient care should be transferred into hospital clinical areas, including ED or AMU.

Where it is deemed safe for patient to remain at home and community testing is required, ID Specialist (or other appropriate clinician) should discuss this with members of an Incident Management Team which include Microbiology lab and Health Protection Team to agree safest method of testing.

The ID Specialist (or other appropriate clinician) will initially assess the patient remotely, via video consultation or telephone.

If the patient is a child, the ID Specialist (or other appropriate clinician) will liaise with the On-Call Consultant Paediatrician at DGRI. Ideally, the Consultant Paediatrician will jointly assess the paediatric patient remotely with the ID Specialist (or other appropriate senior clinician).

If the patient is pregnant, the ID Specialist (or other appropriate senior clinician) will liaise with Senior Midwife on duty at DGRI. Ideally, a Consultant Obstetrician and Senior Midwife will assess the maternity patient remotely with the ID Specialist (or other appropriate senior clinician).

If the ID Specialist (or other appropriate senior clinician) assesses that HCID is a possibility, follow the **ID Specialist (or other appropriate senior clinician) Action Card (Action card 2)**.

3.2 Types of HCID

ALWAYS consider malaria as a differential diagnosis. Malaria is a medical emergency in the UK (i.e. immediate admission and malaria testing). More information on malaria can be found in The Handbook [Treatment of Malaria - Doctors Handbook](#)

HCID's are classified as either contact or airborne:

Contact HCIDs	Airborne HCIDs
Argentine haemorrhagic fever (Junin virus)	Andes virus infection (hantavirus)
Bolivian haemorrhagic fever (Machupo virus)	avian influenza A(H7N9) and A(H5N1)
Crimean Congo haemorrhagic fever (CCHF)	avian influenza A(H5N6) and A(H7N7) [Note 1]
Ebola virus disease (EVD)	Middle East respiratory syndrome (MERS)
Lassa fever	Nipah virus infection

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Lujo virus disease	pneumonic plague (<i>Yersinia pestis</i>)
Marburg virus disease (MARD)	severe acute respiratory syndrome (SARS) [note 2]
severe fever with thrombocytopenia syndrome (SFTS)	

<https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid#list-of-high-consequence-infectious-diseases>

3.3 Most Common HCIDS and Immediate Actions

Below is a summary of the most common HCIDs and any immediate actions, please ensure you cross check for up to date guidance at <https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid#list-of-high-consequence-infectious-diseases>

Avian Influenza

Incubation period: can be up to 10 days, typically 2-8 days.

Route of transmission: via respiratory secretions of cases, mainly by air-borne droplet spread but also via small particle aerosols

- Has there been any known exposure to avian influenza?
- Has the patient been getting followed up by the Health Protection Team?
- Does the patient have any signs/ symptoms compatible with influenza-like illness, conjunctivitis or any severe infectious illness that does not have a plausible alternative explanation **and** close contact within 1 metre with one or more of the following in the 14 days before onset of symptoms:
- Any animal, including birds, suspected or confirmed as having avian influenza – this includes infected premises and/or live bird markets in an area of the world (which includes UK) affected by avian influenza
- Secretions from infected animals (respiratory secretions, faeces or unprocessed animal products like unpasteurised milk)

Immediate actions if avian influenza suspected:

- PPE to be used (**see Appendix 3**)
 - FFP3 respirator
 - Gown
 - Gloves
 - Eye protection
- Discuss with local ID Specialist (or other appropriate clinician)
- Discuss with microbiology department around sampling
- Notify Infection Control Team (if in hospital)
- Notify Health Protection Team (01387 272724 option 6)
- Start oseltamivir immediately if meets case definition
- Follow IPC advice in **Appendix 6**

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Title: Operational Plan for the management of patients with possible or confirmed High Consequence Infectious Diseases (HCID)

Date: 06 May 2026

Version: 2.0

Lead Author: Fiona McKinnon

The only current version of this protocol is on the intranet

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Middle Eastern Respiratory Syndrome – MERS

Incubation period: 14-day incubation period

Route of transmission – respiratory secretions from infected camels, can also spread from person to person through respiratory droplets.

- Does the patient have severe acute respiratory infection and shows **all 3** of the following symptoms:
 - Requires admission to hospital with fever and/or cough
 - Has evidence of pulmonary parenchymal disease (for example, clinical or radiological evidence of pneumonia or acute respiratory distress syndrome (ARDS))
 - Has no other aetiology that fully explains the clinical presentation

- Plus at least one of the following in the 14 days before onset of symptoms:
 - A history of travel to, or residence in, an area where infection with MERS could have been acquired (Bahrain, Jordan, Iraq, Iran, Kingdom of Saudi Arabia, Kuwait, Oman, Qatar, United Arab Emirates, Yemen, Kenya)
 - Has had close contact with a confirmed case of MERS infection
 - Has been in a health care setting in a country in list above
 - Is a healthcare worker caring for patients who have had severe acute respiratory infection, regardless of travel or use of PPE
 - Or if the person is part of a cluster of 2 or more epidemiologically linked cases within a 2-week period who have required ICU admission, regardless of history or travel **or** the patient develops an unusual or unexpected clinical course.

Immediate actions if MERS is suspected:

- PPE to be used (**see Appendix 3**)
 - FFP3 respirator
 - Gown
 - Gloves
 - Eye protection
- Discuss with local ID Specialist (or other appropriate clinician)
- Discuss with microbiology team around sampling
- Notify IPCT (if in hospital)
- Notify Health Protection Team (01387 272724 option 6)

Viral Haemorrhagic Fevers (VHF)

Viral haemorrhagic fevers are severe, life-threatening viral infections caused by RNA viruses from several viral families.

Incubation period: can vary between 3-21 days

Route of transmission – blood/ body fluids from sick or dead patients, direct/indirect contact, but risk of aerosolization, extra precautions for airborne transmission

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- Risk factors include:
 - Travel to a VHF area
 - Exposed to blood, body fluid or tissues of a person or animal infected with VHF
 - Worked in a lab with infectious agents

Immediate actions if VHF is suspected

- PPE to be used (**Appendix 3**)
 - FFP3 respirator
 - Gown
 - Gloves
 - Eye protection
- all patients that trigger as ?VHF should undergo a VHF risk assessment which should be undertaken by the reviewing clinician. Risk assessment can be found here <https://www.gov.uk/government/publications/viral-haemorrhagic-fever-algorithm-and-guidance-on-management-of-patients>
- An initial risk assessment cannot occur without the appropriate history/ information and should occur before contacting the ID/Microbiology/ Imported Fever Service:
- Discuss with local ID Specialist (or other appropriate clinician)
- Discuss with microbiology department around sampling
- Notify Infection Control Team (if in hospital)
- Notify Health Protection Team (01387 272724 option 6)

Crimean Congo Haemorrhagic Fever (CCHF)

Incubation period – up to 14 days

Route of transmission - usually by tick bites or through contact with infected blood or tissues during and immediately slaughter.

- Caused by a tick-borne virus and is endemic in Africa, the Balkans, the Middle East and some Asian countries.
- Has the patient had occupational or recreational exposure to livestock?
- Has the patient been a healthcare worker or been caring for infected persons where adequate infection control precautions have not been taken

Immediate actions if CCHF is suspected

- PPE to be used (**Appendix 3**)
 - FFP3 respirator
 - Gown
 - Gloves
 - Eye protection
- all patients that trigger as possible CCHF should undergo a VHF risk assessment which should be undertaken by the reviewing clinician. Risk assessment can be found here

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<https://www.gov.uk/government/publications/viral-haemorrhagic-fever-algorithm-and-guidance-on-management-of-patients>

- Initial risk assessment cannot occur without the appropriate history/ information and should occur before contacting the ID/Microbiology/ Imported Fever Service:
- Discuss with local ID Specialist (or other appropriate clinician)
- Discuss with microbiology team around sampling
- Notify IPCT (if in hospital)
- Notify Health Protection Team (01387 272724 option 6)

3.4 Testing Process

Following the decision to test, the appropriate clinician will contact the Consultant Microbiologist. If out of hours, the Microbiology Biomedical Scientist (BMS) should be contacted via DGRI switchboard.

Sampling pathway is available at **Appendix 4**

The ID Specialist (or other appropriate senior clinician) will also contact the Senior person on duty for Health Protection (via switchboard). The ID Specialist (or other appropriate senior clinician) decision to test is a threshold for HPT to assess the need to convene a PAG/IMT following the **Health Protection Action card (Action Card 18)**. HPT will manage the wider aspects of the incident, including contact tracing and management of everyone who may have been exposed.

The ID Specialist (or other appropriate senior clinician) may decide that a patient is to be tested without admission. The process for community testing would need to be discussed at IMT on a case-by-case basis.

3.5 Admission and Transfer

Should the ID Specialist (or other appropriate clinician) make the decision to **admit**, this would also be a threshold for the Senior person on duty for Health Protection to assess the need to convene an Incident Management Team (IMT) following the **Health Protection Action card (Action card 18)**. Health Protection will manage the wider aspects of the incident, including contact tracing and management of everyone who may have been exposed.

The ID Specialist (or other appropriate clinician) will discuss the need for admission with the AMU Duty Doctor who will initiate the **AMU Duty doctor Action Card**

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(Action card 8), this includes notification to the Nurse in Charge of AMU, who should then follow the **AMU Nurse in Charge Action Card (Action card 7)**.

If the patient is a paediatric patient, the On-Call Consultant Paediatrician will follow the **On-Call Paediatrician Action Card (Action card 11)**.

Adult patients will be admitted to Room 31 based in Acute Medical Unit (AMU). Paediatric patients may also be admitted to Room 31 with the provision of nursing and medical paediatric staff.

If Room 31 is unavailable, the patient may be admitted to R4 (resus room 4 in ED).

If self-presenting critically unstable to the Galloway Community Hospital ED
Suspected person must be isolated and contained in designated room in GCH ED. Escalation as per Initial Notifier action card should be followed.

The Scottish Ambulance Service (SAS) Service Operations Manager (SOM) and the Consultant in charge of GCH will be invited to the IMT convened by Health Protection. This will allow co-ordinated decision making about transporting the patient to DGRI or other location as appropriate depending on clinical need.

Current inpatient identified as suspected or confirmed HCID

If a current inpatient in DGRI or any other hospital setting is identified as having suspected or confirmed HCID, this should be instantly escalated as per Initial Notifier Action Card, i.e. discuss with ID Specialist (or other appropriate clinician). This should also be flagged immediately to the Infection Prevention and Control Team and notified to Health Protection Team. The patient should NOT be moved unless agreed by the IMT.

3.6 IPC Precautions Required During a Patient Transfer

Transfer to Room 31 AMU (usually from ED isolation room)

The route to be taken by the patient should be identified in advance, cordoned off with clear signage and cleared of other people who are not necessary for the transport.

- Wear HCID assessment PPE to accompany patient during any transfer
- Contact with other patients, hospital staff or visitors must be avoided during transfer
- Patient should wear a surgical mask if this can be tolerated
- *Patients that are well enough to walk (and are continent)*
 - Should perform hand hygiene prior to walking to Room 31.
 - Should be instructed to avoid touching anything during transfer.

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Title: Operational Plan for the management of patients with possible or confirmed High Consequence Infectious Diseases (HCID)

Date: 06 May 2026

Version: 2.0

Lead Author: Fiona McKinnon

The only current version of this protocol is on the intranet

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- *Other patients:* transfer on bed, which is then left in Room 31.
- Staff accompanying the patient should be prepared to manage any bodily fluid spills (see **Infection Control Guidance - Appendix 6**) and therefore should carry a spill kit during the transfer

Intra-hospital transfers to other departments

- Must only occur if clinical need dictates and agreed by IMT
- Receiving department must be informed in advance and pathway agreed
- Staff should accompany patient wearing HCID PPE (**Appendix 3**)
- Patient must be taken straight to and from the investigation/treatment room and must not wait in any communal area
- Patient should wear a surgical mask if this can be tolerated

Transfers to UK High Level Isolation Unit

If the ID Specialist (or other appropriate clinician), along with IMT members, which would include colleagues from the relevant High Level Isolation Unit agree the patient requires to be transferred to a UK High Level Isolation Unit, the SAS SOM will organise transport.

3.7 Initial Ward Examination

Once in the negative pressure room, nursing and medical staff will review and assess the patient together. NO paperwork will be taken into the room and only staff deemed competent in the use of HCID PPE will enter. A buddy MUST ALWAYS be available for donning and doffing PPE.

Ancillary staff will NOT enter any room being used to care for a patient with HCID.

The nurse in the room will admit the patient to the ward, communicating information for the records to a nursing colleague outside the room using a nurse call system.

Nursing staff should liaise with medical staff with regards to the ongoing care of the patient, particularly with regards to any Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) status, observations required, and dependency recorded along with the reasons(s) for doing so, in the Logbook within the ante room.

3.8 Ward Visitors

Adult patients must have no visitors in the patient room or anteroom until the diagnosis has been confirmed, and the patient's consultant has given approval. Visitors must remain outside the patient room and ante-room areas and communicate using the telephone installed in the patient room. Any such visit should always be supervised.

Parents of paediatric patients may be allowed to remain in the room with their child. This would require risk-informed, shared decision making between parents and Paediatrics, an agreement from IMT members and parents should be provided with very clear instruction and supervision in the use of PPE.

4. MEDIA/ STAKEHOLDER CONTACT

All media requests and communication from stakeholders (i.e. politicians, council members) should be directed to the Communications Team. Under no circumstances should any member of staff speak directly to the media unless approved by IMT and Communications Team.

No structured communications should be developed and implemented without engaging with the Communications Team.

The Communications Team can be contacted on dgcommunications@nhs.scot and 01387 241061.

5. STAFF SUPPORT AND WELLBEING

Everyone involved in an HCID incident may benefit from psychological support. NHS Dumfries and Galloway will provide post-incident debriefs and staff wellbeing resources are available via Beacon with additional input/support considered dependent on the situation.

