Frimley Health
NHS Foundation Trust

IPC44: Guidelines for the Management of High Consequence Infectious Diseases (HCID)

Key Points

- This guideline replaces the Trust guideline IPC16 (Guidelines for Control of Viral Haemorrhagic Fevers (VHF), and the Avian Influenza section of IPC12 (Guideline for the management of Influenza).
- High Consequence Infectious Diseases (HCID), including viral haemorrhagic fevers (VHFs), are rare in the UK. When cases do occur, they tend to be sporadic and are typically associated with recent travel to an area where the infection is known to be endemic or where an outbreak is occurring.
- The guideline provides the Trust response for management of HCID cases, with reference to the National Infection Prevention and Control Manual (England) 'Addendum on high consequence infectious disease (HCID) personal protective equipment (PPE)'.
- This guideline outlines the assessment patients for a HCID, and the procedures for managing a suspected or confirmed HCID case.
- **If you are managing a suspected HCID case, refer immediately to Appendix I of this guideline and the HCID Action Cards in Ourplace.**

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Abbreviations

ADR	*Accord Dangereux Routier* (Agreement concerning the International Carriage of Dangerous Goods by Road)
BMS	Biomedical Scientist
CCHF	Crimean Congo haemorrhagic fever
DIPC	Director of Infection Prevention and Control
EBOD	Ebola virus disease
ED	Emergency Department
EPRR	Emergency Preparedness, Resilience and Response
FFP3	Filtering Facepiece Class 3
FHFT	Frimley Health NHS Foundation Trust
GP	General Practitioner
HCID	High Consequence Infectious Disease
HCW	Healthcare worker
ICB	Integrated Care Board
ICC	Incident Control Centre
IRP	Incident Response Plan
IMT	Incident Management Team
IPC	Infection Prevention and Control
MERS	Middle East Respiratory Syndrome
MVD	Marburg Virus Disease
PPE	Personal Protective Equipment
RIPL	Rare and Imported Pathogens Laboratory
SARS	Severe acute respiratory syndrome
UVC	Ultra-Violet C (decontamination)
UKHSA	UK Health Security Agency
VHF	Viral Haemorrhagic Fever

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1. Introduction

This guideline outlines the Frimley Health NHS Trust procedures for assessing patients for a High Consequence Infectious Disease (HCID), and the procedures for managing a suspected or confirmed HCID case.

1.1 Definition of a HCID

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

1.2 Classification of HCIDs

HCIDs are further divided into contact and airborne groups:

- **Contact HCIDs** are usually spread by direct contact with an infected patient or infected fluids, tissues and other materials, or by indirect contact with contaminated materials and fomites.
- **Airborne HCIDs** are spread by respiratory droplets or aerosol transmission, in addition to contact routes of transmission.

1.3 List of HCIDs

For the most current list of HCIDs, please refer to the UK Health Security Agency (UKHSA) HCID webpages, located at: https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid

Contact HCIDs	Airborne HCIDs
Argentine haemorrhagic fever (Junin virus)	Andes virus infection (hantavirus)
Chapare virus infection	Avian influenza A (H7N9) and A (H5N1)
Bolivian haemorrhagic fever (Machupo virus)	Avian influenza A (H5N6) and A (H7N7)[1]
Crimean Congo haemorrhagic fever (CCHF)	Middle East respiratory syndrome (MERS)
Ebola virus disease (EBOD)	Nipah virus infection
Lassa fever	Pneumonic plague (Yersinia pestis)
Lujo virus disease	Severe acute respiratory syndrome (SARS)[2]
Machupo virus infection	
Marburg virus disease (MVD)	
Severe fever with thrombocytopaenia syndrome (SFTS)	

[1] Human-to-human transmission has not been described to date for avian influenza A(H5N6). Human to human transmission has been described for avian influenza A(H5N1), although this was not apparent until more than 30 human cases had been reported. Both A(H5N6) and A(H5N1) often cause severe illness and fatalities. Therefore, A(H5N6) has been included in the airborne HCID list despite not meeting all of the HCID criteria.
[2] No cases reported since 2004, but SARS remains a notifiable disease under the International Health Regulations (2005), hence its inclusion here.

1.4 HCID Risk by Country

For the most current list of HCID risk by country, please refer to the UKHSA HCID webpages, located at: https://www.gov.uk/guidance/high-consequence-infectious-disease-country-specific-risk.

2. Patient Assessment

2.1 Screening and Triage

2.1.1 The 'Travel/ Communicable Disease Screening' tool must be completed on Epic.

2.1.2 Patients attending with suspected HCID require full assessment of risk factors, including travel history and infection exposure history, and have details documented in their Epic notes.

