**Procedure for Infection Prevention and Control Management of Seasonal and Pandemic Influenza**

**Version: 3**

<table>
<thead>
<tr>
<th>Summary:</th>
<th>This Procedure for IPC Management of Seasonal and Pandemic Influenza describe how SHFT will respond to cases of seasonal influenza and manage a pandemic influenza situation. The Action Cards aim to provide clear guidance to SHFT employees in their roles supporting the SHFT response to cases of seasonal influenza or pandemic flu.</th>
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<tbody>
<tr>
<td>Keywords (minimum of 5): (To assist policy search engine)</td>
<td>Seasonal influenza, influenza, influenza management, pandemic, pandemic influenza, influenza plan, infection prevention and control.</td>
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| Target audience: | All Directors, Senior and Area Managers on Call will ensure they are familiar with this Influenza Plan and associated Action Cards and will keep current copies together with an up to date list of the names and contact details of the Senior and Area Managers on Call in their On Call Packs which they will have access to while on call.  

All SHFT Managers will maintain an up to date list of the names and contact details of the staff in their team which they will be able to access in the event of an influenza pandemic. |
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| Approved and ratified by: | EPRR Working Group  
IPC Group  
Date of meeting: |
| Date issued: | February 2017 |
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### Version Control

#### Change Record

<table>
<thead>
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</tr>
</thead>
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<tr>
<td>11/08/2015</td>
<td>P. Rudin/T. Lewis</td>
<td>2</td>
<td></td>
<td>Include references to LRF Pandemic Influenza Response Framework and update contact numbers.</td>
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<td>21/04/16</td>
<td>P. Rudin/T. Lewis</td>
<td>2</td>
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<td>3</td>
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<thead>
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<td>EPRR Working Group</td>
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</tr>
</tbody>
</table>
For Summary Flow Chart for Managing Suspected/Confirmed Cases of Flu go straight to Appendix A page 18

## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>Alerting Southern Health NHS Foundation Trust (SHFT) to an Influenza Pandemic</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>SHFT Response to an Influenza Pandemic</td>
<td>5</td>
</tr>
<tr>
<td>4.</td>
<td>Managing the workforce issues</td>
<td>6</td>
</tr>
<tr>
<td>5.</td>
<td>Training</td>
<td>6</td>
</tr>
<tr>
<td>6.</td>
<td>Infection Control – all patients with known or suspected influenza</td>
<td>6</td>
</tr>
<tr>
<td>7.</td>
<td>Surveillance</td>
<td>15</td>
</tr>
<tr>
<td>8.</td>
<td>Action Cards</td>
<td>16</td>
</tr>
<tr>
<td>9.</td>
<td>Establishing Anti-viral Collection Points</td>
<td>16</td>
</tr>
<tr>
<td>10.</td>
<td>Supporting references</td>
<td>17</td>
</tr>
</tbody>
</table>

## Appendices

<table>
<thead>
<tr>
<th>Appendices</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Flow Chart for Managing Flu Cases - Inpatient</td>
<td>18</td>
</tr>
<tr>
<td>B</td>
<td><strong>Lymington New Forest Hospital Only:</strong> Contact Tracing List Of A Suspected Flu Patient (Index) Not Isolated on Admission</td>
<td>20</td>
</tr>
<tr>
<td>C</td>
<td>FFP3 Fit Testing – competencies</td>
<td>21</td>
</tr>
<tr>
<td>D</td>
<td>Staff Health &amp; Illness relating to Infection Control</td>
<td>22</td>
</tr>
<tr>
<td>E</td>
<td>Flu Symptoms Poster</td>
<td>24</td>
</tr>
<tr>
<td>F</td>
<td>Information for Patients</td>
<td>25</td>
</tr>
<tr>
<td>G</td>
<td>Seasonal / Pandemic Flu Action Cards</td>
<td>27</td>
</tr>
</tbody>
</table>
Seasonal Influenza Management and Pandemic Influenza Plan

1. Introduction

Pandemic influenza is recognized by the Government as the single most disruptive event facing the UK today (NHS England 2013). As such this remains at the top of the UK Government National Risk Register, and on Local Resilience Forums Community Risk Registers.