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APPENDIX 1 – ACTION CARDS:

Action Card 1 - Initial Notifier

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	The clinician who first suspects they have a patient with HCID (may be Community or Acute colleague)
Immediate Action	Isolate the patient and seek immediate assistance
Notification to Location	Alert the Duty Infectious Disease Consultant (DGRI 01387 242426) Community/ Primary Care/ Hospital Setting
Action:	Tick/ time done
Consider HCID risk assessment (Appendix 2)	
Ensure the patient is isolated in a room on their own and establish a method of communication (i.e. mobile phone) DO NOT EXAMINE PATIENT AT THIS POINT	
Consider other illnesses, i.e. Malaria. Malaria remains the most likely diagnosis in febrile returning travellers. Delays in diagnosis and treatment are associated with poor outcomes.	
<p>Clinicians at first point of contact, whether remotely (e.g. NHS 111, Out of Hours, Primary Care) or in person (e.g. ED self-presenter), must make an explicit clinical decision on whether the patient requires inpatient care at Dumfries and Galloway Royal Infirmary.</p> <p>This decision should balance:</p> <ul style="list-style-type: none"> • The clinical condition and physiological stability of the patient • The risk of cross-contamination to patients, staff, and volunteers • The availability of safe alternatives to hospital attendance • Where clinically appropriate, assessment should be undertaken: <ul style="list-style-type: none"> ○ Remotely via telephone or video consultation ○ With augmentation by objective physiological measurements (e.g. oxygen saturation and heart rate monitoring in the patient's location) • This assessment may be dynamic, with repeated review at an interval appropriate to the severity of illness. • Only patients with a clear clinical need for inpatient care should be transferred into hospital clinical areas, including ED or AMU. 	
Telephone DGRI Switchboard and ask to speak to the duty ID Specialist (if no ID specialist available, ask to speak with acute	

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Action:	Tick/ time done
operational manager to ascertain who would be most appropriate to speak with)	
Contact Health Protection Team if a notifiable disease is suspected – during office hours 01387 272724 option 6 and out of hours via DGRI switchboard and ask for on call Public Health person	
Provide details of the patient and their symptoms and any recent travel or exposure to the ID Specialist (or other appropriate clinician)	
If patient is safe to stay at home, then testing method needs to be discussed to ensure safety of staff.	
For hospital infection prevention and control advice during office hours call 01387 241 627	
Other actions to consider: <ul style="list-style-type: none"> • Consider risks of cross contamination • If there is any waste from the patient, it should be managed as below: • All waste should be double bagged. • Refer to Appendix 6 – Infection Control Guidance for cleaning and waste disposal. 	

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Action Card 2 - Duty Infectious Diseases Specialist

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Duty Infectious Diseases Specialist
Immediate Action	Initial clinical assessment and response
Notification	From Primary/ Secondary care clinician or Health Protection
Location	DGRI
Next steps:	Tick
Review patient remotely via video consultation, if possible. If patient is a child, assess in liaison with on-call Consultant Paediatrician	
If VHF is suspected call the Imported Fever Service (see Appendix 10 for contact details)	
Decide: <ul style="list-style-type: none"> Risk assessment of case as high or low possibility If and what testing is to be carried out Whether to admit 	
Notify Microbiology Consultant or Biomedical Scientist	
Notify Health Protection Team – during office hours 01387 272724 option 6 or via DGRI switchboard if out of hours	
For hospital infection prevention and control advice during office hours call 01387 241 627	
Other actions to consider: <ul style="list-style-type: none"> Consider risks of cross contamination If there is any waste from the patient, it should be managed as below: All waste should be double bagged. Refer to Appendix 6– Infection Control Guidance for cleaning and waste disposal. 	

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Action Card 3 - ED Reception

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	The professional who first speaks with patient self-presenting at ED
Immediate Action	Seek immediate assistance from ED nurse in charge
Notification to	ED nurse in charge
Location	ED Hospital Setting
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To protect the function of the ED. • To protect staff, patients, and relatives. • Reduce risk of cross-contamination. • Escalation to senior management. 	
<p>Actions:</p> <p>Ask all patients attending ED (either self-presenting or by ambulance)</p> <ul style="list-style-type: none"> • Has the patient travelled out with Europe? (Appendix 2) • Does the patient have an illness with a history of fever? • Do they have a cough and history of travel to the Middle East in last 14 days? • Have they had exposure and/ or close contact (within one metre) to any animal, including birds, suspected of or confirmed as having avian influenza (this includes infected premises and /or live bird markets affected by avian influenza • If the answer to any of these questions is yes, discuss with ED nurse in charge <u>urgently</u>. <p>Next Steps:</p> <ul style="list-style-type: none"> • Ask the patient to wait outside in private transport if available and patient deemed clinically stable • Ensure the patient can be contacted via mobile phone and worsening advice given or • Re-direct patient to isolation room (T3.G.008.EMC) in the ED waiting area if unwell, ensuring a method of communication (i.e. phone) • Consider risks of cross contamination. • Remain within ED Reception Room and await further instruction from Nurse in Charge. • If there is any waste in the reception area from the patient, it should be managed as below: • All waste should be double bagged. • Refer to Appendix 6 – Infection Control Guidance for cleaning and waste disposal. 	

Action Card 4 - ED Nurse In Charge

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	The nurse in charge of ED
Immediate Action	Locate patient
Notification to	Senior ED doctor on duty
Location	ED Hospital Setting
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To protect the function of the ED. • To protect staff, patients, and relatives. • Reduce risk of cross-contamination. • Escalation to senior management. 	
<p>Actions: Confirm and document that inpatient admission is clinically required prior to activating AMU clearance and transfer to Room 31</p> <p><u>Self-presenting patient:</u></p> <ul style="list-style-type: none"> • Locate the patient – isolation room or private transport in car park. • Inform senior ED Doctor on duty, Capacity Manager and ensure appropriate escalation to Senior Management Team. • Identify staff to don appropriate HCHID PPE as per Appendix 6 • Assign staff member/s to approach the patient by instigating a TALK DON'T TOUCH approach whilst the assessment of the patient is underway. • If patient is situated in isolation room, cordon off area with mobile screen. • Consult with nurse in charge of Acute Medical Unit (AMU) to arrange transfer to Room 31. • If room 31 is unavailable, and the patient is unwell, relocate to R4 within ED. • Ensure appropriate lockdown of receiving hospital areas in preparation to transfer patient. • When room available in AMU, allocate two ED Nurses to be responsible for patient and ensure appropriate PPE is worn. • Consideration for depleted ED Nurse workforce if staff relocated to AMU with patient. • Ensure Action Cards are available for required roles within Incident Response. • Refer to Incident Response Plan, Action Cards if Level 3 Critical Incident Response is activated and declared. • Log all actions. • Await further instruction from Senior Management Team. 	

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- Facilitate business as usual status for other NHS D&G patients and staff who are not involved in the incident.

Patient arriving by 999 Ambulance

- Inform senior ED Doctor on duty, Capacity Manager and ensure appropriate escalation to Senior Management Team.
- Instigate temporary hold of patient within ambulance and arrange for admission straight to room 31.
- If pre-alert received from ambulance crew and if room 31 unavailable or patient unwell – consider direct transfer to R4.
- Allocate two ED Nurses to be responsible for patient and ensure HCID PPE is worn **(Appendix 3)**
- Ensure appropriate lockdown of receiving hospital areas in preparation to transfer patient.
- Log all actions.
- Await further instruction from Senior Management Team.
- Facilitate business as usual status for other NHS D&G patients and staff who are not involved in the incident.

Suspected patient who has breached the Emergency Department

- Inform senior ED Doctor on duty, Capacity Manager and ensure appropriate escalation to Senior Management Team.
- If patient has breached Emergency Care Centre corridor with ambulance crew, consider partial lockdown of area or redirect crew and patient back to ambulance and informed to await further instruction.
- Arrange urgent transfer to room 31 for further assessment.
- If room 31 unavailable or patient unwell – consider direct transfer to R4.
- If patient has breached into main ED resulting in cross contamination of the unit, consider escalation for lockdown or temporary relocation of ED as per plan.
- Log all actions.
- Await further instruction from Senior Management Team.
- Facilitate business as usual status for other NHS D&G patients and staff who are not involved in the incident.

End of shift/ post incident

- Ensure accurate handover notes are produced, and incoming shift are aware of any urgent/ outstanding issues.
- Ensure all documentation is completed, up to date and saved in the appropriate locations.
- Ensure all personal logs and notes from all staff are collected and stored appropriately.
- Complete the staff contact tracing form and notify Occupational Health.

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Action Card 5 - HCID Buddy Role

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	The nurse in charge of ED
Immediate Action	Locate patient
Notification to	Senior ED doctor on duty
Location	ED Hospital Setting
Responsibilities: <ul style="list-style-type: none"> • To support member of staff who are going to be wearing PPE • To protect staff, patients, and relatives. • Reduce risk of cross-contamination. 	
Action	Time done
A doffing buddy must always be present and ready while other staff are donned in PPE.	
<p>Prepare the Zones in the Area: RED, AMBER, GREEN Prior to donning any PPE, ensure room is ready and all equipment is present and readily available.</p> <p>Preparation:</p> <ul style="list-style-type: none"> • HCID Assessment PPE • Yellow Bins with Yellow Liners • Procedure and barrier precaution signs and privacy screens <p>Buddy assistance in Donning:</p> <ul style="list-style-type: none"> • Ensure all staff are supported in donning HCID assessment PPE <p>Doffing Buddy Instructions for sample taking:</p> <ul style="list-style-type: none"> • Always be present and available when the donned staff are in the room, ready to assist in preparing the samples. • Ensure samples are cleaned with 10000ppm chlorine releasing agent and given to laboratory staff for transportation to the laboratory. <p>Assisting in Doffing PPE:</p> <p>Buddy PPE:</p> <ul style="list-style-type: none"> • Buddy in Green Zone of doffing area: • No contact buddy = no HCID PPE required <p>Buddy entering Amber Zone to assist HCW or clean equipment:</p> <ul style="list-style-type: none"> ○ longer-cuffed nitrile gloves 	

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<ul style="list-style-type: none"> ○ fluid-resistant gown ○ Surgical mask (FRSM) ○ Visor ○ wellington boots. ● Always be present and available when the donned staff are in the room, ready to assist in doffing the PPE. ● Prior to giving doffing instructions, provide verbal guidance to the staff on how to make space in waste bin or empty if needed to ensure safety doffing practice. All equipment should be in the amber zone already ● Using Doffing Guide on Appendix 3 use clear and concise instructions to ensure staff member safety remove their PPE. Provide instruction and guidance if PPE removal is incorrect. ● Doffing buddy should have hand sanitiser ready for the doffing staff ● Doffing buddy to provide guidance on safe placement of any wellies into a 50-litre yellow container in the amber zone once removed. 	
<p>Waste Management:</p> <ul style="list-style-type: none"> ● Waste management should be managed as a Category A until the test result is known. ● Waste should be double bagged, clearly labelled and always replaced when two thirds full. ● Any waste leaving the contaminated zones should have the bin lids secured and should be externally disinfected in the Amber Zone with 10000ppm chlorine releasing agent. ● Hold Waste securely in the designated area (AMU DSR) until IMT decision is agreed to remove. ● If patient requires the toilet, a commode should be kept in the room with replaceable liners and the contents inactivated, solidified, and disposed of in the waste. A Sluice Must Not be used. 	
<p>Priorities:</p> <ul style="list-style-type: none"> ● Ensure staff spend no longer than 4 hours in PPE. Rotate staff if required but try to limit staff exposure. ● Provide clear, concise Donning and doffing guidance to staff and always be available when staff are with the patient. ● Escalate early to Nurse in Charge (NIC) or Consultant in Charge (CIC) if further Donning/Doffing staff members are required 	

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Action Card 6 – ED Doctor

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	ED Doctor
Immediate Action	Provide appropriate leadership and clinical care for patient
Notification to	Infectious Disease Specialist
Location	ED Hospital Setting
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To protect the function of the ED. • To provide appropriate medical care. • Consult with relevant specialty partners, e.g. Infectious Disease Team, Microbiology, AMU Clinicians. • To protect staff, patients, and relatives. • Reduce risk of cross-contamination. • Escalation to senior management. 	
<p>Actions:</p> <p>Confirm and document that inpatient admission is clinically required prior to activating AMU clearance and transfer to Room 31</p> <ul style="list-style-type: none"> • Receive initial briefing from Nurse in Charge and discuss appropriate location for patient to be assessed and contained. • If patient is pre-alerted and already considered high-risk by primary care or ambulance service, discuss with ED Nurse in Charge about direct admission to room 31. If room 31 is unavailable, consider R4. • Consider staffing implications if ED Doctor is required to manage patient within AMU for period of unknown time. • Don HCID PPE using buddy system as per Appendix 6 • Proceed to assess the patient with a TALK DON'T TOUCH approach. • Following assessment, discuss patient case with infectious disease specialist for further advice and plan of action • Discuss with Microbiology for sampling advice (Appendix 3) • Obtain blood sampling as instructed by specialist teams. • Handover patient to on call Medical Team as and when appropriate. • Ensure documentation is kept up to date and accurate. 	

Action Card 7 - ED Staff Nurse

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	The nurse who will be admitting/ caring for patient
Immediate Action	Don HCID PPE prior to carrying out admission
Location	ED Hospital Setting
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To protect the function of the ED. • To provide appropriate level of nursing care. • To protect staff, patients, and relatives. • Reduce risk of cross-contamination. • Escalation to Senior Nurse. 	
<p>Immediate actions:</p> <ul style="list-style-type: none"> • Receive initial briefing from Nurse in Charge and discuss appropriate location for the patient. • Don HCID PPE using buddy system as per Appendix 3. • If patient has self-presented to ED and is currently located in the isolation room (T3.G.008. EMC) within the ED waiting area, await instruction to relocate to designated Room 31 or R4. • Perform initial triage through a TALK DON'T TOUCH approach. • Obtain means of communication by picking up deck phone and ensure Nurse in Charge is aware of contact number. • Aim is to contain patient in Room 31 within AMU, although if unavailable consider R4 • If patient requires transfer from isolation room or car park to the appropriate designated location (Room 31 or R4), allocated Nurses will exit the patient out of ED waiting room door and re-enter via the Ambulance entrance doors, when instructed by the Nurse in Charge of ED. • If patient is pre-alerted and already considered high-risk by primary care or ambulance service, liaise with Nurse in Charge re direct admission into room 31. • Continue to work in buddy system and, with the Clinician, provide appropriate level of care to patient when being assessed in isolation room. <ul style="list-style-type: none"> • Doff safely as per HCID guidance (Appendix 3) • Always maintain personal safety. • Provide accurate handovers. • Ensure documentation is kept up to date. • Consider debrief/ wellbeing resources 	

Action Card 8 - Galloway Community Hospital ED

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Clinician in Galloway Community Hospital
Immediate Action	Protect the function of ED, staff and other patients
Notification to	ID Specialist (or other appropriate senior clinician)
Location	Galloway Community Hospital

Responsibilities:

- To protect the function of the Emergency Department and Community Hospital.
- To identify and escalate early any suspected HCID case early, due to remote location and time/ resource required for logistical transfer.
- To protect staff, patients, and relatives.
- Reduce risk of cross-contamination.
- Inform General Manager at DGRI of any immediate risk.

