Interior Health

SYNDROMIC SURVEILLANCE SCREENING TOOLKIT

Developed by IH IPAC in collaboration with the Emergency Services Network

INFECTION PREVENTION AND CONTROL
October 2024

For more information, contact IPAC@interiorhealth.ca

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Abbreviations

ARI	Acute Respiratory Infection
AP	Additional Precautions
AIIR	Airborne Infection Isolation Room
ABHR	Alcohol-Based Hand Rub
ARO	Antimicrobial -Resistant Organism
HCP	Healthcare Providers
IP	Infection Preventionist
PCRA	Point of Care Risk Assessment

Glossary of Terms

Acute Respiratory Infection (ARI)

Any new onset acute respiratory infection that could potentially be spread through the air (either upper or lower respiratory tract), which presents with symptoms of a fever greater than 38°C and a new or worsening cough or shortness of breath (previously known as febrile respiratory illness, or FRI). It should be noted that elderly people and people who are immunocompromised may not have a febrile response to a respiratory infection.

Additional Precautions (AP)

Precautions (i.e., Contact Precautions, Droplet Precautions andAirborne Precautions) that are necessary in addition to Routine Practices for certain pathogens or clinical presentations. These precautions are based on the method of transmission (e.g., contact, droplet, airborne).

Airborne Infection Isolation Room (AIIR)

A room that is designed, constructed, and ventilatedto limit the spread of airborne microorganisms from an infected occupant to the surrounding areas of the healthcare setting. This is also known as a negative pressure room. NOTE: The Canadian Standards Association uses the term Airborne Isolation Room, abbreviated AIIR.

Airborne Precautions

Used in addition to Routine Practices for clients/patients/residentsknown or suspected of having an illness transmitted by the airborne route (i.e., by small droplet nuclei that remain suspended in the air and may be inhaled by others).

Alcohol-Based Hand Rub (ABHR)

A liquid, gel, or foam formulation of alcohol (e.g., ethanol,isopropanol) which is used to reduce the number of microorganisms on hands in clinical situations when the hands are not visibly soiled. ABHR contain emollients to reduce skin irritation and are less time consuming to use than washing with soap and water.

Antimicrobial-Resistant Organism (ARO)

A microorganism that is resistant to the action ofone or more antimicrobial agents and that is of special clinical or epidemiological significance.

Contact Precautions

Used in addition to Routine Practices to reduce the risk of transmittinginfectious agents via contact with an infectious person.

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Droplet Precautions

Used in addition to Routine Practices for clients/patients/residentsknown or suspected of having an infection that can be transmitted by large infectious droplets.

Hand Hygiene

A general term referring to any action of hand cleaning. Hand hygiene relatesto the removal of visible soil and removal or killing of transient microorganisms from the hands. Hand hygiene may be accomplished using soap and running water or an Alcohol- Based Hand Rub. Hand hygiene includes surgical hand antisepsis. Hand Washing: The physical removal of microorganisms from the hands using soap (plain or antimicrobial) and running water.

Healthcare Providers (HCP)

Refers to both Regulated Healthcare Professionals (i.e. Physicians, Surgeons, and Nurses) and Non-regulated Healthcare Professionals (i.e. students,Medical Imaging Technologists).

Healthcare Settings

The term healthcare setting represents a broad array of services andplaces where healthcare occurs, including acute care hospitals, urgent care centres, rehabilitation centres, nursing homes and other long-term care facilities, specialized outpatient services (i.e. hemodialysis, dentistry, podiatry, and chemotherapy).

Infection Preventionist (IPs)

Trained individual(s) responsible for a healthcare setting is IPACactivities.

Point of Care Risk Assessment (PCRA)

The PCRA is a component of Routine Practice thatshould be conducted before every patient/client/resident interaction by a healthcare provider (HCP) to assess the likelihood of exposing themselves and/or others to infectiousagents.

Multidrug-Resistant Organism (MDRO)

While many definitions are often used to characterize patterns of multidrug resistance in medical community, one of the most frequently used definitions describe it as antimicrobial resistance shown by a species of microorganism to at least one antimicrobial drug in three or more antimicrobial classes.

Routine Practices (RP)

The system of infection prevention and control practices recommended by the Public Health Agency of Canada to be used with all clients/patients/residents during all care to prevent and control transmission of microorganisms in all healthcare settings.

Syndrome

A group of signs and symptoms that tend to appear together and collectively characterize a disorder.

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About this Document

Emergency departments (ED) are often the first point of entry for patients to the hospital setting. Implementing syndromic screening at the point of entry in ED involves recognition ofsigns and symptoms of infection that enables healthcare providers in ED to act in a timely manner to reduce the spread of infectious organisms. Syndromic screening serves as an earlywarning system that healthcare providers (HCP) use to detect contagious conditions (e.g., measles, tuberculosis, and prevent further spread by implementing appropriate precautions and the proper disposition of the patient (e.g. removal from waiting area and selection of Additional Precautions).

In addition to the Meditech screening tool available at some Interior Health ED sites, two quick reference documents have been developed for HCPs to use. The Infection Prevention and Control (IPAC) Syndromic Screening Requirements Table is a more detailed tool that gives information regarding management of a suspected condition whereas the Syndromic Additional Precautions Assessment Diagram for Emergency Departments Triage Area provides a quick reference to the type of additional precautions that needs to be implemented. These two documents should be used together for screening in ED Triage areas.

Safety measures that will be in place shall include the placement of Alcohol Based Hand Rub (ABHR), medical masks and posters at the ED entrance directing patients/family members toclean their hands and wear a medical mask (if tolerated) before entering the ED.

Electronic and paper screening forms will be available for HCPs to collect the required information for each of the syndromic categories. Supporting documents in the form of tablesand algorithms for each of the categories have been developed and are included to guide assessment and education for emergency HCPs.

Once the assessment is made that there is a potentially infectious patient, the triage nurse willdetermine if Additional Precautions are required in addition to Routine Practices.

This toolkit replaces the Emergency Department Screening toolkit (Oct 2022) and includes thedocuments required for each of the syndromic precautions assessment for Triage and Admission to the ED.

Although primarily oriented towards Emergency Departments, this toolkit is to be used in other areas of acute care in IH for assessment of patients for specific syndromes/conditions.This toolkit is provided as an adjunct to existing IPAC documents, which can be found here: Infection Prevention and Control - InsideNet

Implementation of the Screening Process

The ED screening process will occur in two phases:

1. Triage- where the assessment of the syndromic symptoms will identify a potentially infectious case and allow the triage nurse to ensure proper precautions are applied anddetermine the most appropriate disposition of the patient.