There are three types of influenza virus – A, B and C. Influenza A viruses cause most winter epidemics and can affect a wide range of animal species as well as humans. Pandemic influenza occurs when an influenza A virus subtype emerges or re-emerges which is markedly different from recently circulating strains. This new strain can spread widely because few people will have acquired immunity to it. It is readily transmissible from person to person and capable of causing illness in a large proportion of those infected (DH 2011)

NHS England is responsible for leading the mobilisation of the NHS economy in the event of an emergency or incident and for ensuring it has both the capability and capacity for service delivery and for NHS command, control communication and coordination and leadership of all providers of NHS funded care.

This Seasonal Influenza Plan and associated Action Cards are appendices to the Southern Health NHS Foundation Trust (SHFT) Incident Response Plan, and these documents should be read in conjunction. The Incident Response Plan provides the strategic framework by which SHFT will plan, prepare for, practise and respond to major incidents and business continuity events and therefore meet its emergency preparedness responsibilities. The Incident Response Plan will be used in concert with this plan upon invocation in response to seasonal or pandemic influenza. This Procedure for Infection Prevention and Control Management of Seasonal and Pandemic Influenza describe how SHFT will respond to cases of seasonal influenza and manage a pandemic influenza situation. The Action Cards aim to provide clear guidance to SHFT employees in their roles supporting the SHFT response to cases of seasonal flu and an influenza pandemic.

All Directors, Senior and Area Managers on Call will ensure they are familiar with this Influenza Plan and associated Action Cards and will keep current copies together with an up to date list of the names and contact details of the Senior and Area Managers on Call in their On Call Packs which they will have access to while on call.

All SHFT Managers will maintain an up to date list of the names and contact details of the staff in their team which they will be able to access in the event of an influenza pandemic.

2. Alerting Southern Health NHS Foundation Trust to an influenza pandemic

In 2011 UK Influenza Preparedness Strategy (DH 2011) recognised a more flexible approach was required to prepare and respond to pandemic influenza and identified 5 states:

- **Detection**: This phase would commence when an influenza-related ‘Public Health Emergency of International Concern’ (PHEIC) is declared by World Health Organisation (WHO). The indicator for moving to the next stage would be the identification of the novel influenza virus in patients in the UK
- **Assessment**: The indicator for moving from this stage would be evidence of sustained community transmission of the virus
- **Treatment**: Treatment of individual cases / or populations via the National Pandemic Flu Service (if necessary). When demands for services start to exceed available capacity, additional measures will need to be undertaken. This decision is likely to be made at a regional or local level as not all parts of the UK will be affected at the same time or to the same degree of intensity
- **Escalation**: This will include prioritisation and triage of service delivery to maintain essential services. The Treatment and Escalation stages form the Treatment Phase
- **Recovery**: The indicator for this response would be when influenza activity is either significantly reduced compared to the peak, or when activity is considered to be within acceptable parameters.

Each stage is non-linear and has identified indicators for moving between them. These stages are not numbered as they may not follow in strict order and it should also be recognised that there may not be clear delineation between stages.

In 2013 the World Health Organisation (WHO) also published updated guidance on pandemic influenza risk management which are more flexible than previous guidance and reflects a continuum of influenza activity

The World Health Organisation (WHO) is responsible for identifying and declaring influenza pandemic based on the global situation.

Upon initiation of a pandemic response in the UK, Local Health Resilience Partnerships will convene a special meeting to consider the response.

Hampshire Isle of Wight Local Resilience Forums (LRF) will co-ordinate multi-agency planning for pandemic influenza via a Strategic Coordinating Group and Tactical Coordinating Group(s)

In hours SHFT will alert staff and patients through the normal management cascade system, and out of hours via the senior and area manager on call system. SHFT will utilize this Seasonal and Pandemic Influenza Plan and the Incident Response Plan as appropriate.

