Table 6 -Summary of HCID IPC Considerations (adapted from CEC NSW)

No.	IPC	Requirements
1.	**Isolation**	**Single room** with ensuite **preferably with negative pressure** ventilation (where available). Where such facilities are not available, interim arrangements may be required, such as use of commodes, disposable urinals and bedpans in the patient's room and designating restricted areas outside of the patient's room. Isolation room should ideally have **an anteroom for putting on and taking off PPE**. If an anteroom is not available, identify a clearly marked donning and doffing zone outside the room. Consider the patient's individual needs, including safety and cognitive capacity, when placing them into isolation. This should be balanced with the need to protect other patients, H&CWs, and public health. Display transmission-based precautions signage on or near patient door and to be clearly visible before any staff/ entry.
2.	**Patient**	Patients to wear a **surgical mask** (as appropriate) as a precaution on triage / registration, prior to placement in the isolation room and during transport. **Limit patient movement** as feasible within the healthcare setting. Manage the patient's **presenting health condition** also with suspected/confirmed HCID requirements
3.	**Visitors/nominated support person**	**Visitors are not recommended** (as appropriate) until the risk is clarified. Risk assess requirements for a **parent/nominated support person/carer** to be with the patient (for example in the case of a child, a vulnerable adult or on compassionate grounds) and support as appropriate. Consider if they are also suspected cases or contacts.
4.	**Hand hygiene**	H&CWs and visitors - WHO five moments for hand hygiene.
5.	**Transmission based precautions**	Apply **standard precautions** for all patients at all times. Use contact, droplet, and airborne precautions based on PCRA. (Refer to Table 1 for examples of HCID pathogens and modes of transmission)
6.	**PPE**	Use **PPE** as per standard precautions with additional PPE based on PCRA (see Table 4 above). PPE **trained observer** to support putting on and taking off PPE (if possible). (Refer to **Appendix 3**).

7.	**Laboratory testing**	Refer to **Section 7** below. **Inform the laboratory in advance of high-risk exposure samples, and label as such.**
8.	**Sharps management**	**Limit the use of laboratory testing** to the minimum necessary for essential diagnostic evaluation and patient care and as per discussion ID consultant/Clinical Microbiology/IPC team. Refer to NCEC National Clinical Guideline No. 30 IPC- Vol 1 (page 48) Sharps containers disposal will follow local waste management and disposal process for waste (see below section on "waste management" in this table).
9.	**Communication**	**Inform H&CWs** of risks and risk management strategies for HCIDs. **Prior to transfer/or care**, relevant H&CWs must be informed of patient's suspected HCID status and exposure risks. Refer to local escalation pathways to communicate risk Maintain **patient privacy and confidentiality**.
10.	**Patient care equipment (Cleaning and Disinfection)**	Non-critical equipment In addition to routine management of non-critical clinical equipment, disinfection is also required, refer to NCEC National Clinical Guideline No. 30 IPC- Vol 1, Table 3 for a summary of good practice statements, Volume 1, Table 9 for cleaning requirements for routine environmental cleaning, and Volume 2, Figure 4 for processes for routine cleaning and product choice For semi-critical and critical equipment Ensure routine disinfection/sterilisation reprocessing occurs, but no additional disinfection or sterilisation cycle is required. Meal delivery Use disposable items for meals. Adhere to environmental and equipment cleaning and disinfection in accordance with NCEC National Clinical Guideline No. 30 IPC- Vol 1 see Section 3.1.3 Routine management of the physical environment, Volume 1, Section 3, Recommendation 13: page 94, Single use or patient dedicated equipment.
11.	**Environmental cleaning/ disinfection**	**Terminal clean/disinfection** • Disposable cleaning cloths, mop cloths, and wipes should be used, and discarded into the clinical waste after each clean. • All cleaning cloths and mop heads must not be reused and must be disposed of as clinical waste. • Mop handle to be thoroughly cleaned, and the cleaning trolley should not be taken into the room.

		• Clean from clean to dirty, patient room first then bathroom. • Change curtains/patient screens. Refer to NCEC National Clinical Guideline No. 30 IPC- Vol 1 from page 69-70 **Disinfection:** Refer to NCEC National Clinical Guideline No. 30 IPC- Vol 1 from page 60 "Use of disinfectants"
12.	**Linen**	**Disposable linen** is the preference for patient clothing and bed linen (where possible). **Dispose of linen in the patient's room**, in appropriate waste bag, not to be carried by H&CW. When handling soiled linen, use Level 1 PPE. Discard all linen, sheets, towels, blankets, patient gown as clinical waste (**Category A**) rather than laundering for reuse. The exception to this is mpox waste which can be treated as Category B. (**Appendix 5**) Avoid any unnecessary manipulation of linen, which should be disposed of safely. For other advice, manage linen in accordance with NCEC National Clinical Guideline No. 30 IPC- Vol 1 section 3.1.8 Handling of linen.
13.	**Waste management**	Waste management should follow best practice and be in accordance with the safe handling of all waste as national and local guidelines, specific legislation and regulations. Waste generated from patient(s) who have been categorised as increased possibility of HCID or have been confirmed with a HCID should be classified as **clinical waste**. This includes any single-use items (for example, PPE, cleaning cloths and wipes) which must be placed in a leakproof bag and discard as clinical waste. The categorisation of waste will vary depending on the HCID. Prior to collection by the contractor, waste must be stored securely, and access restricted to authorised and trained personnel. A waste contractor (appropriately trained and licensed) **must be consulted** to organise the safe transfer/disposal of the waste and must ensure documentation is maintained as part of quality controls and accountability.

		Note: All waste generated during cleaning and disinfection process should be treated as infectious waste. For further advice, refer to Waste management: refer to NCEC National Clinical Guideline No. 30 IPC- Vol 1, section 3.1.7. Advise on the categorisation of waste is available in Appendix 5.
14.	**Patient transfer**	**Adults** (individuals ≥ 16 years old) with confirmed HCIDs (or highly suspicious probable cases) may **be transferred to the NIU**, which is the national referral centre for high risk suspected and confirmed cases of HCID. International transfer of the patient and/or their contacts to Germany may be required (further management will be determined after discussion with the NIU.). The NIU will liaise and consult with key stakeholders to organise the transfer. Transfer of the patient will also depend on patient condition and suitability for transfer in consultation with the NIU. For **paediatric cases**, contact on-site Microbiologist AND Paediatric ID on call in CHI for urgent MDT assessment. If the patient is unstable or there is a delay in transfer, patient will require a **negative pressure room**, combined transmission-based precautions and to follow the advice in table 3 “Immediate actions to be followed”. **Home isolation** may be used for clinically well patients with possible, probable or confirmed cases as determined by the primary clinician. **Patients should be advised to remain in self-isolation pending test result**. Patients and their household contacts should be advised to adhere to Public Health advice on reducing their contacts and preventing infection.