2. Admission to the ED and/or hospital for patients who have been triaged as potentially infectious where more detailed assessments and screening are required such as for respiratory Infection, gastrointestinal Infection, rash, or Antimicrobial-Resistant Organism (ARO)

Point-of-Care Risk Assessment (PCRA)

Point of Care Risk Assessment

Point-of-Care Risk Assessment (PCRA)

The PCRA is a routine practice that must be conducted by a health care worker (HCW) before every patient/client/resident (hereafter 'patient') interaction to assess the likelihood of exposing themselves and/or others to infectious agents. This assessment informs the selection of appropriate actions and personal protective equipment (PPE) to minimize the risk of exposure. This is a general tool. The questions and actions may need to be adapted for specific health care settings and/or roles.

1 Assess before each patient interaction

The patient

- ❑ What are the patient's clinical signs and symptoms related to transmissible infections (e.g., coughing, fever, diarrhoea, vomiting, rash, open wounds)?
- ❑ Does the patient have known conditions or risk factors that require additional precautions? If yes, what additional precautions are required?
- ❑ What is the patient's health status (e.g., are they clinically extremely vulnerable)?
- ❑ Is the patient able to practice personal infection prevention and control (IPC) measures (e.g., hand hygiene, respiratory etiquette) or follow simple instructions?

The task

- ❑ What type of task am I carrying out (e.g., personal care; a non-clinical interaction)?
- ❑ Am I providing direct face-to-face care (e.g., performing an aerosol generating medical procedure (AGMP)) or coming into contact with blood and body fluids?
- ❑ Am I trained, equipped and ready for the task?

The environment

- ❑ Do I have easy access to the equipment and supplies needed to carry out IPC practices (e.g., a sharps container, waste disposal bin, hand hygiene station, PPE, soiled linen hamper, cleaning and disinfection wipes, and other supplies)?
- ❑ Are additional precautions, such as patient placement, ventilation or cleaning practices, required and in place?

2 Plan and implement your actions

- ❑ Ensure appropriate cleaning and disinfection of equipment and the environment.
- ❑ Clean your hands according to the 4 moments of hand hygiene and before donning/after doffing PPE.
- ❑ Select appropriate PPE (see **Step 3**).
- ❑ Support the patient in following personal respiratory hygiene and other IPC measures.
- ❑ Assess the need for any additional precautions, such as:
  - Patient placement and accommodation (e.g., single room, spatial separation, physical barrier).
  - Additional cleaning and disinfection.
  - Signage.

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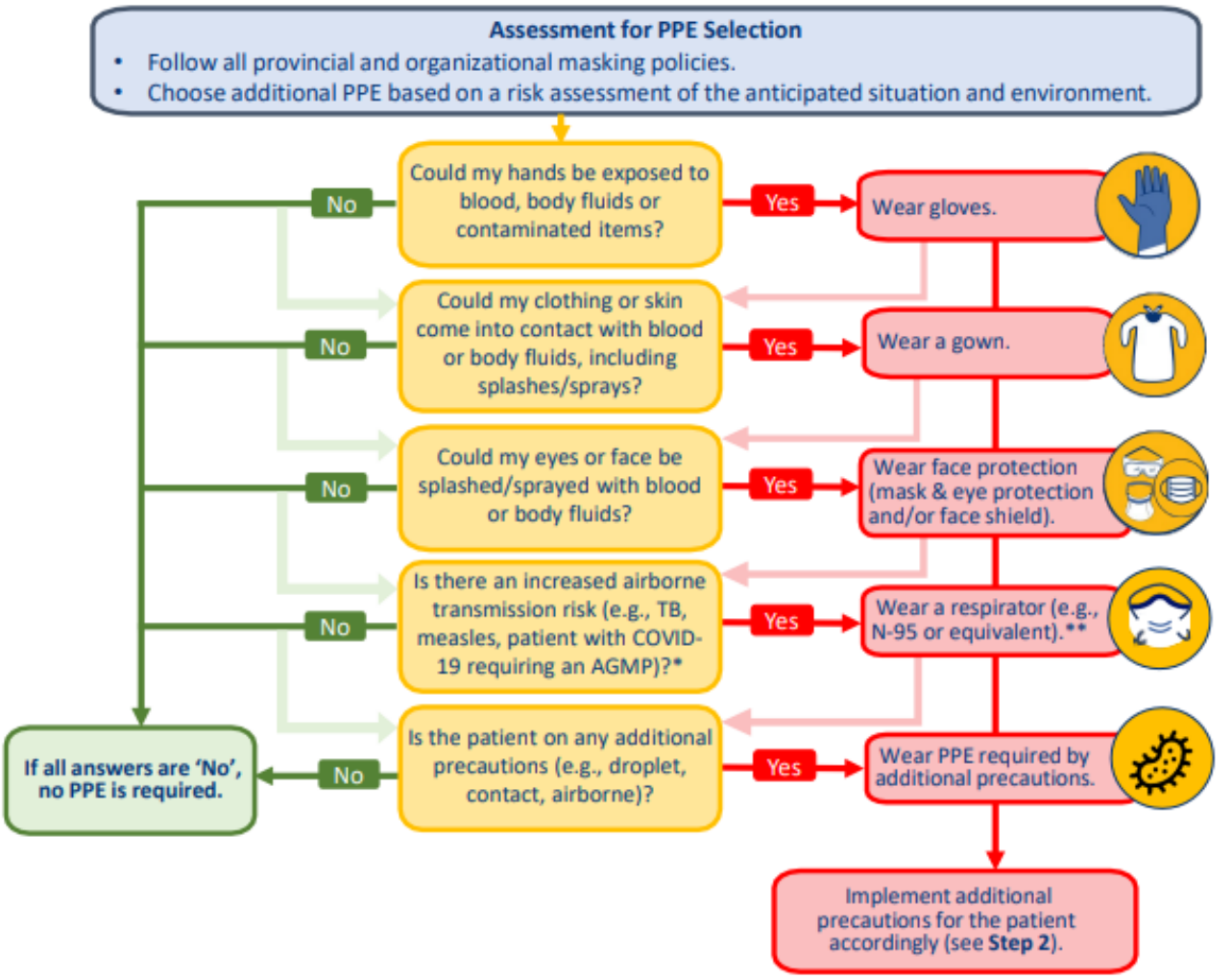
3 Choose appropriate PPE



** Note: An organizational risk assessment is essential for evaluating the hierarchy of controls to minimize risk. The assessment must include reviewing and maintaining ventilation systems. Measures to improve indoor air quality and ventilation are important to decrease the risk of aerosol transmission. See IPC ventilation resources for more information.*

*** Note: HCWs must only wear the respirator (i.e., N-95) that they have been currently fit-tested for and must perform a seal check prior to use. Other equivalent respirators, such as elastomeric half-face respirators (EHFRs if fit-tested) and powered air purifying respirators (PAPRs), may also be used if staff have been provided training on their appropriate use and if organizational procedures related to their use are followed. Respirators will be provided in circumstances where a HCW determines there is an elevated transmission risk through patient interaction.*

Local organizational guidance may include additional precautions required by local epidemiology and other considerations. Please consult your IPC and/or workplace health & safety teams as needed.