Actions:

- If the ED receive information from SAS or Primary Care about any suspected HCID cases on route to GCH, consider redirection to DGRI if patient clinically stable, to avoid secondary transfers.
- Communicate with DGRI as early as possible on any transfers and provide detailed virtual medical handover.
- If suspected patient self-presents to the ED or has breached a ward/ clinical setting, don HCID PPE using buddy system as per HCID guidance (**Appendix 2**) and perform initial triage through a TALK DON'T TOUCH approach.
- Clinical staff must escalate through their appropriate channels, such as discussing case with Infectious Disease Specialist
- Suspected person must be isolated and contained in the designated room in ED, until a senior decision is made on need to treat within present environment or transfer to appropriate specialist centre. This will be discussed in an Incident Management Team meeting.
- IMT will agree with Scottish Ambulance Service around need to transfer suspected HCID patient to either DGRI (Isolation Room 31, Medical Assessment Unit or Infectious Disease Hospital as per Service Level Agreement).
- Consider risks of cross contamination
- If there is any waste from the patient, it should be managed as below:
 - All waste should be double bagged
 - Refer to Appendix 6 for cleaning and waste disposal

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- Advice on deep cleaning of any affected area must be communicated through the infection control team.
- Doff safely as per HCID guidance (**Appendix 3**).
- Always maintain personal safety.
- Any staff contact with suspected case will be managed by Occupational Health during office hours and Health Protection out of hours
- Provide accurate handover.
- Ensure documentation is kept up to date.

End of shift/post incident

- Ensure accurate handover notes and incoming shift are aware of any urgent/ outstanding issues.
- Ensure all documentation is completed, up to date and saved in the appropriate locations.
- Ensure all personal logs and notes from all staff are collected and stored appropriately.
- Complete the staff contact tracing form and notify Occupational Health.
- Participate in hot and cold debriefs.

Action Card 9 - AMU Nurse In Charge

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Nurse in charge of AMU
Immediate Action	Ensure safety of patient and staff
Notification to	ED Senior Doctor
Location	ED Hospital Setting
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To protect the function of the Acute Medical Unit. • To protect staff, patients, and relatives. • Ensure availability and capability of isolation room 31. • Reduce risk of cross-contamination. • Escalation to senior management. 	
<p>Actions: AMU clearance and preparation of Room 31 should only be initiated once a senior clinical decision has confirmed the need for inpatient care <u>STEP 1 – Location</u></p> <ul style="list-style-type: none"> • As soon as informed of suspicious case, discuss with Bed Capacity Team and prepare to clear Room 31. • Identify HCID Band 6 information document. • Clear room 31 of all non-essential equipment. • Ensure all necessary nursing and medical equipment available. • Ensure HCID PPE available in donning area. <p><u>For ED / self-presenters:</u></p> <ul style="list-style-type: none"> • With ED Nurse in Charge, consider route to Room 31 – most likely round outside of ED to ambulance entrance. Ensure correct route identified and followed. Mobile screens required to isolate entrance and exit doors to Room 31. Other staff with non HCID PPE may be required to keep doors open and divert other staff/ patients from the route. • Request additional staff to assist with partial lockdown of area around room 31. <p><u>For GP referred patients:</u></p> <ul style="list-style-type: none"> • Keep patient in transport until Room 31 available. HCID donned staff required to assist patient to Room 31, others clearing path as above. <p><u>STEP 2 – Inform</u></p> <ul style="list-style-type: none"> • Identify the first team who will enter the room (ED Senior Doctor and AMU Nurse). 	

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- Liaise with Capacity Team/ Lead Nurse to facilitate rota (it is anticipated that the maximum time an individual will spend in PPE should be 4 hours. To facilitate a rotation, 3 members of nursing staff will be required for a 12-hour shift).
- Inform the ED Nurse in Charge when ready to accept the patient.
- Inform Medical Consultant when Room 31 prepared and department ready to accept patient.
- Confirm General Manager is aware of incident.

STEP 3 – Clinical Care

- HCID trained Nurse and PPE Buddy will be required to staff area (**Appendix 3**).
- Samples should be taken as per sampling pathway (**Appendix 4**)
- Notify laboratory staff that samples will be taken
- Laboratory colleagues, once notified, will attend AMU to transport samples to the lab
- Initial nursing tasks will require a member of staff in the room, but exposure should be minimised thereafter, only entering the room when necessary.
- Utilise ECG monitoring and saturations probe to provide monitoring.
- Ensure screen of monitor visible to the outside of room.
- IV fluids and drugs are likely to still be required; investigations and equipment will be limited. Plan to batch clinical care interventions together.
- Maintain contact log sheet for all staff entering room.

STEP 4 – Managing waste and Decontamination

- All waste should be double bagged.
- Refer to Appendix 6 for cleaning and waste disposal.
- Once patient has left the room, all equipment and waste to remain in room.
- Open communication with IMT, any cleaning and decontamination needs discussed.
- Room must remain out of use until agreed cleaning has been completed

End of shift/ post incident

- Liaise with AMU Doctor in charge for stand-down of incident.
- Ensure handover notes are accurate and incoming shift are aware of any urgent/ outstanding issues.
- Ensure all documentation is completed, up to date and saved in the appropriate locations.
- Ensure all personal logs and notes from all staff are collected and stored appropriately.
- Complete the staff contact tracing form and notify Occupational Health.
- Participate in hot and cold debriefs.

Action Card 10 - AMU Duty Doctor

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	The duty doctor in AMU
Immediate Action	Carry out admission process and provide safe clinical care
Notification to	AMU Consultant
Location	AMU Hospital Setting
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To protect the function of the Acute Medical Unit. • To provide appropriate level of medical care. • Consult directly with Medical Consultant. • To protect staff, patients, and relatives. • Escalation to senior colleagues. 	
<p>Actions:</p> <p>AMU clearance and preparation of Room 31 should only be initiated once a senior clinical decision has confirmed the need for inpatient care</p> <p>STEP 1 – Handover from ED</p> <ul style="list-style-type: none"> • Discuss with AMU Nurse in Charge (83161) to confirm proposed location of patient (Room 31 in AMU preferable). • Liaise with AMU Nurse in Charge to ensure patient remains in ED isolation room or outside hospital (car/ambulance) until Room 31 available. • Alert AMU Duty Consultant to HCID patient referral, Call in Medical Consultant on-call to attend in person if overnight (2100hrs-0800hrs). • Take handover from ED Senior Doctor but ensure responsibility for patient remains under ED until AMU taken over care – (see below). <p>STEP 2 – Sampling</p> <ul style="list-style-type: none"> • Do NOT approach the patient unless in HCID PPE (Appendix 3) • Do NOT accept patient to Room 31 until ED and AMU Nurses in Charge have ensured a safe route to the room. • ED Senior Doctor will take initial screening swabs and/or bloods in HCID PPE– note blood sampling box and protocol for taking high risk samples – bloods to take depend on disease of concern – if laboratory not informed, support ED staff by taking this on. (Appendix 4) • Generic unknown possible HCID sepsis will require consideration of blood cultures, malarial film, bloods as below – history and exposure will determine need for other samples after initial screening. • Note Bloods will give only FBC, U&Es, LFTs, Bone Profile, and CRP. 	

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- Do NOT take a Venous Blood Gas or Arterial Blood Gas to assist diagnosis as equipment would require to be condemned after exposure if positive to HCID sampling.
- Note, no facility exists to measure Lactate or H⁺ / PO₂ / PCO₂ – use venous bicarbonate on U&Es as surrogate.
- Do NOT remove any equipment from within Room 31.

STEP 3 – Staffing and handover

With AMU Duty Consultant/ ED Senior/ Consultant and AMU Nurse in Charge, consider:

- Consider trained HCID PPE medical staffing resource availability within Emergency Care Centre and plan a proportionate response with the Medical Consultant.
- ED Staff will handover patient to Medical Team in AMU after the completion of screening and sampling/ bloods are taken.
- Ensure IMT are aware of any staffing implications (usually via GM).

STEP 4 – Ongoing Contact

- Minimise patient proximity and contact – use 'TALK DON'T TOUCH' approach.
- Ensure HCID PPE Donned and Doffed with dedicated Buddy as per Appendix 3
- Ensure history taken including travel, places, dates, type of activities undertaken, exposures (bites/ infective contacts), duration of illness, other people unwell.
- Use single-use examination equipment – and note inability to use certain equipment e.g. stethoscope whilst in HCID PPE.
- Should the patient potentially require Critical Care interventions, inform AMU Duty/ Medical on-call Consultant, who will discuss directly with ICU Consultant.

With Nurse designated for Room 31, ensure:

- Observation/ vital sign monitor must be visible from outside room.
- ECG 3 lead monitoring and saturation probe to remain on patient.
- Minimise investigations and contact needed until HCID risk clarified (liaise with Consultant Microbiologist/Health Protection/ Infection Control Team).
- In the event of patient deterioration (observations/ clinical appearance) discuss with Duty Medical Consultant regarding next necessary actions and interventions.
- IV Antibiotics and possibly IV fluids are likely to be necessary in managing infection pending clarification – types determined by clinical presentation.
- Radiology/Imaging is likely to be limited – discuss with Duty AMU Consultant.
- Broad spectrum treatment may be required in absence of clear diagnosis pending HCID sample results or transfer.
- The patient should remain within Room 31 in AMU pending either diagnosis of alternative non-HCID pathology or retrieval out of hospital – Critical Care if required will need to be delivered in Room 31.
- Ensure you and any colleague in contact with patient signs log of staff contacts.

BOARD PUBLIC

End of shift/ post incident

- IMT will agree and disseminate when incident can be stood down.
- Ensure handover notes are accurate and incoming shift are aware of any urgent/ outstanding issues.
- Ensure all documentation is completed, up to date and saved in the appropriate locations.
- Ensure all personal logs and notes from all staff are collected and stored appropriately.
- Complete the staff contact tracing form and notify Occupational Health.
- Participate in hot and cold debriefs.

Action Card 11 - AMU Staff Nurse

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	AMU Staff nurse
Immediate Action	Ensure safe admission and nursing care of patient
Notification to	AMU Nurse in Charge
Location	AMU Hospital Setting
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To protect the function of the Acute Medical Unit. • To provide appropriate nursing care • Consult with Nurse in Charge • Reduce risk of cross-contamination.. 	
<p>Actions:</p> <p>STEP 1 – Handover from ED</p> <ul style="list-style-type: none"> • Identify HCID Band 6 information document. • Clear room 31 of all non-essential equipment. • Ensure all necessary nursing and medical equipment available. • Ensure HCID PPE available in donning area. <p>STEP 2 – Clinical Care</p> <ul style="list-style-type: none"> • HCID trained Nurse and PPE Buddy will be required to staff area. • Samples should be taken as per sampling pathway (Appendix) • Notify labs that samples will be taken • Lab staff, once notified, will attend AMU to transport samples to the lab • Initial nursing tasks will require a member of staff in the room, but exposure should be minimised thereafter, only entering the room when necessary. • Utilise ECG monitoring and saturations probe to provide monitoring. • Ensure screen of monitor visible to the outside of room. • IV fluids and drugs are likely to still be required; investigations and equipment will be limited. Plan to batch clinical care interventions together. • Maintain contact log sheet for all staff entering room. <p>STEP 3 – Managing waste and Decontamination</p> <ul style="list-style-type: none"> • All waste should be double bagged. • Refer to Appendix 6 for cleaning and waste disposal. • Once patient has left the room, all equipment and waste to remain in room. • Open communication with IMT, any cleaning and decontamination needs discussed. 	

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- Room must remain out of use until agreed cleaning has been completed

End of shift/ post incident

- Liaise with AMU Doctor in charge for stand-down of incident.
- Ensure handover notes are accurate and incoming shift are aware of any urgent/ outstanding issues.
- Ensure all documentation is completed, up to date and saved in the appropriate locations.
- Ensure all personal logs and notes from all staff are collected and stored appropriately.
- Complete the staff contact tracing form and notify Occupational Health.
- Participate in hot and cold debriefs.

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Action Card 12 - AMU Consultant

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	The Clinician in charge of AMU
Immediate Action	Protect the function of AMU and staff
Location	AMU Hospital Setting
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To protect the function of the Acute Medical Unit. • To provide appropriate level of medical care. • Consult with relevant specialty partners, e.g. Infectious Diseases, Microbiology, Health Protection. • To protect staff, patients, and relatives. • Reduce risk of cross-contamination. • Escalation to senior management. • Help coordinate patient referral to specialist centre. 	
<p>Actions:</p> <p>Step 1 – Location/ Communication</p> <ul style="list-style-type: none"> • Along with AMU Nurse in Charge, ensure AMU team are aware of their roles. • Confirm General Manager aware – they will liaise with HPT/ IPCT to ensure IMT is being established. • Clinician is required to contact Health Protection Team by phone if not done. • Do NOT approach the patient unless in HCID PPE. • Do NOT accept patient to Room 31 until Bed Capacity staff and AMU Nurse in Charge have cleared a safe route to the room. • Discuss case with appropriate specialty Consultants, i.e. if case involves paediatrics or maternity. • ED staff will undertake screening and initial samples/ bloods. <p>Step 2 – Staffing</p> <ul style="list-style-type: none"> • Ensure staff safety remains paramount, with patient care delivered safely. • Ensure staff contact log sheet completed for all staff entering room. • Take handover from ED Senior Doctor and assume clinical responsibility for patient. • Minimise patient proximity and contact – use ‘TALK DON’T TOUCH’ approach to minimise staff exposure. • Minimise staff patient contact and unnecessary medical equipment within room 31 if patient stable to reduce exposure time. 	