2.1.3 The senior clinician (Registrar/ Consultant) must contact the local duty medical Microbiologist (via switchboard if out of hours) for assessment of case details against case definition.

2.1.4 Staff should use appropriate personal protective equipment (PPE) when assessing and triaging the patient.

2.1.5 Patients meeting the case definition for a HCID must be discussed with the UKHSA Imported Fever Service (0844 778 8990) by the duty Microbiologist, prior to samples being taken for investigation of HCID.

2.1.6 The IPC Team will provide guidance on precautions required for care of patient.

2.2 HCID Plan Activation and Notification

2.2.1 This plan will be activated in one of two ways: either as a result of pre-warning by another health care provider or when a patient has arrived at FHFT without any prior warning and where the duty Microbiologists assessing doctor confirms there is a suspected HCID case.

2.2.2 The Duty/ On-call Microbiologist will contact the most senior IPC Lead on duty, who will attend the site/ department in which the suspected case is located. The IPC Lead will notify the following staff, and arrange an urgent tactical Teams meeting (see Appendix XI Tactical Meeting Agenda):

a) Deputy Director of Infection Prevention & Control (DIPC) or Infection Prevention Nurse Consultant
b) Duty/ On-Call Consultant Microbiologist
c) Paediatric Consultant On-Call (if the patient is a child under 16 years of age)
d) Responsible Clinician from the Ward/Dept that the patient is currently on
e) Divisional Director of Nursing (Urgent Care and Medicine)
f) Head of Nursing (or deputy) for the Ward/Dept the patient is currently on

g) Clinical Matron/Ward Manager of ward where negative pressure isolation room located

h) Occupational Health Consultant or Lead Nurse

i) Gold On-call

j) Silver On-call

k) Site Security Lead

l) Director or Deputy Director of Property and Facilities Management

m) Site Laboratory Lead

n) Site Pharmacy Lead (in hours)

o) Incident Control Centre (ICC) (initiated by Silver Command if required)

p) EPRR Lead

q) Communications

2.2.3 The IPC Team must inform the ICB of a suspected case where the decision has been made to admit them to a Trust inpatient ward.

2.2.4 If the patient is pregnant then the Named Consultant will notify Maternity Assessment Unit to arrange appropriate support for the patient on the isolation ward. If the patient is a child, then the On-Call Paediatrician will arrange appropriate paediatric nursing and medical care of the patient on the isolation ward.

2.2.5 If HCID infection is suspected and, following discussion with the Imported Fever Service by the clinician overseeing the case, and testing has been agreed to, the Duty Microbiologist will provide guidance on the samples, packaging and transport requirements in line with the Berkshire & Surrey Pathology Service standard operating procedures.

2.3 Incident Management Team: Command & Control

2.3.1 The overall management of the Trust's response to dealing with a HCID patient will be in line with the Trust's Command, Control, Communication and Co-ordination (C4) Plan and Incident Response Plan (IRP). Confirmation of a positive case can take up to 72 hours. Therefore, the ongoing management of the patient must be as described within the guideline for both suspected and confirmed cases.

2.3.2 A confirmed HCID case will require the activation of an Incident Management Team (IMT) organised by the IPC Team which will be led by the DIPC or suitable deputy. See IPC Outbreak Plan, and Appendix XI for IMT agenda template.

3. Management of Suspected and Confirmed HCID

3.1 Refer immediately to Appendix I of this document.

3.2 Circulate and initiate the Action Cards in Appendix II.

3.3 The limited negative-pressure isolation room capacity on the FPH and WPH sites, restricts the number of suspected HCID cases that can be admitted to one patient per site. In the event of pandemic or surge requirements, the Trust will act under instruction of the UK Health Security Agency.

4. Education and Training Requirements

4.1 The Health and Safety Executive guidelines 282/28 require that any staff member who wears respiratory protective equipment (i.e. FFP3 respirators must be fit tested, or wear a Powered Air Purifying Respirator), to ensure that they are adequately protected. Fit test train the trainer sessions are provided through the IPC Team at FHFT. Fit testing of ward/ department staff, is carried out by staff trained to fit test in those areas, and co-ordinated by the Trust Fit Test Co-ordinator.