Last updated: July 25, 2023

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IPAC Syndromic Screening Requirements Table

Syndromic Symptoms	Precautions	Action	Disposition / Comments
Respiratory infection (RI) suspected. New or acutely worsening cough and fever, and/or chills, joint/muscular pain, extreme exhaustion/fatigue, sore throat, headache, runny nose, loss of sense of smell or taste[1].	Droplet & Contact	Place medical mask on a patient. Patients with respiratory infections should be placed directly into a single room. If this is not possible separate in waiting area and ensure masking and distancing (2m) from other patients	Single room is preferred. Restrict to bed space with dedicated toilet / commode and equipment if no single room available
Unknown Respiratory Infection & history of travel outside of Canada & United States in last 10 days (Possible emerging respiratory pathogen).	Airborne, Droplet & Contact	Place medical mask on a patient. Remove immediately from waiting area to Airborne Infection Isolation Room (AIIR) or SINGLE ROOM WITH DOORS CLOSED. Notify IPAC immediately.	For patients with unknown RI/ILI and history of international travel outside of Canada / USA isolation required until etiology of infection is established / organism confirmed. Follow IPAC instructions.
Avian Influenza (Birdflu) suspected[2].	Airborne, Droplet & Contact		
Tuberculosis suspected (cough/hemoptysis AND fever, fatigue, night sweats, weight loss).	Airborne		
Rash, Fever, Conjunctivitis suggestive of Measles.	Airborne, Droplet & Contact		
Vesicular rash suggestive of chickenpox, disseminated shingles or mpox.	Airborne & Contact		
Fever, Rash, Headache, altered LOC* Suggestive of an infectious process such as meningitis.	Droplet & Contact if pediatric	Place medical mask on a patient.	Restrict to bed space with dedicated toilet / commode and equipment if nosingle room available.
Necrotizing fasciitis suspected.	Droplet & Contact	Place medical mask on a patient.	
Diarrhea and / or vomiting of suspected infectious origin within last 48 hours.	Droplet & Contact if vomiting	Single room preferred, if no available, restrict to bed space area with dedicated toilet / commode and equipment.	
Diarrhea & suspected *C. Difficile* infection[3].	Contact Plus	Single room preferred, if no available, restrict to bed space area with dedicated toilet/commode and equipment.	
Patient received medical care outside of Canada in last year.	Contact Plus	Single room and dedicated equipment required.	Carbapenemase-producing Organisms (CPO) and/or *Candida auris.* Must be placed in a single room and dedicated equipment required
History of Carbapenemase-Producing organisms (CPO) or *Candida auris.*	Contact Plus	Single room and dedicated equipment mandatory. Notify IPAC immediately.	
History of MRSA**.	Contact	Single room preferred, if no available, restrict to bed space area with dedicated toilet/commode and equipment.	Restrict to bed space with dedicated toilet/commode and equipment if nosingle room available
Abscess or Draining Wound not contained by dressing.	Contact	Confine drainage.	

1. Clinically suspected RI: In children under 5, gastrointestinal symptoms may also be present. In patients under 5 or 65 and older, fever may not be prominent. **2.** Does the patient report close exposure within 10 days before symptom onset to birds, animals or another human with suspected or confirmed avian (bird) influenza A virus infection Exposure may include: being in the same close airspace (< 2meters); touching or handling; consuming under- or uncooked poultry or egg products; direct contact with contaminated surfaces; exposure to manure or litter containing high concentration of virus or a contaminated air space/environment; visiting a live poultry market with confirmed bird infections or associated with a case of human infection. **3.** History of hospitalization or antibiotic use within past 90 days, residence at a long-term care facility, history of *C. difficile* infection; *Level of consciousness; ** Methicillin-resistant *Staphylococcus aureus;* **If the patient is unable to answer any of the following questions initiate appropriate precautions based on best information available**

For more information, contact IPAC@interiorhealth.ca
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Syndromic Additional Precautions Assessment for Emergency Departments Triage Area

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ASSESS PATIENT ON ARRIVAL TO EMERGENCY DEPARTMENT FOR ANY OF THE FOLLOWING

March 28, 2025

Respiratory Infection (RI)[1]

Place medical mask on a patient

- Travel Outside of Canada / USA in last 10 days[2]? Yes → Airborne, Droplet & Contact
- No → Avian Influenza (Birdflu) suspected? Yes → Airborne, Droplet & Contact
- No → Tuberculosis suspected[3]? Yes → Airborne[2]
- No → Respiratory Infection[1] suspected? Yes → Droplet & Contact
- No → Routine Practices / PCRA*

Rash & Fever

Place medical mask on patient

- Measles[4] suspected? Yes → Airborne, Droplet & Contact
- No → MPOX suspected? Yes → Airborne, Droplet & Contact
- No → Chickenpox or Disseminated Zoster suspected? Yes → Airborne & Contact
- No → Meningitis[5] suspected? Yes → Droplet & Contact
- No → NECROTIZING FASCIITIS suspected? Yes → Droplet & Contact
- No → Routine Practices / PCRA*

Diarrhea & Vomiting[6]

- *C. difficile* infection suspected[7]? Yes → Contact PLUS
- No → Diarrhea infectious or unknown origin? Yes → Contact
- No → VOMITING infectious or unknown origin? Yes → Droplet & Contact
- No → Routine Practices / PCRA*

ARO** Risk

- Received Medical Care Outside of Canada in last year? Yes → Contact PLUS
- No → History of CPO*** and/or Candida auris? Yes → Contact PLUS
- No → History of MRSA****? Yes → Contact
- No → Abscess or Draining Wound not contained by dressing? Yes → Contact
- No → Routine Practices / PCRA*

1. Clinically suspected RI - New or acutely worsening cough and fever and/or chills, joint/muscular pain, extreme exhaustion/ fatigue, sore throat, headache, runny nose, loss of sense of smell or taste. In children under 5, gastrointestinal symptoms may also be present. In patients under 5 or 65 and older, fever may not be prominent.

2. Required until etiology of infection is differentiated/organism cconfirmed**.** Follow IPAC instructions.

3. Cough/hemoptysis AND fever, fatigue, night sweats, weight loss.

4. Clinically suspected measles/generalized rash and fever and exposure to measles case/visit to area with documented measles outbreak.

5. Fever, rash, headache, altered level of consciousness suggestive of an infectious process such as meningitis.

6. Diarrhea of suspected infectious origin within last 48 hours. Diarrhea is defined as 3 or more loose bowel movements OR output greater than usual.