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With AMU Nurse in Charge/ ED Consultant:

- Consider trained HCID PPE staffing resource availability within Emergency Care Centre and plan a proportionate response.
- ED Staff will handover patient to medical team in AMU after the completion of screening and sampling/bloods are taken.
- Ensure GM is aware of any staffing issues, they will discuss with IMT.

Step 3 – Clinical Care

- Obtain clinical history from ED Team and clarify infection risk, discuss with Infectious Diseases Consultant or Consultant Microbiologist.
- Consider differential diagnoses – discuss with Infectious Diseases Consultant or Microbiologist.
- Note examination and information yielded may be very limited due to PPE.
- Arterial Blood Gas Machine (with LCT, gas analysis, electrolytes) and mobile radiology will NOT be used to assist diagnosis as equipment would require to be condemned after exposure if positive to HCID sampling.
- Broad treatment cover may be needed in absence of specialist investigations – only standard laboratory samples may be available to test initially – consider carefully.
- Consider if there is a need for further investigations or if these can wait pending tests being result.
- Should the patient deteriorate and require critical care interventions, discuss directly with ICU Consultant. The aim would be to keep patient in room 31 and not transfer through hospital, risking cross-contamination.
- The mobile ICU equipment trolley should be brought to AMU room 31 if critical care is required – care will need to be delivered within Room 31.
- Dependent upon the HCID of concern and clinical status, decisions may be required in collaboration with IMT and ICU Consultant over ability to perform some clinical interventions/ escalation.
- Decisions concerning location of ongoing care, escalation and transfer should be channelled through the IMT.

End of shift/ post incident

- IMT will agree and disseminate re stand down of incident.
- Ensure handover notes are accurate and incoming shift are aware of any urgent/ outstanding issues.
- Ensure all documentation is completed, up to date and saved in the appropriate locations.
- Ensure all personal logs and notes from all staff are collected and stored appropriately.
- Complete the staff contact tracing form and notify Occupational Health.
- Participate in hot and cold debriefs.

Action card 13 - On Call Consultant Paediatrician

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	On-call Consultant for Paediatrics
Immediate Action	Organise admission to DGRI or other as appropriate
Location	DGRI
<p>Actions required:</p> <ul style="list-style-type: none"> • Participate in remote assessment of paediatric patient with ID Specialist (or relevant person) • Following decision to admit, agree that patient should be admitted to Room 31 as per protocol with provision of medical and nursing staff from Paediatrics or if other appropriate room should be used • Ensure laboratories are informed of the HCID status of the patient • Ensure Health Protection Team are aware • Maintain contact with ID Specialist (or other appropriate clinician) re HCID result • Liaise with Paediatric Nursing and Medical teams in relation to care for the child 	

Action Card 14 - Paediatric Ward

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Paediatric nurse
Immediate Action	Ensure safe care of child
Notification to	Consultant Paediatrician
Location	DGRI Paediatrics
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To protect the function of the Paediatric ward. • To provide appropriate nursing care • To recognise the need for patient containment if HCID suspected • Reduce risk of cross-contamination • To protect staff, patients and relatives • To reduce risk of cross-contamination 	
<p>Actions:</p> <ul style="list-style-type: none"> • If HCID is suspected in a child who is coming into hospital, the Consultant Paediatrician will take part in a remote assessment with ID Specialist (or other appropriate senior clinician) • If child is in ED and HCID is suspected, the child will be moved to Room 31 in AMU. If room 31 unavailable or child is critically unwell into Resus 4 in ED • HCID trained Nurse and PPE Buddy will be required to staff area. • Samples should be taken as per sampling pathway. (Appendix 4) • Notify lab that samples will be taken • Lab colleagues, once notified, will attend to transport samples to the lab • Initial nursing tasks will require a member of staff in the room, but exposure should be minimised thereafter, only entering the room when necessary. • Utilise ECG monitoring and saturations probe to provide monitoring. • Ensure screen of monitor visible to the outside of room. • IV fluids and drugs are likely to still be required; investigations and equipment will be limited. Plan to batch clinical care interventions together. • Maintain contact log sheet for all staff entering room. • Ensure Capacity Team/ General Manager is aware as Paediatric staff may be required to care for child in AMU. Staffing for Paediatric Ward needs to be reviewed. • An Incident Management Team will decide on next steps, i.e. testing requirements, whether child is to be moved to appropriate hospital and transportation requirements 	
<p>Managing waste and Decontamination</p> <ul style="list-style-type: none"> • All waste should be double bagged. • Refer to Appendix 6 for cleaning and waste disposal. 	

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- Once patient has left the room, all equipment and waste to remain in room.
- Open communication with IMT, any cleaning and decontamination needs discussed.
- Room must remain out of use until agreed cleaning has been completed

End of shift/ post incident

- Ensure all documentation is completed, up to date and saved in the appropriate locations.
- Complete the staff contact tracing form and notify Occupational Health.
- Participate in hot and cold debriefs.

Action Card 15 - General Practice/ Out of Hours Service

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Clinician in community
Immediate Action	Protect the function of your service while protecting staff and other patients
Notification to	ID Specialist (or other appropriate senior clinician)
Location	Primary Care/Out of hours setting

Responsibilities:

- To recognise need for patient containment if HCID suspected in a community setting.
- To escalate any high-risk incident through appropriate channels of communication.
- To protect staff, patients, and relatives.
- To reduce risk of cross contamination.
- To help protect infrastructure.
- To help maintain business as usual.

Actions:

- Assess if the patient requires inpatient care at DGRI. This should involve discussion with ID Specialist or another appropriate senior clinician
- This decision should balance:
 - The clinical condition and physiological stability of the patient
 - The risk of cross-contamination to patients, staff, and volunteers
 - The availability of safe alternatives to hospital attendance
 - Where clinically appropriate, assessment should be undertaken:
 - Remotely via telephone or video consultation
 - With augmentation by objective physiological measurements (e.g. oxygen saturation and heart rate monitoring in the patient's location)
 - This assessment may be dynamic, with repeated review at an interval appropriate to the severity of illness.
 - Only patients with a clear clinical need for inpatient care should be transferred into hospital clinical areas, including ED or AMU.
- Where it is deemed safe for patient to remain at home and community testing is required, safest method of testing should be discussed with clinician and labs.
- Isolate/ contain person in their appropriate environment until a safe method of transport can be arranged through the SAS if necessary.

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- If testing is being carried out at home, the healthcare staff member must ensure they have appropriate PPE using buddy system as per HCID guidance (Appendix 3).
- Early escalation is essential to protect others from cross contamination.
- Advice on deep cleaning of any affected area must be communicated by the Health Protection Team (or IMT).
- Always maintain personal safety.
- Any staff contact with suspected case should be managed as per normal guidance through Occupational Health Services.
- Provide accurate handover.
- Ensure documentation is kept up to date.

End of shift/post incident

- Ensure all documentation is completed, up to date and saved in the appropriate locations
- Complete the staff contact tracing form and notify Occupational Health
- Participate in hot and cold debriefs

Action Card 16 - Family Support Services - Maternity

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Midwife
Immediate Action	Recognise risk of HCID
Notification to	Senior midwife
Location	DGRI Hospital Setting
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To recognise HCID risk • To recognise need for patient containment if HCID suspected. • To escalate any high-risk incident through appropriate channels of communication. • To protect staff, patients, and relatives. • To reduce risk of cross contamination • To help maintain business as usual. 	
<p>Initial actions</p> <ul style="list-style-type: none"> • Ensure patient is in single room with ensuite facilities, do not move to another room unless specifically advised • Escalate concerns to senior midwife • Minimise contact – only essential staff should attend. • Don PPE as per NHS Scotland HCID PPE ensemble guidance (Appendix 3) • Do not perform invasive procedures unless essential • Avoid unnecessary separation of mother and baby unless clinically indicated • Support continuity of carer if safe and feasible (check if they have already been exposed) <p>Senior midwife</p> <ul style="list-style-type: none"> • Escalate to General Manager on call who will liaise with appropriate clinician for advice. • Discuss with ID Specialist or another appropriate clinician who will assess, provide further advice and next steps • Contact Infection Control Team for advice and support if in hours. 	
<p>End of shift/post incident</p> <ul style="list-style-type: none"> • Ensure all documentation is completed, up to date and saved in the appropriate locations • Complete the staff contact tracing form and notify Occupational Health • Participate in hot and cold debriefs 	

Action Card 17 - Infection Prevention and Control Team

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Infection Control Nurse & Manager
Immediate Action	Provide IPC guidance and support to teams involved
Location	Hospital Setting
<p>Responsibilities:</p> <ul style="list-style-type: none"> • Provide guidance and support to the multidisciplinary team involved with caring for the case(s). • Provide guidance and support to staff in order that they work in accordance with local and national protocol. • Participate in Incident Management Team Meetings. <p>Infection Control Manager (IPCM):</p> <ul style="list-style-type: none"> • Ensure the IPCT have the resources to manage an HCID incident. • To escalate any safety concerns to Executive Director the management of the case. 	
<p>Actions:</p> <ul style="list-style-type: none"> • Ensure communications with national organisations are as per Board and National Policies. • Assist Communications Manager in drafting external communications. • Assist staff members with infection control support and PPE requirements. • Liaise with Infection Control Doctor and/ or Microbiology Consultant • Liaise with Health Protection Team. • Ensure all documentation is completed, up to date and saved in the appropriate locations 	

Action Card 18 - Consultant Microbiologist

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Consultant Microbiologist
Immediate Action	Provide expert microbiological advice and oversight
Location	AMU Hospital Setting
<p>Responsibilities (Within Working Hours):</p> <ul style="list-style-type: none"> • Provide expert microbiological advice and oversight during the identification, investigation, and management of suspected or confirmed HCID cases. • Liaise with clinical teams, Public Health authorities, and designated laboratories to ensure safe and effective response. 	
<p>Actions:</p> <ul style="list-style-type: none"> • Confirm that clinical presentation / travel history meets criteria for HCID, as per UKHSA/PHS guidance, in liaison with clinical team • Liaise with Duty Biomedical Scientist(s). • Initiate laboratory testing protocol and advise on sample types required • Contact Imported Fever Service (IFS) - 0844 778 8990 (or other reference laboratory service) to discuss case details • Coordinate with designated reference laboratories for confirmatory testing 	
<p>End of shift/post incident</p> <ul style="list-style-type: none"> • Ensure all documentation is completed, up to date and saved in the appropriate locations. • Participate in hot and cold debriefs. • Support training and awareness for clinical teams 	

Action Card 19 - Laboratory Staff

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Microbiology lab staff
Immediate Action	Ensure samples are handled safely and securely for testing
Location	AMU Hospital Setting
<p>Responsibilities:</p> <ul style="list-style-type: none"> • Microbiology staff to transport samples from clinical area • Ensure laboratory Standard Operating Procedures (SOP) are in place to enable safe processing and handling of suspected HCID patient sample(s), according to national guidelines, standards, and frameworks. • To provide laboratory testing where applicable • Microbiology staff to liaise and organise transport of samples for further testing • Disposal of laboratory waste safely 	
<p>Actions:</p> <ul style="list-style-type: none"> • Receive initial briefing from Consultant Microbiologist • Co-ordinate with AMU/ ED to discuss appropriate sampling using the 'HCID Testing Kit' located in AMU Room 31(annexe), which contains all the appropriate containers required. Sampling will depend on the HCID suspected. Laboratory testing process is available through a SOP held within the department • Microbiology to co-ordinate with Blood science staff for access to Containment Level 3 facilities. • Record all staff access. • Process tests where applicable using appropriate PPE • Communicate results of malaria screen for further risk assessment to the Consultant Microbiologist • Contact Edinburgh SNVTS to arrange transport of samples via category A or B transport for testing • Ensure documentation of transportation is recorded • Segregate laboratory waste and complete documentation for high-risk waste disposal • Perform disinfection and decontamination procedures for laboratory work surfaces and analysers 	

Action Card 20 - Health Protection Team

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Senior Health Protection team member
Immediate Action	Protecting the population of Dumfries and Galloway, provide expert Health Protection advice
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To ensure the function of Health Protection. • All team members should be aware of current returning worker schemes • To Chair any IMT's. • Consult with relevant specialty partners, e.g. Infectious Diseases, Microbiology, Public Health Scotland. • To protect the population of Dumfries and Galloway, including staff, patients, and relatives. • Reduce risk of cross-contamination. • To provide expert Health Protection advice. 	
<p>Actions:</p> <p><u>If person is part of a returning worker scheme or known exposure</u>, and is notifying HPT of new symptoms, they should be encouraged to isolate at home if well.</p> <ul style="list-style-type: none"> • They should be advised to call their GP (office hours) or 111 if it is out of hours or they are not registered with a GP. If they become very unwell, they should call 999. When making any call, the person should let services know that they are in the returning workers scheme and have returned from a VHF affected country. • Discussion with appropriate clinician is required, i.e. Infectious Diseases Specialist, Primary Care, Out of Hours, AMU or ED for initial assessment. • Once clinical assessment has been arranged, the HPT, as point of contact for those assessed as category 2, 3 and 4 will: <ul style="list-style-type: none"> ○ contact PHS immediately by phone in and out of hours ○ ensure that symptoms are clearly communicated to PHS ○ ensure that contact details of the returnee are communicated to PHS ○ ensure appropriate clinical assessment of returnee's resident in Scotland at the time they become symptomatic, contact IFS and arrange appropriate transport where required <p><u>If person has presented at ED:</u></p> <ul style="list-style-type: none"> • Check with clinician if detailed history has been taken, this needs to be thorough and cover any travel and contacts including sexual contacts. 	

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- If travel and contact history has not been done, this needs to be done by clinician as a matter of priority.
- Clinicians should discuss with Imported Fever Service as to whether HCID is a possibility.
- Ensure most recent guidance is being followed, contact tracing, isolation etc.
- Liaise with Public Health Scotland as required
- Chair any PAGs or IMTs required
- Carry out enhanced contact tracing as per normal processes
- Assess any contacts – assess need for post-exposure prophylaxis or other control measures as per guidance.
- Ensure HPZone is kept up to date.
- Ensure accurate handover if situation is ongoing.