4.2 Limited in-house training on the use of the Unified HCID PPE is provided by the IPC Team. Clinical Divisions (especially those with departments with greater opportunity of presentation of suspected HCID cases (including the Emergency Departments and wards with negative-pressure isolation rooms)) are advised to co-ordinate attendance of key registered senior nursing and medical staff at the national HCID training programme (one day for PPE course; two days for HCID Trainer course): https://www.hcid-training.co.uk/index.php/booking-page/

4.3 Additional exercises in the practical application of this guideline are managed by EPRR.

5. Monitoring

Monitoring of this guideline will be through the IPC Annual Audit and Surveillance programme. The likelihood of a patient presenting with a suspected or confirmed HCID is low, and should this occur, the IPC Team will monitor the following:

- Compliance with transmission-based precautions including use of PPE
- Compliance with informing all relevant personnel including Consultant Microbiologist/ Virologist, IPC Team, and UKHSA
- Numbers (if any) of staff affected
- Desktop/action card and live simulation exercise every three years to be coordinated and organised through the EPRR Manager.

References

List of HCID and HCID country specific used in the guideline should be added in the reference list. UK Health Security Agency (2026) *High consequence infectious diseases (HCID).* Available at: High consequence infectious diseases (HCID) - GOV.UK (Accessed: 03 November 2026).

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Appendix I Clinical management of suspected and confirmed HCID cases

1. Patient Assessment and Management

1.1 The priority of the patient assessment and management is to ensure access to appropriate care in an environment that provides protection to others.

1.2 Where a patient is being referred by another healthcare provider (UKHSA, 111, GPs etc.) they are responsible for notifying the receiving area prior to the transfer of the patient, after discussions with the Duty/ On-call Microbiologist.

1.3 Patients identified to be at risk of a HCID based on their presenting complaint and travel and/or exposure history, must be segregated immediately from other patients, in a single room with a door that can close. Clinical rooms designated for the assessment and care of patients with suspected or confirmed HCID are highlighted in Section 2.1. Other specialities (including Paediatrics and Obstetrics) will provide assistance to those wards/ departments where necessary, including if family support is required.

1.4 A record of staff and patient contacts (Appendix III) must be commenced from the point of first suspicion of HCID.

1.5 Staff undertaking patient assessment in the room must wear a minimum of airborne personal protective equipment (PPE).

1.6 Once a detailed history has been taken from the patient, the senior clinician (Registrar/ ST4 or above) must contact the Duty/ On-call Microbiologist, for assessment of the case details against the HCID case definition.

1.7 The Duty/ On-call Microbiologist will contact the UKHSA Imported Fever Service and will confirm with the senior clinician whether the patient requires management as a suspected HCID case.

1.8 The patient must remain isolated in the designated room until further decisions are made. Continue to provide the clinical care and treatment that the patient requires. Consider whether any of the interventions can be postponed until confirmation of results and if tasks can be undertaken without exposing the HCW to bodily fluids this is preferable. Restrict the number of contacts to those staff who are immediately required to provide the care and treatment.

1.9 If the patient requires interpreting services, this must be supported using digital services and in accordance with the Trust Interpreting Services guidelines.

1.10 Staff (Medical and Nursing) must ensure the patient and their relatives are communicated with in a clear and sensitive manner, informing them of the procedures that will be in place as precautionary measures and they must update the patient regularly.

1.11 Visitors are not recommended. If required, they should ideally be kept to pre-exposed persons only to avoid further contacts. They should also be encouraged to don PPE and supported with doffing of the PPE accordingly and safely.

1.12 If, during the assessment period, any patient who is suspected to have a HCID was to deteriorate and require critical care, a discussion must occur between the Resus Team and the Critical Care team who will respond accordingly.

1.13 If the case does not meet the definition for a possible HCID, contact lists can stop, and care returned to standard for the patient. Clinical staff should liaise with Microbiology/ IPC Team if clinical suspicion remains, to agree what next steps are required.

1.14 If the case meets the definition for a possible HCID:

- The Duty/ On-call Microbiologist will contact the most senior IPC Lead on duty to attend the site/ department where the patient is located, to provide support and guidance to the clinical team.
- The IPC Lead will initiate an urgent HCID Tactical Teams meeting to co-ordinate management of the patient.
- Registered nursing and midwifery staff designated to provide direct care for the patient, are advised to be experienced Band 6 or above. Registered medical doctors are advised to be Registrar/ ST4 or above. All staff entering the room must be trained and competent in the donning and doffing of HCID PPE.
- Two HCWs are advised to provide patient care in the room at the same time, to observe and advise each other on safe working processes, and ensure breaches in PPE are actioned promptly.
- Staff entering the patient's room must wear the unified HCID PPE ensemble – the two HCID Grab Boxes provide 24hrs PPE supply for the initial management of the patient.
- A Buddy must be nominated to ensure care staff have undertaken donning and doffing of the PPE accordingly and safely.
- A Runner must be nominated to locate and supply necessary equipment required.
- Transfer to be arranged to a either a specialist HCID Treatment Centre, or inpatient negative-pressure isolation room at Frimley Health.