7. History of C. d*ifficile* infection, hospitalization or antibiotic use within past 90 days.

* Point of Care Risk Assessment
** Antimicrobial-resistant Organisms
*** Carbapenemase-producing Organisms
**** Methicillin-resistant *Staphylococcus aureus*

Use this diagram with IPAC Syndromic Screening Requirements Table #828720

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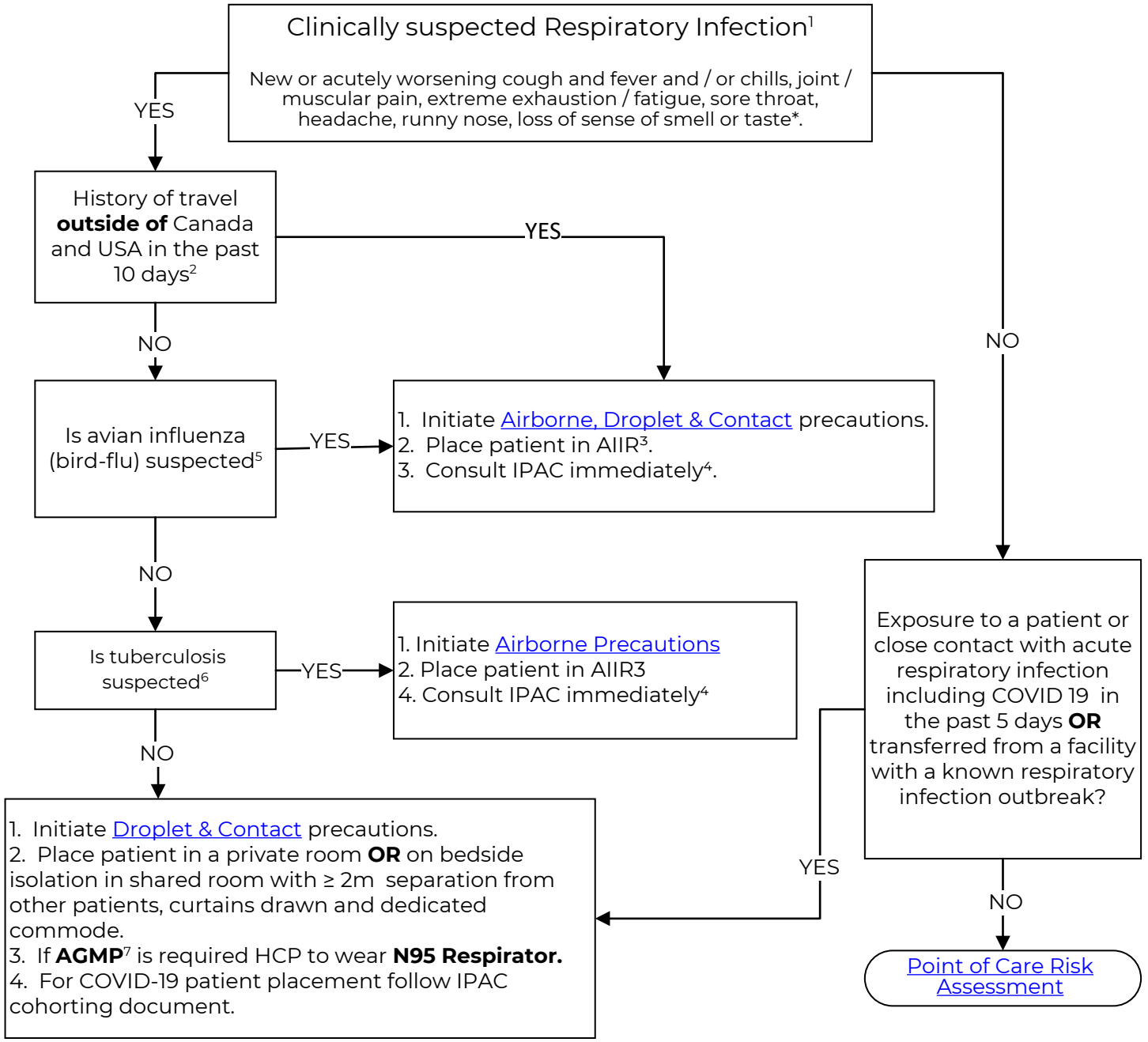
RESPIRATORY INFECTION (RI) ADDITIONAL PRECAUTIONS ASSESSMENT

May 2025



LEGEND

1. Clinical assessment and evaluation of individual patient by healthcare provider and impression of respiratory infection.
2. Symptoms may include cough OR hemoptysis AND fever, fatigue, night sweats or weight loss.
3. Airborne Infection Isolation Room (AIIR). If AIIR not available place patient in **a private room with door closed.**
4. Consult IPAC during workhours and Medical Microbiologist on call after hours and inform them about case.
5. Exposure within 10 days before symptom onset to poultry OR exposure to birds, animals or another human with suspected or confirmed avian (bird) influenza A virus infection. Being in the same close airspace (< 2meters); touching or handling; consuming under- or uncooked poultry or egg products; direct contact with contaminated surfaces; exposure to manure or litter containing high concentration of virus or a contaminated air space/environment; visiting a live poultry market with confirmed bird infections or associated with a case of human infection.
6. Symptoms may include cough or hemoptysis AND fever, fatigue, night sweats or weight loss.
7. Aerosol Generating Medical Procedure.

*In children under 5, gastrointestinal symptoms may also be present. In patients under 5 or 65 and older, fever may not be prominent

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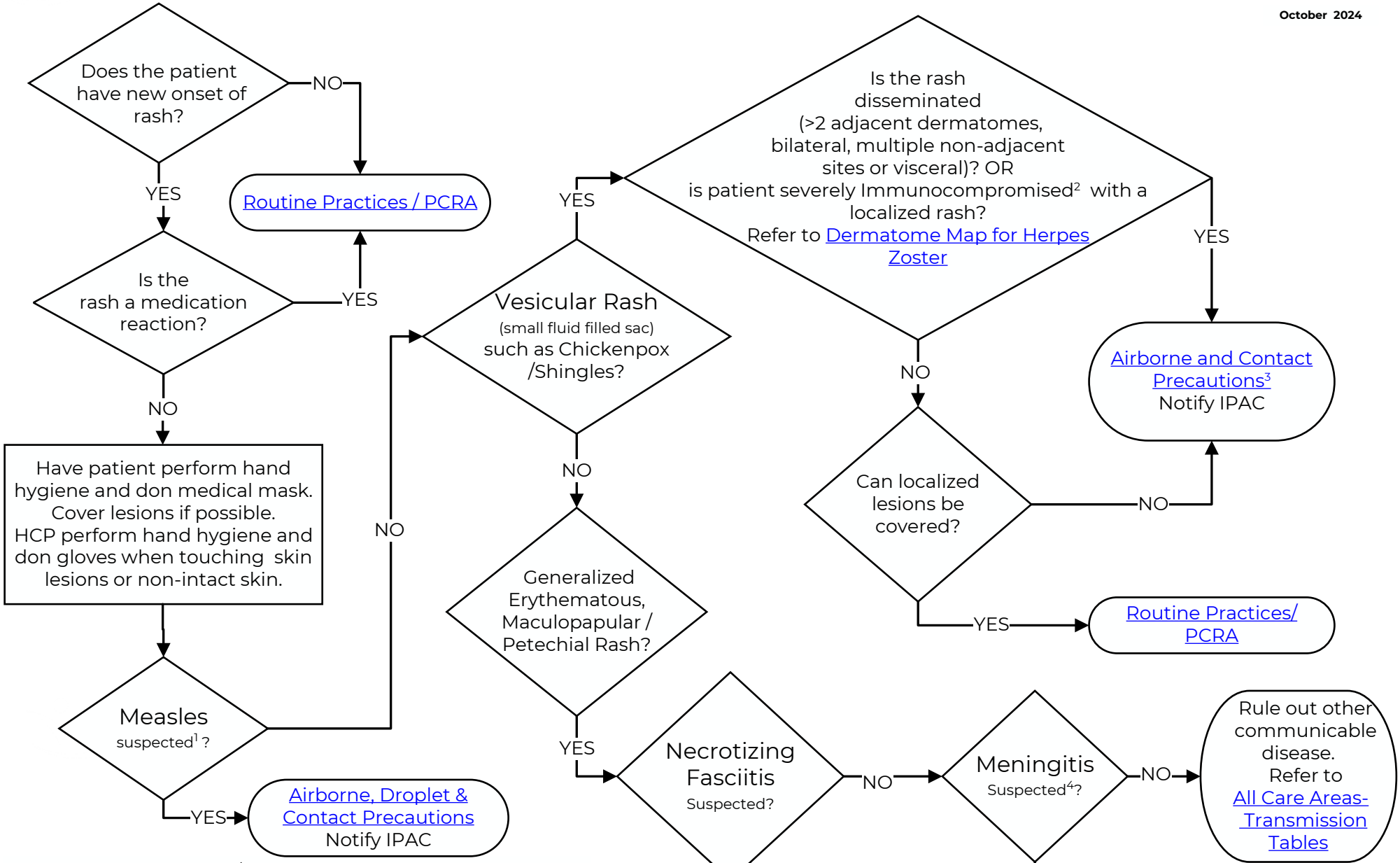
Rash & Fever Additional Precautions Assessment