3. **Southern Health NHS Foundation Trust response to an Influenza Pandemic**

Following evidence of sustained community transmission of the virus, the World Health Organisation (WHO) may make a declaration of a pandemic. SHFT will establish its Incident Management Team as per the Incident Response Plan, specifically to manage the Trusts response to Pandemic Influenza. This Incident Management Team core membership will comprise of:

- Associate Director – Governance
- Head of Risk & Business Continuity
- Chief Pharmacist
- Head of Procurement
- Head of Estates and Facilities
- Lead Manager for Operational Human Resources and Best Practice
- Lead Nurse Infection Prevention and Control
- Head of Learning and Development
- Head of Communications

The Incident Management Team will inform the SHFT response to the pandemic and be responsible for briefing the Executive Team and Board, and for communicating with staff.
(When the WHO alert level phase 6 and the UK alert level 4 is reached, the Incident Response Plan will be invoked, following close liaison with NHS England and a SHFT Incident Management Team established.)

SHFT will also contribute as appropriate to the multi-agency partnership working within Hampshire and Isle of Wight and Thames Valley Local Resilience Forums response to the influenza pandemic; including membership of Tactical Coordinating Groups

4. Managing the workforce issues

Pandemic influenza could result in a staff absence of up to 50% of the workforce.

*When the World Health Organisation (WHO) declares pandemic phase 5 SHFT will instigate its Fast Time Sickness Reporting System*

This will be in addition to the normal sickness reporting system and will ensure that the Pandemic Influenza Incident Management Team, and when established the Team has the information necessary to manage the workforce resource to support critical functions and core service continuity.

In consultation with the Director of Workforce and the Executive Team, the Incident Commander will determine whether business continuity plans, the prioritization of services, and the policy *An Emergency Event: Guidelines on Managing the Workforce Issues* should be invoked.

Please see Appendix B for details on staff affected with influenza type illness and returning back to work.

5. Training

During the World Health Organisation (WHO) pandemic phase SHFT staff will receive additional training as deemed appropriate i.e. vaccination, infection prevention and control. Specific requirements and for which staff the training will be made available will be determined at the time.

6. Infection Control – All patients with Known or Suspected Influenza

This guidance is taken from *Pandemic (H1N1) 2009: A summary of Guidance for Infection Control* which was developed by the Health Protection Agency and the Department of Health. In addition guidance has been included from PHE on managing respiratory tract infections in health care settings (PHE 2016)

**INFLUENZA**

**Clinical features**

Influenza is a respiratory illness characterised by fever, cough, headache, sore throat, aching muscles and joints. There is a wide spectrum of illness ranging from minor symptoms through to pneumonia and death. The most common complications of influenza are bronchitis and secondary bacterial pneumonia.

**Incubation period**

The incubation period is the time between catching an infection and symptoms appearing. This will vary depending on the infectious dose you are exposed to and the immune status of the patient. For Influenza the incubation period is 1-3 days.
Infectious period
The infectious period is the time period over which an infected person can spread the infection to someone else. For many acute respiratory viral infections, the infectious period is unknown and so for practical purposes it is often assumed to equate to the duration of symptoms. Infectivity for influenza is greatest in the first 48hrs, and the infectious period can last up to 7 days in adults and 10 days in children. Some immunocompromised patients can shed the virus for weeks. If a patient is febrile, assume they are still infectious.

Methods of Spread:

Droplet transmission
Droplets may be generated from the respiratory tract during coughing, sneezing or talking. If droplets from an infected person come into contact with the mucous membranes (mouth or nose), or surface of the eye of a recipient, they can transmit infection. These droplets remain in the air for a short period and travel one to two metres, so physical closeness is required for transmission.

Airborne transmission
Aerosol generating procedures (AGP) are considered to have a greater likelihood of producing aerosols compared to coughing. Aerosols are smaller than droplets and can remain in the air for longer, and therefore, potentially transmit infection by mucous membrane contact or inhalation.

Contact transmission
Contact transmission may be direct or indirect. Infectious agents can be inadvertently passed from an infected person (for example after coughing into their hands) to a recipient who, in the absence of correct hand hygiene, may then transfer the organism to the mucous membranes of their mouth, nose or eyes.

Indirect transmission takes place when a recipient has contact with a contaminated object, such as furniture or equipment that an infected person may have coughed or sneezed on. In the absence of correct hand hygiene, the recipient may transfer organisms from the contaminated object to the mucous membranes of their mouth, nose or eyes.