2. Admission Process

2.1 Patients suspected as having a HCID (as advised by the Duty/ On-call Microbiologist) should (and confirmed HCID must) be transferred as a priority to a specialist HCID Treatment Centre.
The nearest HCID Treatment Centres to Frimley Health are:

- **Airborne HCIDs** (both Adult & Paediatric): John Radcliffe Hospital at Oxford University Hospitals (via switchboard 0300 304 7777)
- **Contact HCIDs**: Royal Free London (Adult) (020 7794 0500) and St Mary's Hospital, London (Paediatric) (via switchboard 020 3312 6666)

2.2 In the event of transfer to a HCID Treatment Centre not being possible, the predetermined areas for isolation of suspected cases in the Trust are as below:

	Frimley Park Hospital	**Wexham Park Hospital**
Identification of suspected case in Emergency Department	Placement in single rooms 16 or 17 for assessment only	Placement in ED Blue rooms 19 or 25 for assessment only
Identification of suspected case in Outpatient Department	Isolate in the consultation room in which appointment taking place, for assessment only	Isolate in the consultation room in which appointment taking place, for assessment only
Identification of suspected case in inpatient ward	Isolate in negative-pressure isolation room 16 or 17 on ward	Isolate in negative-pressure room 12 on ward AMU Blue.

	G1, or isolation room 05 or 06 on MADU. Two rooms must vacated for use: One room used for patient; One used for staff showering and changing.	Two rooms must be vacated for use: One room used for patient; One used for staff showering and changing.
Decision to admit a suspected/ confirmed HCID case ***(only in the event of unavailability of HCID Treatment Centre bed)***	Isolate in negative-pressure isolation room 16 or 17 on ward G1 (priority), or isolation room 05 or 06 on MADU. Two rooms must be vacated for use: One room used for patient; One used for staff showering and changing. If Level 3 care is approved, admission to negative-pressure isolation room B5 on ICU.	Isolate in negative-pressure room 12 on ward AMU Blue. Two rooms must be vacated for use: One room used for patient; One used for staff showering and changing. If Level 3 care is approved, admission to negative-pressure isolation room on ICU.

2.3 Post-transfer of the patient, any room (including lifts) occupied and all equipment therein, must be decontaminated following the process in Section 15. The room/ lift must remain closed to patient and staff use until decontamination is completed.

2.4 Transfers from ED or other hospital wards/ departments to the isolation area, are likely to cause distress to members of the public, staff and patients, whilst increasing the risk of exposing others to the patient. Transfers must be planned and receiving departments pre-notified. Patient movement must be carefully considered, adopting the following principle: **Patient transfer should be done so in a swift continuous manner, whilst being as discrete as possible to reduce fear and potential exposure to others.**

2.5 The process of a rolling lock down must be implemented by security and managed by the Silver On-call when transfers require movement through a hospital building. A minimum of three security team members are advised – one to lead, one to follow, and one to act as way-finder ahead of the lead. Security staff must not travel in the lift with the patient and must apply a 'talk don't touch' approach with communication.

2.6 The predetermined routes for transfer within the WPH and FPH sites are summarised in the table below:

Scenario	**Route Summary**
Direct admission to isolation ward (FPH G1)	Ambulance (or other transporting vehicle) to drive G1 access door on the FPH fire road
Direct admission to isolation ward (FPH MADU)	Fire exit at rear of M Block > M Lifts > MADU
Direct admission to isolation ward (WPH AMU Blue)	Fire exit > Patient lifts > AMU Blue
ED to isolation ward (FPH G1)	*If ambulant: priority route via wheelchair (or walking) to G1 access door on FPH fire road* If non-ambulant: Yellow street > Green street > Red street > G1
ED to isolation ward (FPH MADU)	Yellow street > M Lifts > S01 > MADU

ED to isolation ward (WPH AMU Blue)	ED Blue > Patient lifts > AMU Blue
Other routes	Use best judgement based on the principle of discreet and swift transfer avoiding where possible, areas of high pedestrian, clinic activity.

2.7 The patient must be accompanied by two members of the nursing team: One nurse designated the clinical nurse, and the other, the spillage healthcare worker.