End of shift/ post incident:

- Ensure all documentation is completed, up to date and saved in HPZone
- Participate in hot and cold debriefs.

Action Card 21 - General Wards/ Other Areas Including Midpark

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Duty doctor in general wards/ Midpark
Immediate Action	Escalate concerns and discuss with ID Specialist (or other appropriate clinician)
Location	DGRI/ Midpark
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To recognise need for patient containment if HCID suspected in a general ward • To escalate any high-risk incident through appropriate channels of communication. • To protect staff, patients, and relatives. • To reduce risk of cross contamination. • To help protect infrastructure. • To help maintain business as usual. 	
<p>Actions:</p> <ul style="list-style-type: none"> • Discussion required with ID Specialist or another appropriate clinician • Early escalation is essential to protect others from cross contamination. • Suspected person must be isolated and contained in a safe environment, until a senior decision is made on need to treat within present environment or transfer to isolation room within DGRI. This decision will be made by an IMT. • Once patient has left the room, all equipment and waste to remain in the room • Cleaning and decontamination needs will be discussed at IMT • Room must remain out of use until agreed cleaning has taken place • Don and doff safely as per Appendix 3 • Always maintain personal safety. • Any staff contact with suspected case should be managed as per normal guidance through Occupational Health Services. • Provide accurate handover. • Ensure documentation is kept up to date. 	
<p>End of shift/post incident</p> <ul style="list-style-type: none"> • Ensure all documentation is completed, up to date and saved in the appropriate locations • Ensure all personal logs and notes from all staff are collected and stored appropriately • Complete the staff contact tracing form and notify Occupational Health • Participate in hot and cold debriefs 	

Action Card 22 - General Manager

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	General Manager
Immediate Action	Provide senior operational and tactical management support
Notification to	Executive Director
Location	DGRI
<p>Responsibilities:</p> <ul style="list-style-type: none"> • Provide senior operational and tactical management support. • Risk assessing incident and determining appropriate level of response as outlined in section 3.3 of the Incident Response Plan. • Consult with the on-duty/call Executive Director around any incidents at Level 2, 3 or 4, that have significant service implication concerns or likely to generate national interest. • Declare Critical or Major Incident if necessary for Level 3 or 4 response. • Ensure appropriate organisational communications are issued, helping raise staff awareness of any incident. • Ensure effective communications. • Ensure appropriate Business Continuity Plans are identified and actioned as per incident requirement. • Ensure incident management and decision logs are maintained. • Identify any resource impacts arising from the incident. 	
<p>Actions:</p> <ul style="list-style-type: none"> • Start and maintain a personal log. • Participate in IMT's • If IMT in agreement and patient is confirmed HCID, support clinician with early liaison with Infectious Disease Hospital as per Service Level Agreement. • Support activation of Business Continuity Plans in effected area/s as required. • If major incident is declared, GM will follow major incident pathways • Commence rolling briefs and situation reports. • Ensure efficient staffing rota/s are populated if incident becomes protracted. • Report up to Strategic members as required. • Arrange appropriate representation through NHS D&G Resilience Team at Scottish Government Resilience Room (SGoRR) if the nature of the incident requires national support. 	

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End of shift/post incident

- Ensure accurate handover notes are provided to General Manager taking over and make them aware of any urgent/ outstanding issues.
- Ensure all documentation is completed, up to date and saved in the appropriate locations.
- Ensure all personal logs and notes from all staff are collected and stored appropriately.
- Complete the staff contact tracing form and notify Occupational Health.
- Participate in hot and cold debriefs.

Action Card 23 - Occupational Health

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Occupational Health
Immediate Action	Participate in IMT and follow up staff contacts
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To follow up staff contacts of an HCID and provide appropriate occupational health advice • Participate in IMT's 	
<p>Actions:</p> <ul style="list-style-type: none"> • Ensure staff contact tracing form has been completed (Appendix 7) • Follow up any staff contacts as per guidance • Participate in any IMT's and provide IMT with information on staff contacts • Any staff member who contacts OH with symptoms should be discussed with Health Protection if appropriate 	

Action Card 24 - Support Services

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Support services Manager
Immediate Action	Participate in IMT and follow up staff contacts

Responsibilities:

- Area Support Services Manager or depute to participate in IMT and ensure any actions agreed are implemented, monitored, recorded and reviewed as required.
- Ensure staff wear appropriate PPE when carrying out any duties in relation to incident

National Cleaning Services Specification - SHFN 01-02 V6 July 25

Actions:

- Altered domestic service provision occurs when an infection related outbreak/ incident occurs. Service provision may also need to be upscaled and work schedules altered when risks such as high consequence infectious diseases (HCIDs) are suspected or confirmed.
- Local board governance procedures should be followed.
- Refer to local policy but consideration should be given to enhanced/ increased frequency cleaning. This can be requested of Domestic Services by a member of the IPCT/ Clinical Service or as part of the Multidisciplinary Team (MDT) decision making process at a Problem Assessment Group (PAG) or Incident Management Team (IMT) meeting where there is a suspected or confirmed outbreak or infection related incident
- Domestic services representation should be made available to support the MDT during the PAG/ IMT process
- In the absence of a PAG/ IMT, regular communication between the IPCT and Domestic Services Team is essential to agree step up/ step down of enhanced and/ or increased frequency cleaning arrangements
- Internal NHS board operational arrangements to enact and enable this request will be the responsibility of Domestic Services Procedure must be agreed as per local arrangements and determined by management structures within NHS boards

Action Card 25 – Estates/ SERCO

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Estates/SERCO
Immediate Action	Ensure the functioning and maintenance of the environment
Responsibilities <ul style="list-style-type: none"> • Ensure the function and maintenance of the environment within which healthcare is provided • Estates/ SERCO will prioritise their service requirements which may be ongoing to support any significant healthcare event affecting infrastructure 	
Actions <ul style="list-style-type: none"> • Assist with implementation of lockdown plan if required • Assist with providing floor plans for both SERCO and NHS Estates buildings if required • Participate in IMT when requested 	

Action Card 26 – Executive Directors

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Executive Director
Immediate Action	Provide leadership to teams dealing with incident
Location	Hospital Setting
Responsibilities: <ul style="list-style-type: none"> • Ensure core functions of NHS Dumfries and Galloway continue to be delivered safely and efficiently • Liaise with the Chief Executive if required • Support Incident Management Team (IMT) if required • Ensure effective communication with the Chairman, Scottish Government MPs & MSPs, Local Council, Emergency Services and other NHS Boards, as required 	

Action Card 27 - Incident Management Team

High Consequence Infectious Disease (HCID) Protocol	
Roles and Responsibilities	
Who	Incident Management Team
Immediate Action	Investigate and manage the response to an incident
<p>Responsibilities:</p> <ul style="list-style-type: none"> • To investigate and manage the response to an incident. • IMT Chair has overall responsibility for the incident management and the IMT aims are to: <ul style="list-style-type: none"> ○ Minimise the number of cases of illness by promptly recognising the incident. ○ Define case, identify and controlling the source of exposure. ○ To minimise mortality. ○ To provide an early and effective response. ○ To communicate effectively with the public and other agencies. ○ To collect information to help understand the nature of the incident. ○ To work with partners. 	
<p>Actions:</p> <ul style="list-style-type: none"> • The IMT Chair will be Public Health competent person on duty. Initial Problem Assessment Group will have been chaired by Public Health. • Microbiology, IPCT and Health Protection staff will be active participants of an IMT • Liaise with relevant stakeholders i.e. Public Health Scotland. • Ensure relevant partners and agencies are invited to the IMT. • Ensure appropriate communications are developed and shared with relevant parties. • Ensure documentation and recording of meetings is accurate, including an accurate decision log. • Once an HCID has been confirmed by appropriate laboratory testing, cases should be transferred to a designated HCID treatment centre, this will be co-ordinated by the Incident Management Team. <p>Map Appendix 5 highlights designated patient transfer routes from Self Presenters or Patients in Room R4 within the Emergency Department to Isolation Room 31 and Ambulance patients' direct route to Isolation Room 31</p>	
<p>End of shift/post incident</p> <ul style="list-style-type: none"> • IMT agrees when the response to an incident is over. • Make a statement to this effect for release to appropriate people. • Document the incident to ensure lessons learned are identified and shared. <ul style="list-style-type: none"> • Participate in any debriefs. • Prepare IMT report. 	

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Action Card 28 - De-escalation of a Suspected HCID Patient

De-escalation can only occur with the agreement of the consultant in charge of the patient in liaison with the ID and/or Microbiology consultant after review of patient history, examination and/or results. Once agreed, the following actions should be taken:

	Actions:	Who	Time done
1	Inform the senior nurse/ Nurse in Charge of AMU	Lead clinician	
2	Document de-escalation decision in patient's note	Lead clinician	
3	Inform the patient & relatives	Lead clinician	
4	Notify referring centre – GP, ED or other	Lead clinician	
5	Notify HPT (if involved)	Lead clinician	
6	Complete any outstanding investigations	Lead clinician	
7	Notify other necessary nursing staff	Nurse in charge	
8	Do PPE stock check	Nurse in charge	
9	Do equipment stock check	Nurse in charge	
10	Refill grab bags	Nurse in charge	

APPENDIX 2 - RISK ASSESSMENT SCREENING TOOL

NOTE: This is a screening tool only and may not capture all HCIDs/risks due to the ever-changing nature of HCIDs.



Do you have a fever or are worried about infection? 

Please inform the receptionist if:

You have travelled outside Europe in the past 21 days 

OR

You have had contact with unwell or dead birds in the past 14 days 

WHAT TO EXPECT

If you meet the above criteria, we need to ask you some additional questions to ask about specific infections which are important to recognise and treat in a special way.

PROUD TO MAKE A DIFFERENCE 

Screening for high risk infections



Receptionists: Please ask all patients the following:

Do you had a new fever, cough, diarrhoea or rash? AND

1. Have you travelled outside of Europe in the past 21 days and if so where did you visit?
2. Have you have had contact with unwell or dead birds in the past 14 days



If yes to either question, immediately inform a senior member of nursing staff about potential High Consequence Infectious Disease risk

High Consequence Infectious Disease (HCID) Risk assessment

All patients screened by reception staff as potential HCID risk should be isolated pending HCID risk assessment by a trained triage nurse or medic

Airborne PPE is recommended initial risk assessment in the triage room
(FFP3 Mask, Gown, Gloves, Visor)

Perform risk assessment using STH HCID Algorithm (quick examples below)

Key VHF questions

Travelled to an area with a current VHF outbreak?
Been to an endemic Lassa fever region?
Contact with caves/bats/mines/ticks/rats?

Key Airborne questions

Visited a MERS region/Middle east?
Contact with a MERS case?
Contact with camels/close contact with live, dying or dead domestic poultry or wild birds

APPENDIX 3 – DONNING AND DOFFING PROTOCOLS

Personal Protective Equipment (PPE) for suspected high consequence infectious diseases **How to put on PPE (donning).**



This PPE must only be used by staff trained and assessed as competent. The products shown are for illustrative purposes only.

- before putting on PPE, ensure you are hydrated, have been to the toilet if needed and feel well to enter the patient room
- if necessary, change into scrubs. Tie long hair back. Remove any jewellery/ ID badges/ lanyards
- collect all the PPE components and take to the area where PPE is put on
- perform hand hygiene and cover any cuts, abrasions or breaks in skin with a waterproof dressing
- PPE should be put on with a buddy present.

Step 1

- Put on wellington boots, half to one size bigger than your normal shoe size. Use a new pair of boots for each entry.
- Used boots should remain in bins until HCID results are known. Boots can be reused prior to results, if decontaminated as described in the doffing process.



Step 4

- Put on inner pair of gloves — standard non-sterile, nitrile, short-length gloves.



Step 2

- Put on your disposable FFP3 respirator and check for fit. This **MUST** be the mask that you are fit tested to. If you have not been fit tested, you **MUST NOT** enter the patient's room.



Step 5

- Put on the long, reinforced gown. **Do not use** the inside tie.
- Lightly secure the Velcro fastening at the back of the neck— light enough to allow easy removal, but ensuring the gown will remain closed.
- Tie the gown at the side and ensure the gown cuffs fully overlap the inner pair of gloves.



Step 3

- Put on the hood. Check the fit around the face and jaw (no gaps) and ensure a good overlap is achieved with the mask.



Step 6

- Check for sufficient overlap between the top of the boot and the bottom of the gown: 10-15 cm.
- If too long, trim the gown so it is not a trip hazard. If less than 10cm overlap achieved, check if a longer gown is available.
- If unable to achieve 10 cm overlap, do not continue—inform your senior nurse/ doctor.



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Step 7

- Put on middle pair of gloves—these are long cuffed (mid-length) non-sterile gloves and should fully overlap the cuff of the gown.



Step 11

- Put on visor and ensure the band of the visor overlaps with the hood, with no skin showing.
- Check the visor shield overlaps with the sides of the hood, and there is no skin exposed round the jaw line.



Step 8

- Tape the middle pair of gloves to the gown using 4 strips of microporous tape placed lengthways.



Step 12

- Put on outer pair of gloves—standard short gloves for clinical staff.
- If a sterile procedure is to be performed, replace the nitrile gloves with sterile gloves in the patient's room at the time of the task.
- For cleaning tasks, heavy duty style gloves may be donned instead of nitrile gloves.



Step 9

- Take the long length, thick plastic apron. Break the head loop where it usually sits at the back of the neck.



Step 13

- The buddy should run through each step to check all items are in place.
- The time should be written on the shoulder once all checks have been completed.
- If any gaps are noticed, these must be addressed. If unable to be corrected, inform your senior and do not enter the patient room until advised it is safe to do so.
- After entering the patient room, remain vigilant of PPE integrity for yourself and any other staff members.
- In the event of a high exposure episode e.g. projectile vomiting, or if there is any concern about PPE integrity, leave the room at the earliest opportunity and inform your buddy prior to doffing.