October 2024

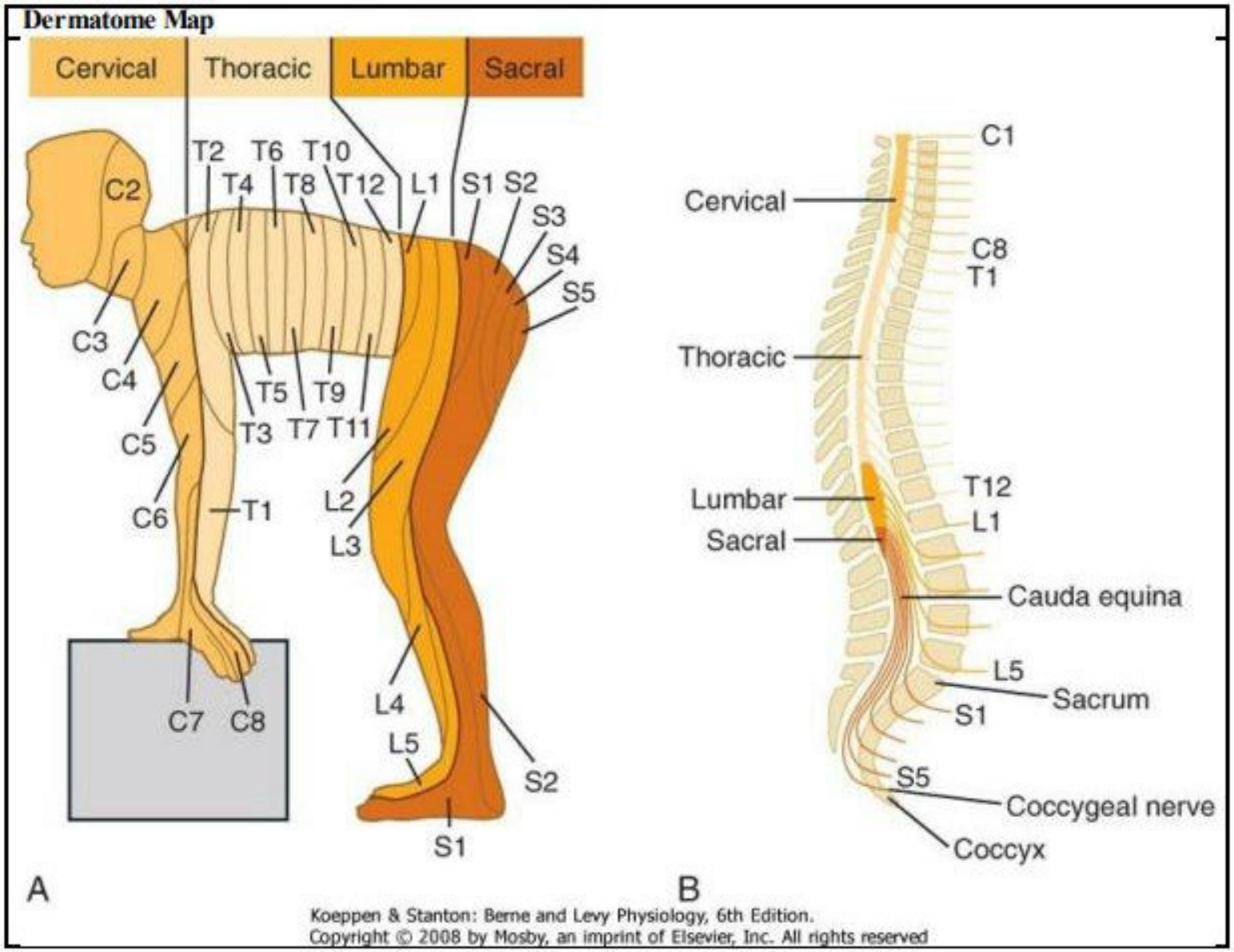


1. Clinically suspected measles/generalized rash and fever and exposure to measles case / visit to area with documented measles outbreak.
2. Refer to Immunocompromised Patients Definitions
3. If an Airborne Infection Isolation Room is not available, then place patient in a private room with doors closed.
4. Fever, rash, headache, altered level of consciousness.

*Droplet & Contact Precautions for pediatric population

For more information, contact IPAC@interiorhealth.ca

Dermatome Map for Herpes Zoster (Shingles) Assessment



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A ***PRINTED*** copy of this resource may not be the most recent version.

Emergency Department See, Think, Do– Approach to Suspect Measles

Follow Routine Practice and Point-of-Care Risk Assessment (PCRA)
With every patient, every task, every time.