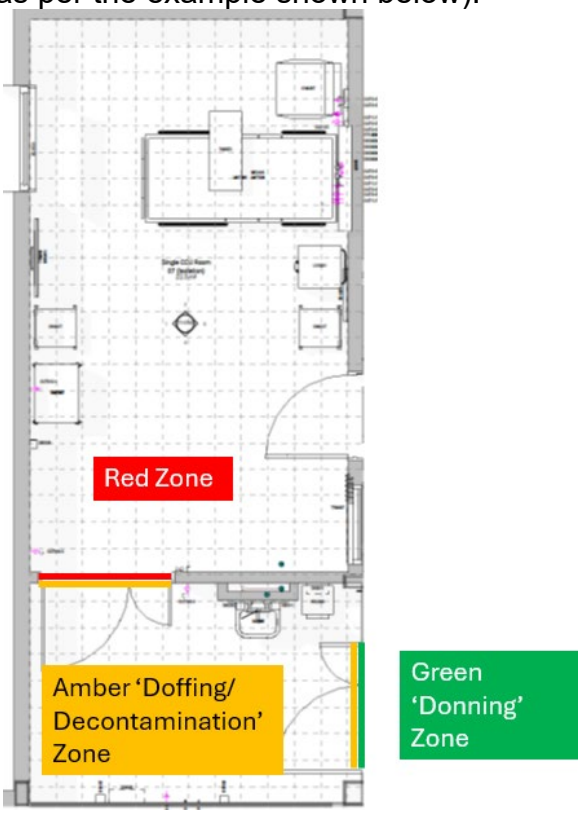
2.8 The spillage HCW will be responsible for taking appropriate chemicals and materials to deal with any spillage of blood or body fluids that may occur (yellow clinical waste bags, yellow tie tags, and either a dedicated spill kit, or 10,000ppm hypochlorite solution (e.g. Haz-Tabs), solidifying gel (e.g. Vernagel), and disposable paper towels).

2.9 Staff in PPE should avoid touching surfaces such as lift call buttons, door handles, and handrails by using an object such as a tongue depressor to press buttons. However, if this is not possible, the spillage HCW will be responsible for wiping any touch points during the journey, once the team have passed through an area.

2.10 During the transfer, the patient should wear an un-valved FFP3 respirator. Staff must wear appropriate PPE (as described in section 7). All PPE for areas such as Radiology, must be provided by the transferring ward. The staff on the ward will ensure all staff are wearing the correct PPE, and that this is removed appropriately and safely in the designated disrobe area on the ward.

2.11 <u>Isolation Room Zoning</u>

HCID isolation room zoning is designed to achieve absolute physical separation between contaminated and uncontaminated areas. It relies on a three-zone system (Red, Amber, Green) enforced by strict pressure cascades and unidirectional movement to prevent pathogen transmission (as per the example shown below):



Red Zone (High Risk): The patient's room and en-suite facilities. This is where direct clinical care occurs and the highest risk of infection exists.

Amber Zone (Medium Risk): The anteroom (or transitional space just outside the patient room). This area is used for the of doffing (removing) PPE, and the temporary storage of infectious waste prior to disposal, and contaminated equipment prior to decontamination.

Green Zone (Uncontaminated): The clean corridor and external staging areas (including adjacent single room), which can be used for donning of PPE. No contaminated equipment, clinical waste, or exposed staff are allowed here.

Zones can be indicated using the posters within Appendix XV, and floor tape provided in the HCID Grab Box.

2.12 As a minimum, two rooms must be vacated by the Site Team to enable management of the patient:

- One negative-pressure isolation room – for patient isolation
- Adjacent en-suite single room – for use by clinical staff providing care for the patient with suspected HCID (showering, re-dressing, taking of rest periods).

2.13 The IPC Team will provide guidance on whether larger areas of corridor require closure to general access, or additional rooms required to be vacated for staff management of the patient or their family.

2.14 Plan method of documentation (or observations) and communication with colleagues – writing communication on paper and sticking to the internal window is an effective method, to enable workstations on wheels to remain outside of the care room. FPH ward G1 has intercom system for communication between the room and nursing station.

3. Collection of Specimens

3.1 **Samples must not be taken from a patient with suspected or confirmed HCID until discussed with, and advised by the Duty/ On-call Microbiologist**, due to the increased risk of infection to the healthcare workers. Specimens must only be collected by those competent and experienced in the procedure. The procedure for specimen collection can be found in Appendix XIII.

3.2 The Duty/ On-call Microbiologist will provide advice and guidance specific to HCID specimens. This will include the requirement and arrangements for specimens to be sent to RIPL at Porton Down Laboratory.

3.3 **The pneumatic tube system must not be used to transfer specimens to the laboratory.** The laboratory must be informed in advance and specimens taken in person. All pathology specimen forms must be clearly marked as a possible or confirmed HCID case and packaged as advised by the Duty Microbiologist. All blood specimens MUST be labelled and placed within the appropriate container.

3.4 The pathology laboratory must be alerted in advance, that suspected HCID samples will be arriving. This specimen must then be walked over to the laboratory by the Runner or another responsible person and the specimen handed over to the named laboratory senior Biomedical Scientist (BMS). If handling of the samples is required within the pathology laboratory, this must not take place outside of the biosafety cabinet. The equipment and work area should be decontaminated immediately after the test is carried out, in line with laboratory protocol for decontamination as for other high-risk specimens.