Step 10

- Put on the apron, tying at the top behind the neck, and bottom around the waist.
- A 'high fit' should be achieved, with the apron high up over the chest area.



Personal Protective Equipment (PPE) for suspected high consequence infectious diseases

How to remove PPE (doffing).



Removal of PPE must be done with a buddy - follow their instructions.
The products shown are for illustrative purposes only.

- open the door out of the patient room. Ensure a buddy is available to observe PPE removal. If buddy is not present, shout for attention of a staff member to assist you, **DO NOT attempt to remove PPE without a buddy**
- ensure demarcated PPE removal areas are clearly marked before starting the process. **Do not exit into clean / Green zone wearing PPE**
- if aware of any PPE breach or high-exposure contamination to PPE, inform the buddy before removing PPE

Step 1 - in patient (red) area

- Remove your apron by pulling forward from the front of the apron to break the neck and waist strings.
- Roll the dirty outer side of the apron into itself, keeping hold of the inner 'clean' side.
- Continue to roll it up, and then place in the bin.



Step 4 - In doffing (amber) area

- To remove your visor, stand straight, do not bend forwards, as this brings the bottom of the visor into contact with your (clean) upper body.
- Reach for the elastic strap at the back of the head, close your eyes and lift the strap upwards then over the head.
- Place the visor into the bin.



Step 2 - in patient (red) area

- Remove your top gloves without touching the pair below. Glove removal should follow one of two 'pinch and pull' methods (HSE or Health Education England's e-Learning for Healthcare), according to whichever the wearer is already trained in.



Step 5a (front opening hood) - in doffing (amber) area

- Remove the hood touching **only** its outer surface.
- Bring your hand towards the chin area and locate the upper Velcro fastening on the hood.
- Slowly release the Velcro fastening and pull out to the side, keeping it in your vision.
- Repeat for the Velcro fastening at the base of the hood.



Step 3 - In doffing (amber) area

- Untie the gown at the waist.
- Remove by grabbing shoulder areas and pulling to release the Velcro at the back of the neck.
- Pull the gown away from the body, folding inside out, and gathering up the material. The taped long gloves should come off with your gown.
- Carefully place into the bin but **do not push down**.



Step 5b (closed neck hood) - in doffing (amber) area

- Remove the hood touching **only** its outer surface.
- If the elasticated rim of the face opening is under the rim of the lower edge of the mask, carefully pull the hood forward slightly at chin level to free it.



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Step 7

- Put on middle pair of gloves—these are long cuffed (mid-length) non-sterile gloves and should fully overlap the cuff of the gown.



Step 11

- Put on visor and ensure the band of the visor overlaps with the hood, with no skin showing.
- Check the visor shield overlaps with the sides of the hood, and there is no skin exposed round the jaw line.



Step 8

- Tape the middle pair of gloves to the gown using 4 strips of microporous tape placed lengthways.



Step 12

- Put on outer pair of gloves—standard short gloves for clinical staff.
- If a sterile procedure is to be performed, replace the nitrile gloves with sterile gloves in the patient's room at the time of the task.
- For cleaning tasks, heavy duty style gloves may be donned instead of nitrile gloves.



Step 9

- Take the long length, thick plastic apron. Break the head loop where it usually sits at the back of the neck.



Step 13

- The buddy should run through each step to check all items are in place.
- The time should be written on the shoulder once all checks have been completed.
- If any gaps are noticed, these must be addressed. If unable to be corrected, inform your senior and do not enter the patient room until advised it is safe to do so.
- After entering the patient room, remain vigilant of PPE integrity for yourself and any other staff members.
- In the event of a high exposure episode e.g. projectile vomiting, or if there is any concern about PPE integrity, leave the room at the earliest opportunity and inform your buddy prior to doffing.



Step 10

- Put on the apron, tying at the top behind the neck, and bottom around the waist.
- A 'high fit' should be achieved, with the apron high up over the chest area.




APPENDIX 4 – HCID SAMPLING AND PACKAGING: CATEGORY A SAMPLES

HIGH-CONSEQUENCE INFECTIOUS DISEASE ASSESMENT

Sampling and packaging: Category A Samples

- Samples from the following HCID are classified as category A infectious substances: **Ebola, Marburg, CCHF, Lassa, Nipah, Hendra**
- Samples should be transported via specialist courier in triple packaging with a rigid outer container
- This procedure requires a buddy to receive samples in green zone**



EQUIPMENT LIST



1. Primary specimen bag(s)
2. Secondary specimen bag(s)
3. Rigid plastic container with secure lid
4. Outer transportation bag/box
5. Absorbent wadding
6. Parafilm
7. 2 cardboard bowls
8. Alcohol wipes (70% isopropyl)
9. Sampling equipment
10. Permanent marker pen
11. Local sample request form
12. UKHSA sample request form

AMBER 'SEMI-CLEAN' ZONE



1. Change top pair of gloves
2. Place samples into secondary biohazard bags
3. (use one secondary biohazard bag to group samples going to the same lab)
4. Ask buddy to open the door to the clean area and hold out the rigid plastic container
5. Drop secondary specimen bags into the container without touching this
6. Dispose of cardboard bowl
7. Return to patient care zone or proceed to PPE doffing

PREPARATION



1. Discuss with local (Virology) /national specialists (Imported fever service)
2. Complete testing form(s) and leave in outer packaging with green zone buddy
3. Pre-label specimen tubes
4. Stack cardboard bowls and place sampling equipment, pen, bags, alcohol wipes and parafilm
5. Pre-cut micropore tape strips and attach to bowl

SAMPLE TRANSPORT



1. Category A samples should be transported by an appropriate courier
2. The outer bag should be clearly labelled with UN 2814
3. Ensure appropriate paperwork is included in the packaging prior to transportation
4. Ensure security seals are in place on the outer box
5. Call the recipient in advance to inform them of the transport

RED ZONE SAMPLING



1. Enter patient area wearing HCID assessment PPE
2. Take samples and place in outer bowl
3. Move away from patient
4. Change top pair of gloves
5. Separate bowls
6. Clean the outside of samples using alcohol wipes and place into 'inner bowl'
7. Secure sample lids with parafilm
8. Place each sample into a primary specimen bag
9. Dispose of the dirty bowl
10. Alert green zone buddy you are leaving the room

Learning Resources



For a free learning module on HCID sampling, scan the QR code, or visit:

www.hcid-training.co.uk/

APPENDIX 5 - EMERGENCY CARE CENTRE FLOOR PLAN

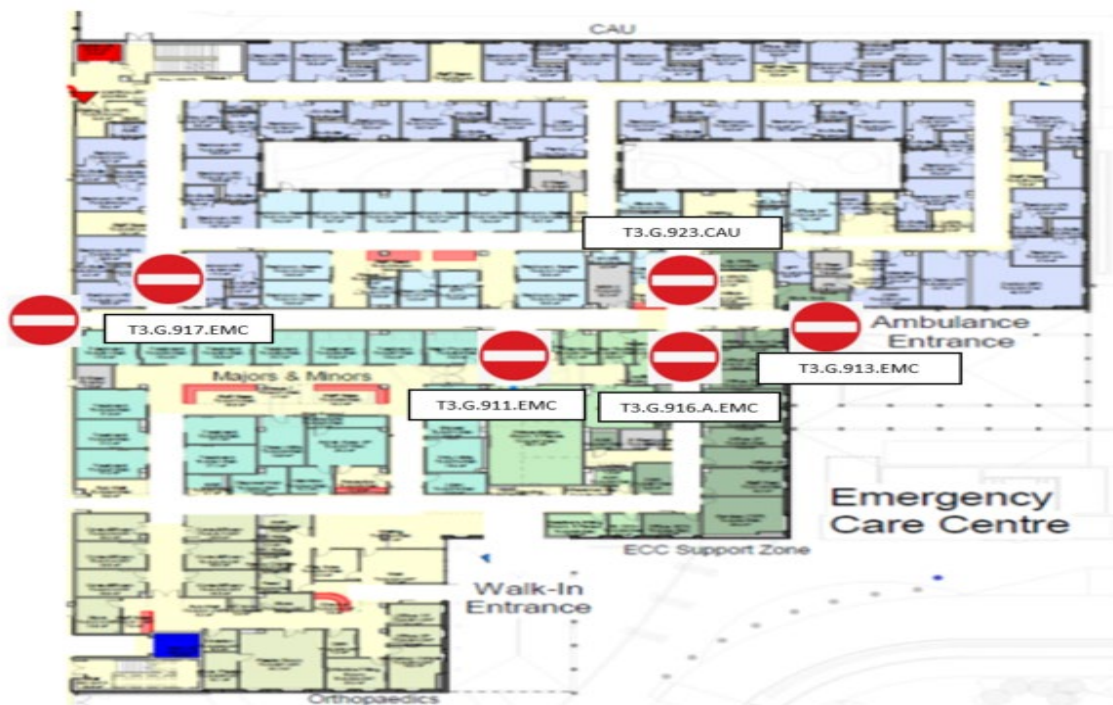
Map below highlights designated patient transfer routes from Self Presenters or Patients in Room R4 within the Emergency Department to Isolation Room 31 and Ambulance patients' direct route to Isolation Room 31.



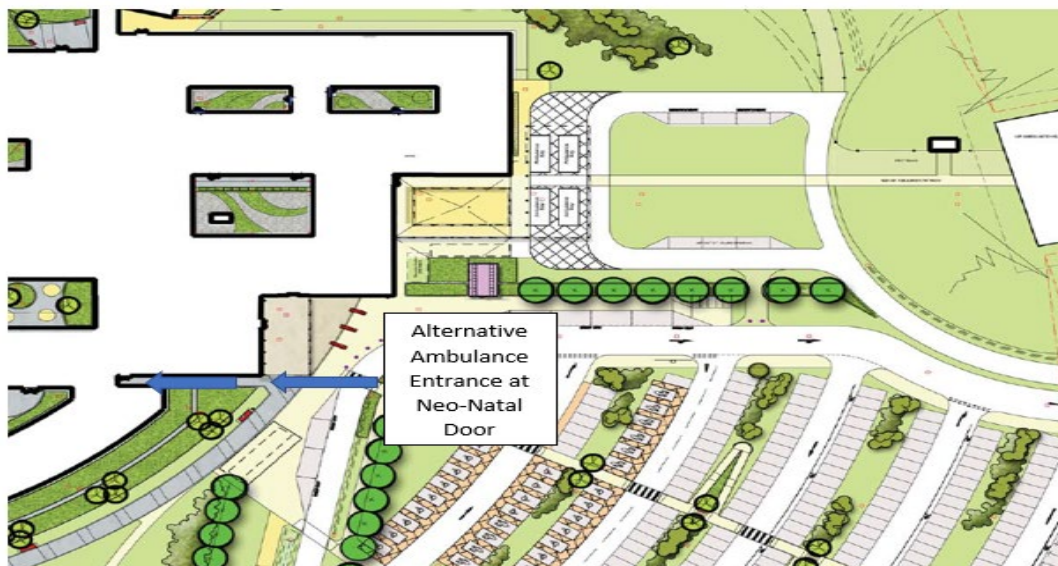
- If the Emergency Care Centre corridor is contaminated by the transfer of a patient to Room 31, the corridor should be closed and secured until further guidance is received.
- Contact Estates and ask for the following doors to be electronically locked (as shown in floor plan below).

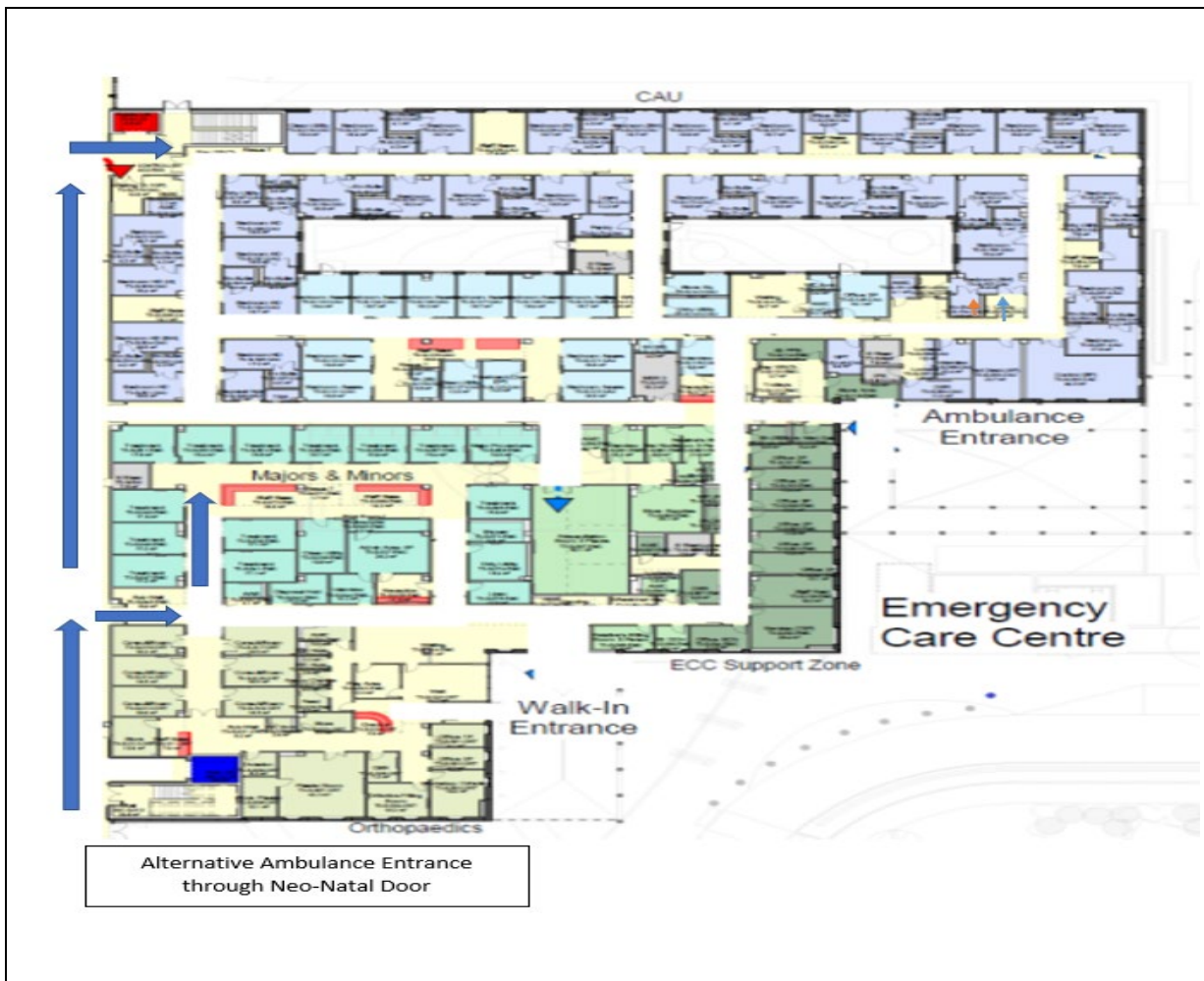
T3.G.917.EMC
T3.G.911.EMC
T3.G.916.A.EMC
T3.G.913.EMC
T3.G.923.CAU

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- Contact the Nurse in Charge of the Emergency Department and ask them to arrange re-direction of ambulances to the neonatal entrance as shown in the floor plan below. Staff must direct ambulance crews along back corridor into the Emergency Department or Acute Medical Unit (as shown in floor plans below)





APPENDIX 6 - INFECTION PREVENTION AND CONTROL GUIDANCE

Printed copies must not be considered the definitive version

Infection Control Precautions

- Specific infection prevention and control (IPC) measures are required for suspected and confirmed HCID cases, in all healthcare settings (specialist and non-specialist).
- Specific IPC guidance for a suspected and confirmed HCID case is available:
 - PPE
 - NHS Scotland: National Infection Prevention and Control Manual
 - <https://www.nipcm.scot.nhs.uk/addendum-for-high-consequence-infectious-disease-hcid/>
- All other aspects, including disease-specific measures:
 - UKHSA HCID guidance
 - <https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid#infection-prevention-and-control-in-healthcare-settings>

This document has been derived from the above and adapted to the local settings and requirements of NHS Dumfries and Galloway.