The influenza viruses can be transferred from surfaces such as glass or plastic to hands up to 24hrs after contamination has taken place. From materials such as pyjamas, magazines and tissues, influenza viruses may be transferred up to 2 hours (PHE 2016).

Influenza viruses can be removed from the skin by washing with soap and water or inactivated by using alcohol hand rub, and similarly can be removed from surfaces by cleaning with normal detergents and cleaners.

All staff, including those who have previously been infected with or vaccinated against a specific respiratory pathogen, should comply with recommended infection control precautions as outlined in this document.

Standard infection prevention control precautions are required from all healthcare workers (HCW) for the care of all patients and patients’ environments, to prevent cross-transmission from recognised and unrecognised sources of infection.

6.1 Management of Suspected / Confirmed cases

6.1.1 Isolation/Treatment – see also Management Flow Chart Appendix A

- Patients with suspected or confirmed influenza in inpatient settings, should ideally be placed in single rooms immediately on admission or when infection is suspected.
Perform nose and throat screen using a viral swab (green top) and request viral PCR and not MC&S

Patients should be treated using antiviral treatment guidelines from Public Health England (PHE 2016)

Patients should remain isolated until asymptomatic AND 5 days minimum from the onset of symptoms. If a patient is febrile, assume they are still infectious

For prolonged illness with complication ie pneumonia, control measures should be used during the duration of acute illness and until signs of respiratory disease have resolved. The decision to discontinue isolation should be based on assessment of the patient's clinical condition (PHE 2016) and discussed with senior medical staff

When isolation in single rooms is not possible, patients should be cohorted (grouped together with other patients who have influenza and no other infection) in a segregated area to reduce the risk to other patients.

Display signage to control entry into isolation/cohort areas – see appendix E

Ensure personal protective equipment and foot operated clinical waste bin (orange bag) are outside of the room for the disposal of surgical face mask

A distance of at least one metre should be maintained between patients' beds

Special environmental controls, such as negative pressure rooms, are not necessary to prevent the transmission of influenza either by respiratory droplets or aerosols

Provide patients in isolation with information if applicable – see Appendix F

### Cohorting

During influenza outbreaks, a designated bay or ward may be necessary for the treatment of patients with influenza.

#### Cohort Bays:

If a cohort bay is set up, in addition to the above, it must also:

- Be separated from non-segregated areas in the ward by closed doors
- Have clear signage displayed warning of the segregated influenza area
- Have PPE, hand hygiene facilities and a foot operated waste bin available outside the room
- Ideally have designated staff assigned to work only in the cohort bay

#### Cohort Wards:

If a cohort ward is set up, in addition to the above, it must also:

- Have a reception area that is separate from the rest of the hospital and if feasible a separate entrance/exit
- Should not be used as a thoroughfare by other patients, visitors or staff including patients being transferred, staff going for meal breaks and staff and visitors entering the building
- To control entry, signage should be displayed warning of the segregated influenza area

### Re-opening isolation rooms / cohort bays

Prior to re-opening, isolation rooms or cohort bays must undergo a full infectious terminal clean – see 6.1.7 Environmental Infection Control

### 6.1.2 Contacts of Confirmed Flu Cases

- If a suspected flu case was not isolated on admission and then screens Flu Positive, any contacts must be reviewed and assessed
- In Lymington hospital, for patients admitted via MAU with suspected flu who cannot be isolated, a Contact Tracing form must be completed. On completion this form must be kept in the notes of the suspected flu patient – see Appendix B
- If a contact has respiratory symptoms, they must be screened, isolated and offered treatment for flu as PHE antiviral guidelines (PHE 2016). If a symptomatic contact
cannot be isolated in a single room, a surgical face mask can be considered to be worn by the patient whilst awaiting screening results.

- If a contact is asymptomatic, they should be offered prophylaxis for flu as per PHE antiviral guidelines if contact is within 48hrs of exposure (PHE 2016). A contact viral screen is not required unless they develop respiratory symptoms.
- Once a flu positive has been removed from the bay, the bed space can be cleaned and another patient admitted. The bay does not need to be closed and staff should follow excellent hand hygiene and standard infection prevention precautions.