3.5 Final packaging, completion of RIPL forms, and arrangement of transport to RIPL Porton Down, is completed by the senior BMS.

4. Differential Diagnosis of a HCID

4.1 Most febrile patients with a recent history of travel to the HCID affected areas will have alternative infectious causes for their fevers. These will need to be tested for and discounted if advised by the Duty/ On-call Microbiologist. These include:

Infection	Advice
Malaria	Presents with acute fever, headache and sometimes diarrhoea (children). Blood smears must be examined for malaria parasites. PCR is also available. Presence of parasites does not exclude a concurrent viral or bacterial infection.
Shigellosis and other bacterial enteric infections	Blood cultures and stool cultures must be taken, and malaria excluded.
Typhoid fever	Presents with fever, headache, rash, gastrointestinal symptoms, with lymphadenopathy, relative bradycardia, cough and leucopaenia and sometimes a sore throat.
Yellow fever and other Flaviviridae	Present with haemorrhagic complications.
Mpox	Bacterial skin infections, other viral infections presenting with blistering rash (eg varicella zoster, herpes simplex, enterovirus, molluscum contagiosum), Drug reactions, Erythema Multiforme, other Sexually acquired infections including syphilis, disseminated gonococcal infection, lymphogranuloma venereum (LGV)
Others	Leptospirosis, hantavirus, viral hepatitis, rheumatic fever, typhus, systemic plague, systemic tularaemia, and mononucleosis produce signs and symptoms that may be confused with a VHF in the early stages of infection.

5. Pregnant Staff

Pregnant staff MUST NOT be involved in the treatment of a HCID patient.

6. Detention of a Patient

6.1 A patient can be detained under the measures contained in the Public Health (Control of Disease) Act 1984 (as amended) together with the Health Protection (Local Authority Powers) Regulations 2010 and the Health Protection (Part 2A Orders) Regulations 2010.

6.2 A local authority can apply to a justice of the peace for an order (Part 2A Order) if it considers it necessary to deal with a threat to human health from infection or contamination that presents or could present a risk of significant harm only if a critical assessment of the available options to achieve the health protection outcome has concluded that other options can be discounted.

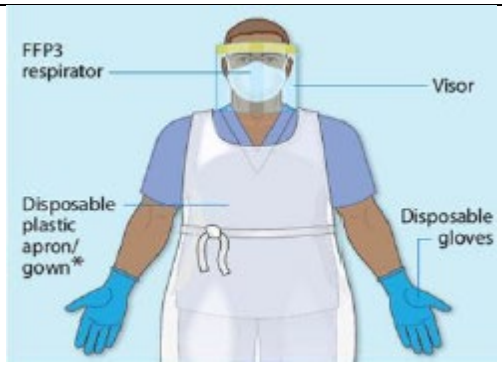
6.3 Once the order has been signed off it provides authority to the Chief Executive Officer of the Trust to require a patient to undergo medical treatment for their condition and place restrictions on their movements and access to others. Within FHFT the patient would be confined to a negative-pressure isolation room. If a person is required by a Part 2A Order to be detained or to stay in isolation or quarantine and absconds, they may be taken into custody by the police while the Order remains in force.

6.4 The Facilities Team will, for the purpose of carrying out the order, ensure suitable security personnel are positioned to prevent a patient from absconding from care. Security will

undertake duties to keep staff safe from physical violence but will not intervene to assist medical intervention. If there is persistent risk of absconding or refusal of medical treatment the police should be notified and requested to assist. Any police or security staff required will be provided with adequate PPE.

7. Personal Protective Equipment (PPE)

7.1 **Refer to Appendices IV and V for detailed PPE donning and doffing guidance.**
PPE is essential to ensure the safety of staff involved in the treatment of the patient. There are two levels of PPE that can be applied; to support the initial assessment of a patient, and then for on-going management once the patient is assessed as a suspected HCID case. They are defined in the table below. (The IPC Team will provide direction on any changes to the PPE requirements depending on the outcome of the assessment and in accordance with the specific HCID national guidance).