Personal Protective Equipment

All healthcare workers who may care for an individual with a suspected or confirmed HCID, and those who may undertake the buddy role, must be trained and competent in the donning, doffing and disposal of the HCID PPE ensemble.

Types of UK HCID PPE ensemble

Two types of ensemble are used in the UK:

HCID assessment PPE ensemble

- To be worn by staff to assess and provide clinical care to potential cases where HCID (associated with a pathogen of any transmission route) is suspected

HCID treatment PPE ensemble.

- To be worn for continued care of confirmed HCID cases within specialist treatment centres. There are currently none of these centres in Scotland.

The PPE ensemble referred to throughout this guidance is the HCID assessment PPE ensemble

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Competency: Education and training

Healthcare workers should undertake donning and doffing practice sessions including verbal instructions from a buddy prior to undertaking a competency assessment.

Healthcare workers are considered competent in the donning and doffing of HCID assessment PPE when they can do so independently without prompts from the buddy. This ensures the healthcare worker can primarily demonstrate the order and process for donning and doffing without a verbal reminder. The inclusion of a verbal reminder during live clinical management of a suspected or confirmed case of HCID then acts as a further secondary level of assurance.

Roles

The healthcare worker roles described in this guidance are:

- **HCID caregiver or caregivers**
 - Refers to the healthcare workers who will deliver direct care to a suspected or confirmed HCID case.
- **Buddy**
 - Refers to the healthcare worker who supports the HCID caregiver or givers during donning and doffing.

Personal Protective Equipment Components

Component	Requirement
FFP3 Respirator	<ul style="list-style-type: none">• The mask's seal must not be disrupted by the hood.• The elastic straps should be configured according to the manufacturer's instructions.• In addition, each time an FFP3 respirator is worn, the wearer should perform a fit check (according to the manufacturer's guidance), to ensure that the mask is sited correctly, and an adequate seal has been achieved. More information can be found in the TBP chapter of the NIPCM.

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Component	Requirement
Hood	<ul style="list-style-type: none"> The hood's face opening must be in close contact with the face and gaps avoided.
Full-face visor	<ul style="list-style-type: none"> The bottom of the visor must be a minimum of 2 cm below the chin and the visor must be compatible with the FFP3 respirator that is being used.
Gown	<ul style="list-style-type: none"> Fluid-resistant to relevant standards The gown must be long enough to overlap the wellington boots by 10 to 15 cm but not be so long as to trail on the floor and cause a trip hazard.
Apron	<ul style="list-style-type: none"> Wide, extra-long, medium thickness The apron must not be so long as to cause a trip hazard. The top of the apron must be at the level of the clavicles. This may be achieved by breaking the neck loop and re-tying it to make the neck length shorter.
Inner gloves	<ul style="list-style-type: none"> Standard single-use disposable, short, non-sterile nitrile gloves. The cuff of each inner glove should be worn under the cuff of the gown.
Middle gloves	<ul style="list-style-type: none"> Single-use disposable longer-cuffed nitrile gloves. The cuff of each middle glove should be worn over the cuff of the gown. Each middle glove cuff must be attached to the corresponding sleeve of the gown by applying

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Component	Requirement
	<p>four lengths (approximately 10 cm each) of microporous tape.</p> <ul style="list-style-type: none"> • Taping ensures that the middle gloves are removed simultaneously as the gown is removed.
Outer gloves	<ul style="list-style-type: none"> • Glove choice will depend on the activities being undertaken. • For basic care, venepuncture and planned medical procedures, use single-use, disposable, standard nitrile gloves. • For heavier duties, such as environmental cleaning and dealing with body fluid spills, use single-use, disposable, heavy-duty (domestic) gloves. • The outer gloves may be removed and replaced as required during patient care.
Wellington Boots	<ul style="list-style-type: none"> • Reusable surgical wellington boots must have a leg that is long enough to allow the gown and apron to overlap the top of the boot by at least 10cm. • Boots that are at least half to one size larger than the wearer's shoe size facilitate easier removal with a 'step-out' removal technique. • However, the size required to achieve easier removal should be ascertained during the training exercises and each individual should know which size is suitable for them. • Boots should not be of a size which may cause a trip hazard.

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COMPONENT	HCID CAREGIVER	BUDDY
FFP3 Respirator	√	√
Hood	√	√
Full-face Visor	√	√
Gown	√	√
Apron	√	√
Gloves	√	√
Wellington Boots	√	√

Donning (putting on) HCID PPE

Buddy PPE Donning order

1. Wellington boots
2. Gown
3. FFP3
4. Full-face visor
5. Non-sterile gloves worn over gown cuffs

PDF poster available (link checked 16/10/2025): <https://www.england.nhs.uk/wp-content/uploads/2024/10/PRN01180-app-2-how-to-put-on-ppe-donning-a1-v2.pdf>

Personal Protective Equipment (PPE) for suspected high consequence infectious diseases

How to put on PPE (donning).



This PPE must only be used by staff trained and assessed as competent. The products shown are for illustrative purposes only.

- before putting on PPE, ensure you are hydrated, have been to the toilet if needed and feel well to enter the patient room
- if necessary, change into scrubs. Tie long hair back. Remove any jewellery/ ID badges/ lanyards
- collect all the PPE components and take to the area where PPE is put on
- perform hand hygiene and cover any cuts, abrasions or breaks in skin with a waterproof dressing
- PPE should be put on with a buddy present.

Step 1

- Put on wellington boots, half to one size bigger than your normal shoe size. Use a new pair of boots for each entry.
- Used boots should remain in bins until HCID results are known. Boots can be reused prior to results, if decontaminated as described in the doffing process.



Step 4

- Put on inner pair of gloves — standard non-sterile, nitrile, short-length gloves.



Step 2

- Put on your disposable FFP3 respirator and check for fit. This **MUST** be the mask that you are fit tested to. If you have not been fit tested, you **MUST NOT** enter the patient's room.



Step 5

- Put on the long, reinforced gown. **Do not use** the inside tie.
- Lightly secure the Velcro fastening at the back of the neck— light enough to allow easy removal, but ensuring the gown will remain closed.
- Tie the gown at the side and ensure the gown cuffs fully overlap the inner pair of gloves.



Step 3

- Put on the hood. Check the fit around the face and jaw (no gaps) and ensure a good overlap is achieved with the mask.



Step 6

- Check for sufficient overlap between the top of the boot and the bottom of the gown: 10-15 cm.
- If too long, trim the gown so it is not a trip hazard. If less than 10cm overlap achieved, check if a longer gown is available.
- If unable to achieve 10 cm overlap, do not continue—inform your senior nurse/ doctor.



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Step 7

- Put on middle pair of gloves—these are long cuffed (mid-length) non-sterile gloves and should fully overlap the cuff of the gown.



Step 11

- Put on visor and ensure the band of the visor overlaps with the hood, with no skin showing.
- Check the visor shield overlaps with the sides of the hood, and there is no skin exposed round the jaw line.



Step 8

- Tape the middle pair of gloves to the gown using 4 strips of microporous tape placed lengthways.



Step 12

- Put on outer pair of gloves—standard short gloves for clinical staff.
- If a sterile procedure is to be performed, replace the nitrile gloves with sterile gloves in the patient's room at the time of the task.
- For cleaning tasks, heavy duty style gloves may be donned instead of nitrile gloves.



Step 9

- Take the long length, thick plastic apron. Break the head loop where it usually sits at the back of the neck.



Step 13

- The buddy should run through each step to check all items are in place.
- The time should be written on the shoulder once all checks have been completed.
- If any gaps are noticed, these must be addressed. If unable to be corrected, inform your senior and do not enter the patient room until advised it is safe to do so.
- After entering the patient room, remain vigilant of PPE integrity for yourself and any other staff members.
- In the event of a high exposure episode e.g. projectile vomiting, or if there is any concern about PPE integrity, leave the room at the earliest opportunity and inform your buddy prior to doffing.



Step 10

- Put on the apron, tying at the top behind the neck, and bottom around the waist.
- A 'high fit' should be achieved, with the apron high up over the chest area.



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Doffing (taking off) HCID PPE

Buddy PPE Doffing order

Buddy PPE should be doffed using the techniques for each item described above.

Buddy PPE doffing order

1. Gloves
2. Gown
3. Full-face visor
4. FFP3
5. Wellington boots

PDF poster available (link checked 16/10/2025): <https://www.england.nhs.uk/wp-content/uploads/2024/10/PRN01180-app-3-how-to-remove-ppe-doffing-a1-v2.pdf>

The Health and Safety Executive guidelines 282/28 require that any staff member who wears respiratory equipment i.e. FFP3 respirators must be fit tested. A fit test is required on FFP3 face masks to ensure a mask is a good fit and seal for an individual. Contact Occupational Health (01387 244626) if your last test was over 3 years ago or you have never had a fit test. Do not wear an FFP3 mask if you have a beard.

Personal Protective Equipment (PPE) for suspected high consequence infectious diseases

How to remove PPE (doffing).



Removal of PPE must be done with a buddy - follow their instructions.
The products shown are for illustrative purposes only.

- open the door out of the patient room. Ensure a buddy is available to observe PPE removal. If buddy is not present, shout for attention of a staff member to assist you, **DO NOT attempt to remove PPE without a buddy**
- ensure demarcated PPE removal areas are clearly marked before starting the process. **Do not exit into clean / Green zone wearing PPE**
- if aware of any PPE breach or high-exposure contamination to PPE, inform the buddy before removing PPE

Step 1 - in patient (red) area

- Remove your apron by pulling forward from the front of the apron to break the neck and waist strings.
- Roll the dirty outer side of the apron into itself, keeping hold of the inner 'clean' side.
- Continue to roll it up, and then place in the bin.



Step 4 - In doffing (amber) area

- To remove your visor, stand straight, do not bend forwards, as this brings the bottom of the visor into contact with your (clean) upper body.
- Reach for the elastic strap at the back of the head, close your eyes and lift the strap upwards then over the head.
- Place the visor into the bin.



Step 2 - in patient (red) area

- Remove your top gloves without touching the pair below. Glove removal should follow one of two 'pinch and pull' methods (HSE or Health Education England's e-Learning for Healthcare), according to whichever the wearer is already trained in.



Step 5a (front opening hood) - in doffing (amber) area

- Remove the hood touching **only** its outer surface.
- Bring your hand towards the chin area and locate the upper Velcro fastening on the hood.
- Slowly release the Velcro fastening and pull out to the side, keeping it in your vision.
- Repeat for the Velcro fastening at the base of the hood.



Step 3 - In doffing (amber) area

- Untie the gown at the waist.
- Remove by grabbing shoulder areas and pulling to release the Velcro at the back of the neck.
- Pull the gown away from the body, folding inside out, and gathering up the material. The taped long gloves should come off with your gown.
- Carefully place into the bin but **do not push down**.



Step 5b (closed neck hood) - in doffing (amber) area

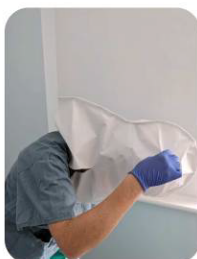
- Remove the hood touching **only** its outer surface.
- If the elasticated rim of the face opening is under the rim of the lower edge of the mask, carefully pull the hood forward slightly at chin level to free it.



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Step 6 - in doffing (amber) area

- To lift off the hood, **close your eyes** and bend forwards from the waist/hips, making sure you keep your chin well away from your chest.
- Lift the hood up and over the head, then away from you.
- Stand straight again and place the hood into the bin.



Step 10 - stepping out of doffing (amber) area into clean (green) zone

- To remove your boots, move towards the clean zone so that you can easily step into it. The clean zone should be clearly marked.
- If needed, step onto each heel to loosen before either boot is removed.
- Step out of boot into the clean zone. Do not step back into the dirty area. A buddy in the green zone may support boot removal.



Step 7 - in doffing (amber) area

- Remove your bottom gloves using the same technique as before and dispose into bin.



Step 8 - in doffing (amber) area

- The buddy will dispense alcohol gel into your hands for hand hygiene.
- Perform hand hygiene using the 6-step technique.
- Ensure alcohol gel is completely dry before proceeding to next step.