SEE Presenting Complaint	THINK Travel/Exposure/Immunity	DO Patient Accommodation
FEVER & RASH Clinical signs Fever (≥ 38.3°C) **and c**ough, runny nose (**c**oryza) or **c**onjunctivitis, **followed by** Generalized maculopapular rash appearing 3-7 days after symptom onset.	**Could it be** Measles**?** Look for: Risk factors. Known Exposure to measles case or area with documented measles outbreak or recent travel. Born 1970 or later **and** unvaccinated against measles / has only received 1 dose of measles-containing vaccine/unsure of immunity.	• **Patient to don medical mask immediately.** • Remove patient from waiting room. • Place patient in AIIR room with DOOR CLOSED. • If no AIIR room available place patient in SINGLE ROOM with DOOR CLOSED. • Post Airborne, Droplet & Contact sign outside room. • Alert physician immediately. • Notify local **Infection Preventionist or** on call Medical Microbiologist (evenings & weekends) for case follow up. ***See Test & Report***

TEST

- **ED physician to assess patient for clinical signs of measles and risk factors** (see above box): date of onset of each sign should be noted, especially rash.
- **ED physician to order:** Measles PCR on urine **AND** nasopharyngeal swab specimens **AND** measles IgM & IgG serology. *Samples should be collected before discharge*.

REPORT

If clinical signs highly suspicious for measles and risk factors for measles present, ED physician to immediately phone CD Unit at 1-866-778-7736 (M-F, 8:30-16:30) **or** On-call Medical Health Officer (MHO) 1-866-457-5648 (evenings & weekends) to assess likelihood of measles case.

Treatment

Treatment recommendations are from Child Health BC and approved for guidance in Interior Health.

There is no specific antiviral treatment for measles infection. Medical management is supportive and aimed at symptom relief and management of complications.

If suspected secondary bacterial infection, before starting antimicrobial therapy, take blood and any other relevant samples for culture and treat with antibiotics (refer to the Empiric Antimicrobial Guide on PHSA SHOP).

- Moderate to severe otitis media — amoxicillin PO or amoxicillin-clavulanate PO
- Pneumonia — amoxicillin PO or ampicillin IV
- Sepsis — cefotaxime or ceftriaxone IV (refer to Provincial Pediatric Sepsis Recognition and Management Guideline on PHSA SHOP)

Use of Vitamin A: Vitamin A does NOT prevent or treat measles but there is evidence that patients with measles who are treated with vitamin A have decreased risk of mortality and severe ophthalmologic sequelae. Vitamin A should be given in the doses outlined below (higher doses pose risk of vitamin A toxicity).

Give vitamin A for confirmed or highly suspected diagnoses of measles in children who have not already had one or more doses of vitamin A if:

- they require **admission to hospital**
- OR they have **immune compromising conditions (even if admission to hospital is not needed)**

In these situations, give vitamin A orally once daily for 2 days, as follows:

- Infants < 6 months of age — 50,000 international units
- Infants 6 to 11 months of age — 100,000 international units
- Children ≥12 months — 200,000 international units

For patients with chronic kidney disease, consult pediatric nephrology at BC Children's Hospital (604-875-2345, page the pediatric nephrologist on call) prior to initiating vitamin A.

Two products of oral vitamin A are available:

- Vitamin A liquid containing 10,000 international units per drop (approx. 0.033 mL). This is the **preferred product** for pediatric patients. A dose of 100,000 international units is 10 drops or 0.33 mL.
- Vitamin A oral capsule containing 10,000 international unit per capsule (not appropriate for young children or for the dosages recommended in the management of measles).

Additional IH Resources

1. Infection Prevention and Control (IPAC): Measles Resource
2. Infection Prevention and Control (IPAC): Measles Quick Guide
3. Management of Patient Requiring Airborne Isolation IN THE ABSENCE OF AIIRs
4. Clinical Care of Children/Youth (age 0 – 17 years) with Suspected or Confirmed Measles

Effective Date	May 1, 2025,		
Partners Reviewed	CDU, ED		
Last Reviewed			
Approved By	IPAC		
Owner	Infection Prevention and Control		
Revision History	Date	Section	Revision
	July 3, 2025	Treatment	New section

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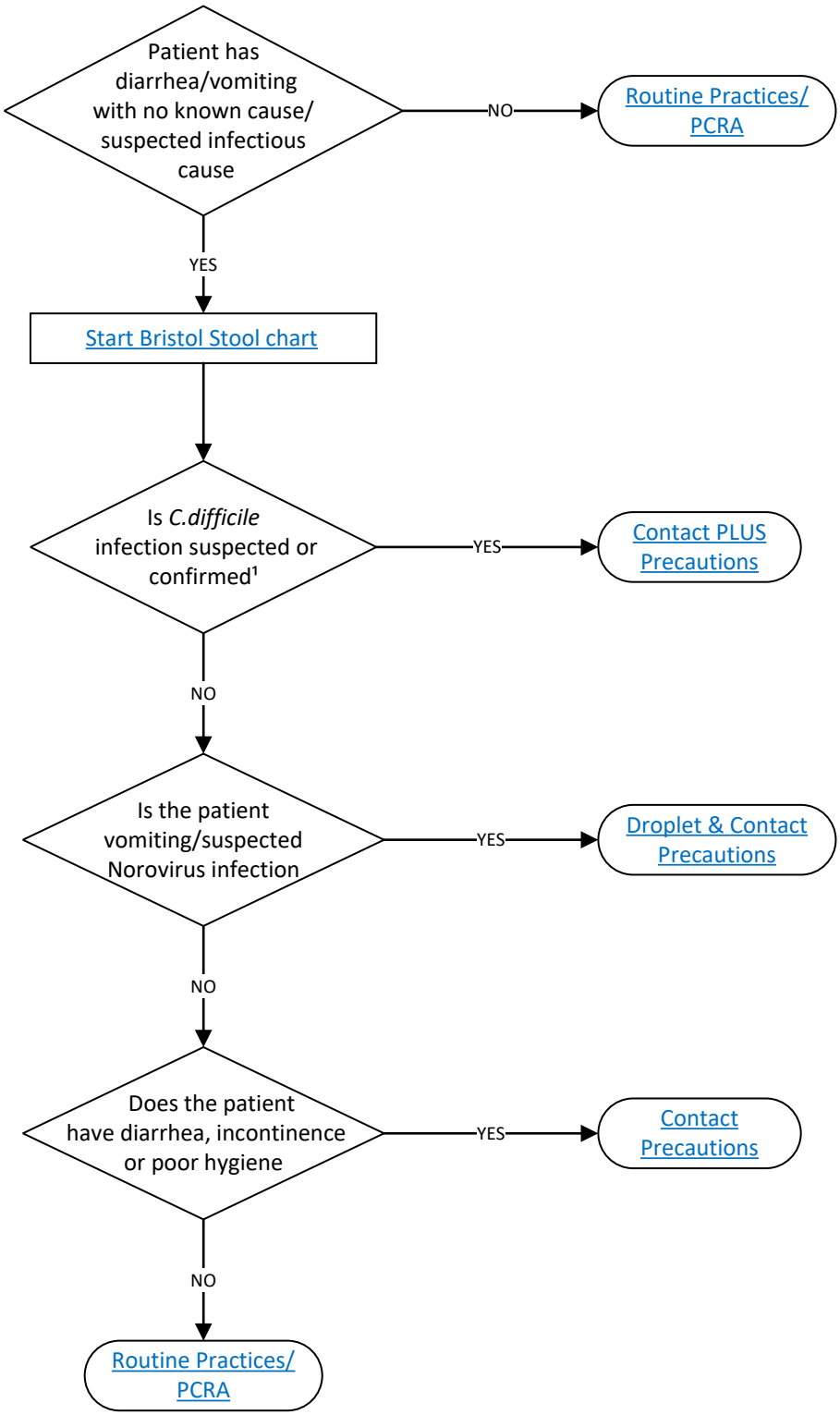
GASTROINTESTINAL INFECTION ADDITIONAL PRECAUTIONS ASSESSMENT

October 2024



LEGEND

1. History of hospitalization or antibiotic use within past 90 days, residence at a Long Term Care facility, history of *C. difficile* infection.