<table>
<tr><th colspan="2">Personal Protective Equipment during Patient Management</th></tr>
<tr><th>Low Possibility of HCID
(Use during triage/ initial patient assessment)</th><th>Suspected/ Confirmed HCID</th></tr>
<tr><td><u>Airborne PPE</u>
Gloves
Plastic apron (gown if extensive splashing expected)
FFP3 respirator
Disposable visor</td><td><u>Unified HCID PPE Ensemble (HCID Assessment PPE)</u>
Disposable surgical scrubs
Wellington boots
Triple gloves
Long-sleeved fluid-resistant gown
Plastic apron
Surgical hood
FFP3 respirator
Disposable visor</td></tr>
<tr><td>
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<tr><th colspan="2">Working with specimens in laboratory</th></tr>
<tr><td colspan="2">Routine/ Standard IPC precautions – as samples handled in containment</td></tr>
</table>

7.2 PPE must always be applied in a ‘clean’ (Green Zone) area prior to engaging in any patient treatment. PPE must be removed in a designated area (Amber Zone).

7.3 A ‘Buddy’ must always be involved when donning (putting on) or doffing (taking off) PPE, to ensure that it is done correctly.

7.4 Wearing HCID PPE traps body heat and prevents sweat evaporation and can place staff at a high risk for heat stress, dehydration, and cognitive impairment. To mitigate these risks:

- Staff must be well-hydrated prior to commencement of a period of patient care. Carry out a baseline check, asking: 'has the staff member drank at least 500ml water prior to starting, are they well-rested, have they had a recent toilet break?'
- Structured work-rest cycles must be in place: limit time spent continuously in HCID PPE (a maximum of 1-2 hours), active monitoring of wellbeing of work colleague in the room (aided by staff working in pairs), and on recognition of symptoms of fatigue, dizziness, or drop in focus, safely decontaminate and exit.
- Active environmental cooling: Rest between care periods in a designated cool, well-ventilated area to bring core body temperature down before needing to don a new set of PPE and continue care.

7.5 The HCWs working with the patient will don PPE first under the supervision of the Buddy. Once the HCWs are dressed, the buddy will then don PPE in preparation to assist the HCW out of their PPE if necessary. Once the HCW has undressed, the PPE buddy will then undress from their PPE.

7.5 **PPE Buddy**

Refer to Appendix VI.

- Whilst PPE is designed to ensure staff safety, it must be put on and taken off correctly to minimise exposure. Staff donning and doffing PPE must be observed by a trained Buddy, who will read out aloud instructions to ensure that the processes are rigorously followed.
- The PPE buddy must be fully trained in donning and doffing procedures and follow donning and doffing order.
- Where potential exposure to HCID is identified the IPC Team and Occupational Health must be informed.

7.6 **PPE Storage Locations**

HCID PPE Grab Boxes containing equipment required for HCID Assessment, are accessible in the FPH and WPH Emergency Departments.
The location of PPE utilised routinely for standard IPC precautions, and transmission-based precautions in clinical departments (including examination gloves, FFP3 respirators, and visors) must be clear to clinical staff, as these PPE items will not be included in the Grab Boxes.

A PPE trolley should be organised, in the Green Zone, with items arranged in order that they will be donned.

8. Waste Management

8.1 Waste from patient thought to be suspected of a HCID must be managed as Category A pathogen waste. At any time where it is established that the patient is either positive or negative for HCID, Estates and Facilities must be informed. In cases where it is a confirmed positive Estates and Facilities will notify Grundon and the Dept. of Transport (Vehicle Certification Agency) to arrange collection of waste by ADR-compliant transport.

8.2 All waste from suspected or confirmed HCID patient will be required to be placed in a 4-layer packaging of:
a) Two heavy-duty yellow clinical waste bags UN-approved, ≥50µm/ or approved
b) A rigid plastic leak proof burn bin UN3291(medi-bins) suitable for bulk,
c) 770 litre bin, lined with plastic, for collection storage and transportation or the medi-bins

8.3 Medicines for destruction should be stored in the same way as all other waste but should be kept separate from other waste generated through the care of the patient so that they can be separated if separate disposal methods are required.

8.4 Facilities will arrange for a lined 770 litre clinical waste bin to be taken to the clinical area. This bin will have been brought to the ward and positioned outside the rooms to allow the bins to be passed directly into the waste container. The outside of the yellow medi-bins must be decontaminated with 1000ppm hypochlorite solution (eg. Chlor-clean), and they placed vertically into a lined, wheeled bin, which is marked UN3549, and with the word 'OVERPACK'. It is envisaged that separate waste collections will be required to be organised two possibly three times a day. This must be with prior arrangement with Estates and Facilities.

8.5 Category A waste should not be allowed to accumulate for any period of time (no more than 24 hours recommended). However, where possible waste will be held in a secure external location in the waste compound until the HCID status of the patient is verified. Facilities to be informed if it is envisaged this will be over the recommended 24 hours.

9. Toilets and Commodes

9.1 Toilets must not be used.

9.2 Commodes must be decontaminated after each use with a 10,000ppm sodium hypochlorite solution. After use, the contents are to be solidified with high-absorbency gel and then incinerated. For non-ambulant patients, disposable bedpans should be used and the contents to be solidified with high-absorbency gel and then incinerated.