Step 11

- Turn round, pinch the inner surfaces of boots together and place into the bin.
- Do not touch the outer surfaces.
- If unable to safely reach from the clean zone, leave boots where they are and the next person to enter doffing zone can move them.



Step 12

- Used boots should not be re-worn. Boots may be decontaminated by autoclave or other suitable methods identified for HCID pathogens. If these are not available, isolate boots until HCID results known.



Step 9 - in doffing (amber) area

- Remove FFP3 respirator by standing up straight and reaching to the back of the head to find the bottom strap and bring it up to the top strap.
- Lift straps over the top of the head. Avoid bending your neck as this allows the respirator to touch your upper body.
- Let the respirator fall away from your face and place in the bin.



Step 13

- Without touching anything on yourself or in the environment, immediately wash your hands with water and liquid soap using the 6-step technique.



Waste Management

Waste from suspected cases and/or confirmed cases must be treated as Category A.

Initial Waste Handling

Non-sharps:

- All waste should be secured with swan neck ties in double yellow waste bags
- Place in hard yellow waste receptacle (Pictured below), located in Amber area of Room 31 Doffing Room
- Absorbent sachets (In locked cupboard, Room 31) should be placed in hard yellow waste receptacle before sealing
- Prior to transfer to storage area (outlined below), hard yellow waste receptacle should be disinfected with 10,000 ppm chlorine releasing agent
- Clearly label as: UN 3549



Sharps disposal:

- Sharps container should be closed with permanent closure
- Double bagged in yellow waste bags with swan neck ties
- Place in hard yellow waste receptacle (Pictured below), located in Amber area of Room 31 Doffing Room
- Absorbent sachets (In locked cupboard, Room 31) should be placed in hard yellow waste receptacle before sealing
- Prior to transfer to storage area (outlined below), hard yellow waste receptacle should be disinfected with 10,000 ppm chlorine releasing agent
- Clearly label as: UN 3549

Storage area: Initial Storage & Transport

Waste should be segregated and safely stored while waiting test results and/or decision from IMT for removal from the department.

- The DSR in AMU should be used for storage of waste generated from room 31

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- Supports Supervisor should be contacted, informing of need to relocate the current use of DSR room to Orthopaedic outpatients

Removal of waste from Storage Area / Department

Removal from DSR by Support Services **MUST** be agreed by IMT

- Yellow waste transporter should be collected by Support Services from disposal hold and taken to the DSR for transfer of stored waste
- Prior to transfer to yellow waste transporter the waste should be cleaned again with 10,000 ppm chlorine releasing agent



- If HCID test results subsequently confirm the patient as negative, waste can then be treated as category B: this decision will be directed via the IMT.

Linen Management

Linen from suspected cases and/or confirmed cases must be treated as Category A.

- Re-useable linen must not be returned to the laundry
- Treat, store, transport and dispose of as Category A infectious waste (Section 3 above)

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- It should be segregated and safely stored while waiting test results and/or decision from IMT for removal from the department (DSR in AMU)

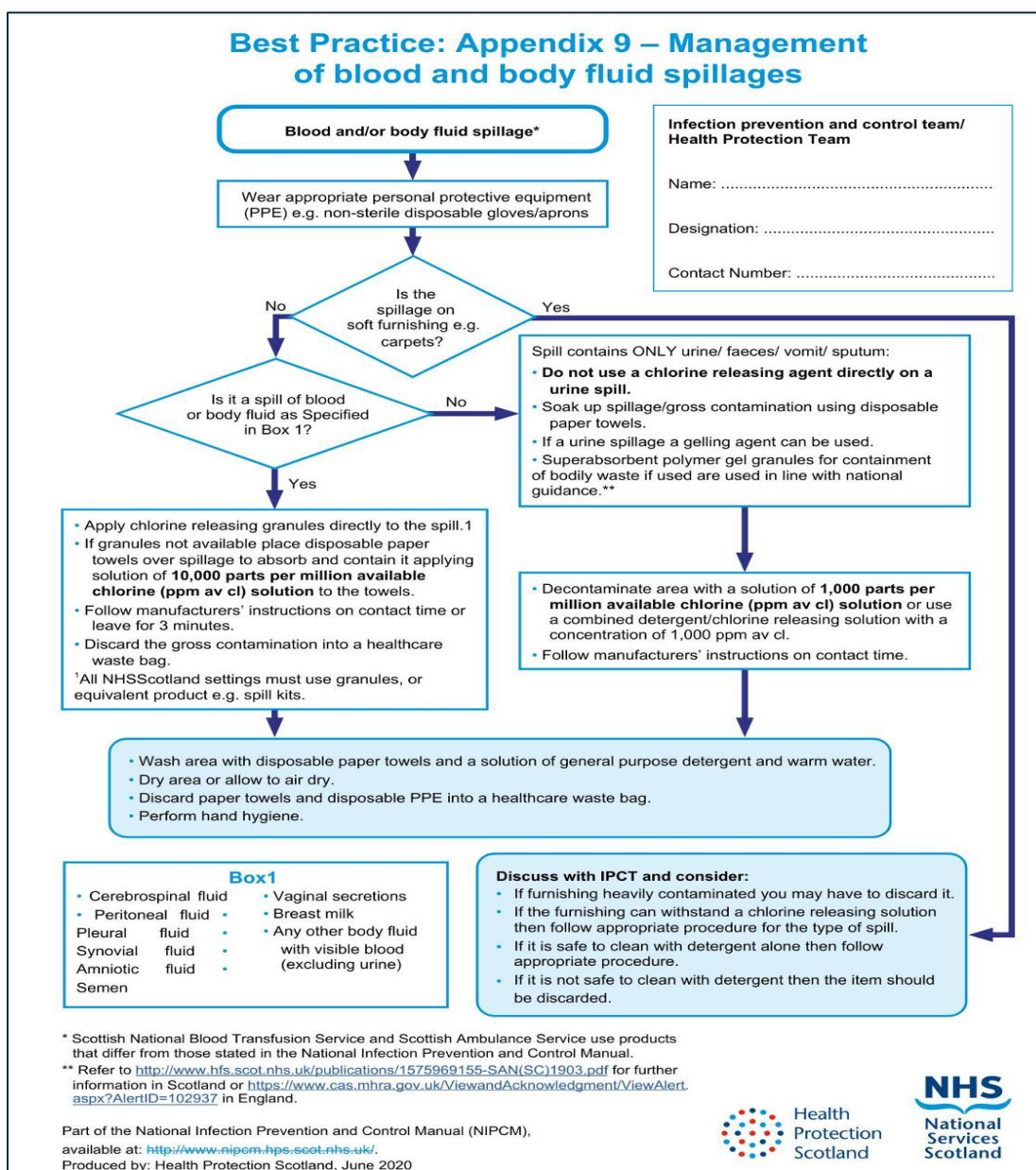
If HCID test results subsequently confirm the patient as negative, waste can then be treated as category B and treated as per Standard Infection Control Precautions (SICP's): **this decision will be directed via the IMT.**

Blood and Body fluid Management

Spillage Management

Manage as per NHS Scotland NIPCM Appendix 9 (link last checked 16/10/2025):
<https://www.nipcm.hps.scot.nhs.uk/media/1701/2020-06-nipcm-appendix-9.pdf>

- Wear appropriate PPE
- Use 10,000ppm chlorine releasing agent
- Solidify if necessary
- Discard as Category A waste (Refer to Section 3)



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Decontamination

Routine Cleaning

- Wear appropriate PPE
- 1000 ppm chlorine releasing agent for hard surfaces
- 10,000 ppm chlorine releasing agent for toileting facilities
- Should be performed by clinical staff as part of care activities

Decontamination of Equipment

Single-use item

- Dispose of as Category A Waste (Section3)

Reusable equipment

- Should remain in Room 31, if possible, for duration of patients stay
- Equipment removed from Room 31 should be decontaminated with 10000ppm chlorine releasing agent, taken out of use and stored until result received.
- If HCID test results subsequently confirm the patient as negative, equipment can return to use: **this decision will be directed via the IMT.**

Terminal Cleaning

The decision for terminal cleaning of the room must be directed via the IMT, and the HCID test results will be taken into consideration.

HCID test result negative:

- Wear appropriate PPE
- Allow for sufficient fallow time, if required
- Remove and disposal of all waste and unused consumables
- Decontaminate all reusable equipment
- Leave decontaminated equipment within the area
- Decontaminate room with 1000 ppm chlorine releasing agent

HCID test result positive:

- The required steps will be directed by the IMT in conjunction with the IPC team and Support Services.

Care of the Deceased

Variation in hazard group classification of HCIDs exists, with some classed as hazard group 3 or 4. Refer to NICPM appendix 12 (link checked 16/10/2025):

<https://www.nipcm.scot.nhs.uk/appendices/appendix-12-application-of-infection-control-precautions-in-the-deceased/>

The IMT / IPC team must be involved hazard group category decision making.

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Managing deceased suspected and/or confirmed HCID patients (Group 4 Hazard)

- Wear appropriate PPE
- Washing and/or dressing of the deceased should not be carried out
- Deceased individuals should be placed in a sealed double plastic body bags with absorbent material placed between each bag
- The surface of the outer bag should then be disinfected with 10000 ppm chlorine releasing agent
- Post-mortem examination should not be performed and viewing of the deceased should be avoided
- The bag should be labelled as high risk of infection

Managing other suspected/confirmed HCID patient

- A local risk assessment should be undertaken to inform any decision making on:
 - Washing & dressing
 - Viewing of the deceased

Discontinuation of HCID precautions

The decision to discontinue HCID precautions will be led via the IMT.

HCID precautions must be maintained until:

- The patient is confirmed not to have an HCID, based on laboratory testing and clinical assessment
- The diagnosis is reviewed and validated by **UK Health Security Agency (UKHSA)** or relevant national authority.

If HCID is ruled out:

A risk assessment must be conducted to determine if Transmission-Based Precautions (TBP's) are still required for other infections.

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APPENDIX 7 - OCCUPATIONAL HEALTH CONTACT TRACING FORM

Occupational Health Department

Contact List

Patient's Name:	Initial Contact Area:
DoB:	Manager:
Date received:	Action initiated:

PLEASE COMPLETE THE FOLLOWING, INDICATING ALL MEMBERS OF STAFF IN YOUR AREA WHO HAVE POTENTIALLY BEEN IN CLOSE CONTACT WITH THE ABOVE PATIENT. PLEASE INCLUDE NURSING, MEDICAL, STUDENTS, BANK STAFF AND DOMESTICS

Full Name (block capitals)	Specific Occupation (including grade)	Date of Birth (mandatory)	Occupational Health Use Only			
			Immunity or vaccine	Inform and Advise Letter Required Yes/No	Inform and Advice letter date sent	Appointment required

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APPENDIX 8 - INCIDENT MANAGEMENT TEAM SAMPLE AGENDA

The following is a suggested agenda for the first IMT meeting, usually chaired by the Senior member of Health Protection Team. It should be viewed as an initial guide: items may be added or deleted as the incident progresses.

IMT MEETING AGENDA		Checklist <input type="checkbox"/>
1	Introductions	
2	Confidentiality	
3	Membership	
4	Urgent Matters Arising	
5	Declarations of conflicts or vested interests	
6	Situation report: <ul style="list-style-type: none"> ▪ Patient history, status and current location ▪ ID assessment – differential diagnoses, testing and admission decisions 	
7	Response coordination: <ul style="list-style-type: none"> ▪ Transportation to hospital ▪ Security and safety of admission route ▪ Ward preparedness including IPC / PPE supplies ▪ Microbiological sampling and transport ▪ Other medical laboratories – IPC awareness ▪ Environmental cleaning and waste disposal across patient journey prior to hospital ▪ Contact tracing and public health surveillance ▪ Command and control structure and updates + reminder of strategy 	
8	Risk Communication: <ul style="list-style-type: none"> ▪ Advice to professionals directly involved in clinical care ▪ Advice to wider professional groups ▪ Media statement ▪ Briefing to Scottish Government 	
9	Actions – Go through them and update – from previous meeting	
10	AOCB	
11	Confirm Actions raised and Lead Personnel responsible	
12	Set time and date of next meeting	

APPENDIX 9 - REFERENCE MATERIALS

National Guidance

High Consequence Infectious Diseases (definition and list of diseases) -
<https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid>

Avian Influenza – exposure outwith the UK -
<https://www.gov.uk/government/publications/avian-influenza-guidance-and-algorithms-for-managing-human-cases>

Avian Influenza – exposure within the UK -
<https://www.gov.uk/government/publications/avian-influenza-guidance-and-algorithms-for-managing-incidents-in-birds>

Middle East Respiratory Syndrome - Coronavirus (MERS-CoV) -
<https://www.gov.uk/government/collections/middle-east-respiratory-syndrome-coronavirus-mers-cov-clinical-management-and-guidance>

Viral Haemorrhagic Fevers (VHF) -
<https://www.gov.uk/government/publications/viral-haemorrhagic-fever-algorithm-and-guidance-on-management-of-patients>

<https://www.nss.nhs.scot/publications/viral-haemorrhagic-fever-vhf-infection-prevention-and-control-precautions-summary-for-the-hospital-setting-version-31/>
(including PPE)

<https://www.nss.nhs.scot/publications/advice-for-purchase-of-required-ppe-for-viral-haemorrhagic-fever-vhf-preparedness/>

Transmission based precautions -
<https://www.nipcm.scot.nhs.uk/addendum-for-high-consequence-infectious-disease-hcid/>

<https://www.hcid-training.co.uk/index.php/printable-resources/>

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APPENDIX 10 – LIST OF USEFUL TELEPHONE NUMBERS

NAME	NUMBER	
DGRI switchboard	01387 246246	
Health Protection Team	01387 272724 option 6 or via switchboard	In-hours Out of hours
Infection Prevention & Control Team	01387 241030	8:30am - 5pm Mon - Fri 9am - 12:45pm Sat & Sun
Imported Fever Service	0844 778 8990	In-hours and out-of-hours
West of Scotland Specialist Virology Lab	0141 201 8722 0141 211 4000	In-hours Out-of-hours
Public Health Scotland	Via HPT	
Scottish Ambulance Duty Strategic Ops Manager	0333 772 6156	In-hours and out-of-hours