PCRA Point of Care Risk Assessment

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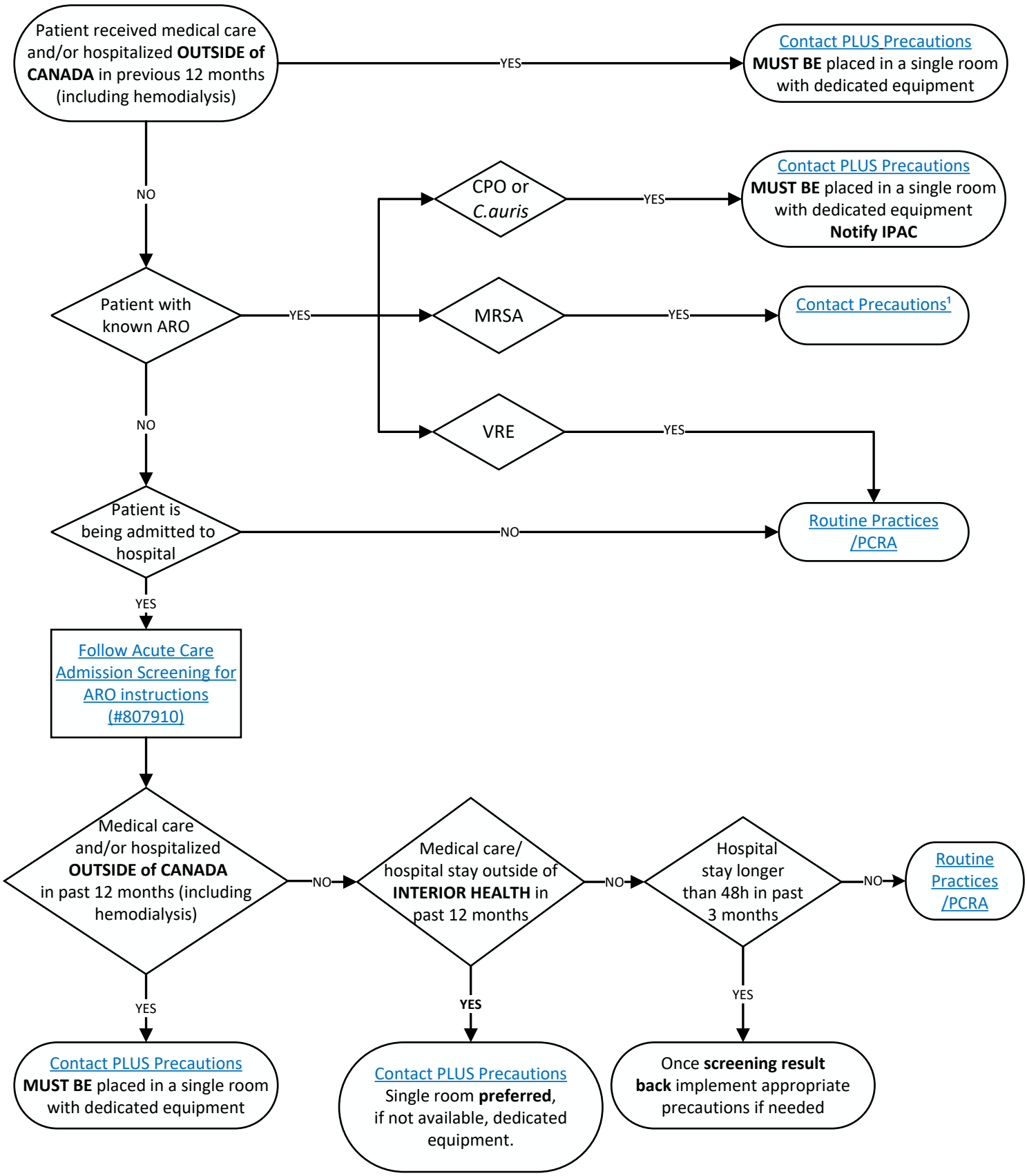
ANTIMICROBIAL-RESISTANT ORGANISMS (ARO) ADDITIONAL PRECAUTIONS ASSESSMENT

September 2024



[1] Review Contact Precautions for guidance on Patient Placement and Accommodations

For additional information contact IPAC@interiorhealth.ca

ARO Antimicrobial-resistant Organism
CPO Carbapenem-producing Organisms
MRSA Methicillin-resistant *Staphylococcus aureus*
PCRA Point of Care Risk Assessment
VRE Vancomycin-resistant enterococci

Definition & Management of Immunocompromised Patients

I. Definition of an Immunocompromised Patient

The Interior Health Authority All Care Areas - Transmission Tables identifies specific requirements for immunocompromised patients in several of the diseases and conditions. These patients may require an extended duration for Additional Precautions because of reduced immune response in clearing certain infections, prolonged shedding of a microorganism, greater risk of developing or reactivating certain infections or an atypical presentation of a communicable illness. Patients with at least one of the following criteria are considered to be clinically immunocompromised and require special considerationas outlined in the diseases and conditions descriptions in the All Care Areas - Transmission Tables.

- Hematopoietic stem cell transplant patients in the first 24 months after transplant.
- Patients with neutrophil count $< 0.5 \times 10^9$/ L for duration ≥ 48 hours.
- Patients receiving corticosteroid therapy equivalent to prednisone ≥ 20mg/day for duration of≥ two weeks.
- HIV positive patients with CD4< 200 x 10^6/ L.
- Patients with inflammatory bowel disease, rheumatologic conditions, multiple sclerosis, or solid organ recipients receiving immunosuppressive therapy, such as, infliximab, etanercept, and methotrexate.
- Oncology patients receiving chemotherapy.
- Oncology patients receiving active radiation other than internal radiation (e.g. brachytherapy) or radiation therapy limited to very small, focused areas (e.g. for localized skin cancers).
- Patients with extensive loss of skin/mucous membrane barrier defenses e.g., graft versus host disease, Steven-Johnson syndrome, scalded skin syndrome, major burns.
- Patients with congenital or acquired hypogammaglobinemia or agammaglobulinemia, severe.
- combined immunodeficiency or other congenital immune deficiency syndrome.
- Hematopoietic stem cell transplant patients.

Other conditions causing immunocompromised patient status may be identified or require consultationwith Infection Prevention and Control (IPAC) staff.