10. Linen

Linen used for patients who are possible or confirmed HCID must be treated as disposable. This must be place in the yellow clinical waste bag for incineration and must not go back to the laundry area.

11. Patient Care Equipment

11.1 Dedicated equipment must be used in the isolation room.

11.2 All reusable medical equipment must be thoroughly cleaned and disinfected with SoChlor or approved alternative. If there is contamination with blood, then the equipment must be disinfected with 10,000ppm sodium hypochlorite. All pieces of equipment should also undergo UVC decontamination before being returned to service. Any equipment that cannot be adequately cleaned and disinfected must be placed into waste bag and placed in a rigid container with a label detailing the product and serial number of the item and contact infection prevention for further advice.

11.3 The use of equipment that re-circulates air e.g. fans; hot air warming blankets must not be used.

11.4 Disposable crockery and cutlery must be used.

12. Last Offices

12.1 Handling of the body should be kept to a minimum. Washing and/or dressing of the body should be avoided. The body should be placed into a clear body bag with both ID tags clearly visible. This must be placed in a second clear body bag with absorbent material in between layers. The bag should be disinfected with 1,000ppm sodium hypochlorite solution.

The body bag should be wrapped in a clean sheet. Once sealed the body bag must not be opened without consultation with the Consultant in Health Protection or Infection Prevention Doctor.

12.2 Postmortem examination poses a significant risk to staff and should not be performed. Some diagnostic tests may be required but these must only be taken following discussion with the Pathologist, Consultant Microbiologist/ Virologist, and Consultant in Health Protection.

13. Accidental Exposure

13.1 If staff sustain accidental exposure to blood or body fluids either through percutaneous injury, contact with broken skin or mucocutaneous injury then they must follow measures detailed in the Occupational Health guidance.

13.2 Discuss immediately with Occupational Health or if out of hours, on-call Consultant Microbiologist.

14. Communications

Should a patient be admitted who is suspected of having or is confirmed of having HCID, no statement is to be made by the Trust or its staff without prior consultation with UKHSA and NHS England.

15. Room Decontamination

15.1 Routine daily cleaning of the side-room must be carried out by the nursing staff providing patient care. Disposable cleaning equipment such as cloths and mops must be used. Where disposable equipment is not available dedicated equipment must be used and disposed of as clinical waste on patient discharge.

15.2 If there is no contamination with blood or body fluids are present then 1,000ppm sodium hypochlorite can be used. Where there is contamination with blood or body fluids, 10,000ppm sodium hypochlorite solution product must be used. The area must then be cleaned with 1,000ppm sodium hypochlorite.

15.3 Decontamination on discharge

15.3.1 Patient is negative: Standard terminal cleaning to be performed.

13.3.2 Patient is either still suspected to have a HCID, or has a confirmed HCID:

- Following the discharge of the patient the room the room will be decontaminated. Staff decontaminating the room must wear the appropriate level of PPE as defined section 7. Decontamination will be undertaken in the following order:
    - Nursing staff will clean all spillages using 10,000ppm sodium hypochlorite solution
    - Nursing staff to clean the room with 1,000ppm sodium hypochlorite solution
    - Facilities to use UVC robot for decontamination of room.

13.3.3 The room must not be occupied by another individual until decontamination has been completed.

16. Occupational Health Screening

Occupational Health, in conjunction with the local UKHSA Health Protection Team will screen and monitor all staff who have been involved in the patient's treatment, or if they have come into contact with the samples if confirmed positive to ensure that there is no on-

going risk. They will risk assess staff to ensure that they are safe to return to work. This will include psychological support if required. Unless otherwise advised by UKHSA or Occupational Health there will be no restrictions on staff returning to work.

Full version control record

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Contributor(s):	Infection Prevention & Control Team
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This guideline has been registered with the Trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	21/10/2026	Victoria Gentry	FINAL	Guideline ratified at Healthcare Infection Control Committee 21/10/2026

Related Documents

Document Type	Document Name
National Infection Prevention & Control Manual	Addendum on high consequence infectious disease (HCID) personal protective equipment (PPE): https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/addendum-on-hcid-ppe/
E-learning	NHS High Consequence Infectious Disease e-learning resources: https://learninghub.nhs.uk/catalogue/HCID
IPC44: Guidelines for the Management of HCID Appendices II to XV	FHFT Extranet: https://our.fhft.nhs.uk/az-department-information-and-contacts/infection-prevention-and-control/navigate/9743/66003#document-library-66003
Plan	Command, Control, Coordination and Communication (C4) Plan
Plan	Trust Incident Response Plan