II. Management of Immunocompromised Patients

Accommodation in a single room with washroom is preferred for all patients considered to be clinicallyimmunocompromised. Routine Practices are the standard of care when working with immunocompromised patients. If an immunocompromised patient is suspected or known to have a communicable illness, implement the appropriate Additional Precautions in addition to Routine Practices.

For specialized units that predominantly care for clinically immunocompromised patients, it isrequired to exclude:

- Plants and flowers (fresh, dried, and artificial)
- Pet therapy and pet visitation

Special attention to minimize dust accumulation and dispersal is advisable (e.g. no fans, no clutter,routine cleaning, and disinfection practices).

For immunocompromised patients who are not on these specialized units, please consult with IPACstaff to determine if these exclusions are applicable for the individual patient.

A protective environment room is the preferred accommodation only for hematopoietic stem cell transplant recipients. This is a specially engineered patient room with hepafiltered supply air and positive pressure airflow designed to minimize fungal spore counts in the air. In absence of a protectiveenvironment, a single room is recommended for hematopoietic stem cell transplant recipients.

"Reverse isolation" is an outdated term and practice without evidence of benefit for hospitalizedimmunocompromised patients and such measures are not recommended.

Reference Resources

Guidelines for Preventing Infections Complications Among Hematopoietic Cell Transplantation Recipients: A Global Perspective" (Endorsed by IDSA) Biol Blood Marrow Transplant; 2009; 15:1143-1238. http://www.idsociety.org/OtherGuidelines/

Guidelines for Preventing Opportunistic Infections Among HIV-Infected Persons --- 2002. MMWRReports and Recommendations. MMWR Recommendations and Reports. 51(RR08)1-46. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5108a1.htm

Guidelines for Environmental Infection Control in Health-Care Facilities. Recommendations of CDC andthe Healthcare Infection Control Practices Advisory Committee (HICPAC). MMWR Recommendations and Reports. 52(RR10)1-42
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in HealthcareSettings. Table 5. Components of a Protective Environment. Adapted from MMWR 2003:52(RR10) http://www.cdc.gov/hicpac/2007IP/2007ip_table5.html

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American Cancer Society, Infections in People with Cancer, Last Medical Review: 2/16/2015 LastRevised: 2/25/2015.
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Emergency Department Mpox Assessment Algorithm

Contact[1] with suspected, probable, or confirmed caseof mpox within 21 days of symptom onset
OR
Travel to areas[2] where suspected or confirmed mpox cases have been identified in the 21 days before symptom onset

YES

Patient presents with acute **rash**[3] and ANY of the symptoms[4]

- fever (>38.5°C)
- lymphadenopathy
- back pain
- headache
- myalgia
- weakness/fatigue

OR
An unexplained acute genital, perianal, or oral lesion(s) **with or without** symptoms

YES

- Place patient in a single room with door closed or airborne isolation room if available (AIIR)
- Place patient on airborne, contact and droplet precautions
- Collect appropriate specimen: (BLUE TOP UTM swab)
  - Viral swab of vesicular/pustular fluid (use single swab on 2-3 open or recently unroofed lesions) **AND/OR**
  - Lesion material (roofs, crusts, aspirate, exudate tissue) **AND/OR**
  - Tissue biopsy in sterile container **AND/OR**
  - Rectal swab if proctitis present
- Order Monkeypox Virus Skin swab OR Monkeypox Virus Skin lesion

ED/Unit staff to contact the Communicable Disease Unit by phone at 1-866-778-7736 Monday to Friday 8am to 4pm or by email (CDUnit@interiorhealth.ca) or fax 1-250-549-6310 during off hours for follow-up the next business day. Direct notification to the MHO is not required.

Is patient being admitted to hospital?

YES

- Place patient in a single room with door closed or airborne isolation room if available (AIIR)
- Place patient on airborne, contact and droplet precautions
- Contact Infection Preventionist (Monday-Friday 8am-4pm) or microbiologist on call (off hours) to report case
- If positive, patient should continue on isolation until all lesions have resolved, and a fresh layer of skin has formed
- For discontinuation of isolation contact Infection Preventionist

NO

- Instruct patient to avoid close, intimate contact and sex with others
- Do not share towels, clothing, sheets or other things that have touched your skin
- Continue to cover any sores or blisters as much as possible with clothing or bandages

NO

Contact[1] with suspected, probable or confirmed case of mpox within the past 21 days

NO

Further isolation based on clinical assessment

YES

Clinician to contact Communicable Disease Unit (CDU) to determine need for **post exposure prophylaxis** by phone at 1-866-778-7736 Monday to Friday 8am to 4pm or by email (CDUnit@interiorhealth.ca) or fax 1-250-549-6310 during off hours for follow-up the next business day. Direct notification to the MHO is not required

Is patient being admitted to hospital?

YES

- Place patient in a single room with door closed or airborne isolation room if available (AIIR)
- Place patient on airborne, contact and droplet precautions for at least 21 days from their last exposure if symptoms do not develop
- Contact Infection Preventionist (Monday-Friday 8am-4pm) or microbiologist on call (off hours) to report case

NO

- Instruct patient to self- monitor for symptoms for 21 days from their last exposure.

Effective Date	August 2022		
Last Reviewed			
Approved By	IPAC		
Owner	Infection Prevention & Control		
Revision History	Date	Section	Revision
	May 2024	Title, Risk Factors	Mpox, formly designated monkeypox

Note: *mpox, formerly designated monkeypox*
Legend:

[1] Face-to-face exposure, including health workers without eye and respiratory protection; direct physical contact with skin or skin lesions, including sexual contact; or contact with contaminated materials such as clothing, bedding or utensils.

[2] For cities or regions with mpox cases, please visit: https://www.who.int/emergencies/disease-outbreak-news/item/2022-DON385

[3] The rash associated with mpox can be confused with other diseases that are encountered in clinical practice (e.g., secondary syphilis, herpes, chancroid, and varicella zoster). **However, a high index of suspicion for mpox is warranted when evaluating** people with a characteristic rash, particularly for individuals who report anonymous sexual contacts and who present with lesions in the genital/perianal area or for individuals reporting a significant travel history in the month before illness onset or contact with a suspected or confirmed case of monkeypox.

[4] Skin rash typically develops 1 to 5 days after prodromal symptoms such as fever, headache, myalgia, lymphadenopathy, back pain, headache, or weakness/ fatigue. **Prodromal symptoms can be absent or occur later.** For details about clinical presentation visit:http://www.bccdc.ca/health-professionals/clinical-resources/mpox#clinical

Effective Date	December 2023		
Last Reviewed	October 2024		
Approved By	IPAC		
Owner	Infection Prevention and Control		
Revision History	Date	Section	Revision
	April 19, 2024	P.13	Addition of Measles Algorithm
	May 2024	P.18	Addition of Mpox Algorithm
	October 2024		Point of Care Risk Assessment Updated ARO Diagram Updated Updated Additional Precaution signs and Resource links