### 6.1.3 Hand hygiene

- Hands must be cleaned immediately before every episode of direct patient care or contact with patients, and after any activity, or contact that potentially results in hands becoming contaminated. This includes the removal of protective clothing (including gloves), cleaning of equipment and handling of waste.
- Hands should be cleaned between caring for different patients and between different care activities for the same patient, even if gloves have been worn.
- Hand hygiene includes hand washing with soap and water and thorough drying, OR the use of alcohol-based products (e.g. alcohol hand rub) that do not require the use of water.
- If hands are visibly soiled or contaminated, they should be washed with soap and water and dried. If not visibly soiled, an alcohol hand rub can be used.
- Touching the face with gloved hands or hands that have not been recently cleaned should be avoided.
- All staff, patients and visitors should clean their hands when entering and leaving areas where care is delivered.

### 6.1.4 Good respiratory hygiene remember: ‘Catch it, bin it, kill it’

Patients, staff and visitors should be encouraged to minimise potential influenza transmission through good respiratory hygiene and cough etiquette:

- Hands should be kept away from the eyes, mouth and nose.
- Disposable, single-use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing noses.
- Used tissues should be disposed of promptly in the nearest waste bin.
- Tissues, waste bins (preferably lined and foot operated), and hand hygiene facilities should be available for patients, visitors and staff.
- Hands should be cleaned (using soap and water if possible, otherwise using alcohol hand rub) after coughing, sneezing, using tissues, or after any contact with respiratory secretions and contaminated objects.
- Some patients (e.g. older people and children) may need assistance with containment of respiratory secretions. Those who are immobile will need a container (e.g. a plastic bag) readily at hand for immediate disposal of tissues.
- In common waiting areas or during transport, symptomatic patients may wear surgical masks to minimise the dispersal of respiratory secretions and reduce environmental contamination.

### 6.1.5 Personal Protective Equipment

Personal Protective Equipment (PPE) is worn to protect staff from contamination with body fluids and to reduce the risk of transmission of influenza between patients and staff, and from one patient to another. Before entering the isolation room/area staff must clean their hands and put on the required PPE.
Appropriate PPE for the care of patients with influenza is summarised in the table below:

<table>
<thead>
<tr>
<th></th>
<th>Entry into the cohorted area but no patients contact</th>
<th>Close patients contact (within 2 metres)</th>
<th>Aerosol generating procedures</th>
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<tr>
<td>Hand hygiene</td>
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<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Gloves</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Plastic apron</td>
<td>√</td>
<td>√</td>
<td>X</td>
</tr>
<tr>
<td>Gown</td>
<td>X</td>
<td>X</td>
<td>√</td>
</tr>
<tr>
<td>Surgical mask</td>
<td>√</td>
<td>√</td>
<td>X</td>
</tr>
<tr>
<td>FFP3 respirator</td>
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<td>X</td>
<td>√</td>
</tr>
<tr>
<td>Eye protection</td>
<td>X</td>
<td>Risk assessment</td>
<td>√</td>
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</table>

**Eye protection**
- As part of standard precautions, eye protection should be used when there is a risk of contamination of the eyes from splashing, e.g. by secretions (including respiratory secretions), blood, body fluids or excretions
- An individual risk assessment should be carried out at the time of providing care
- Disposable, single use eye protection is recommended
- Eye protection should always be worn by all those present in the room during potentially infectious aerosol-generating procedures.

**Fluid Repellent Surgical masks**
Fluid Repellent Surgical masks are worn to protect the wearer from the transmission of influenza by respiratory droplets. Droplet transmission occurs when droplets are expelled from the respiratory tract of an infected individual (e.g. during coughing and sneezing) directly onto a mucosal surface or conjunctiva of a susceptible individual. Droplets travel only short distances through the air. Traditionally a distance of 1 metre has been used for employing droplet precautions, however, this distance should be considered as the minimum rather than an absolute distance

- Surgical masks should be fluid repellent and should be worn by healthcare workers for any close contact with patients with influenza symptoms (i.e. within approximately two metres). The mask will provide a physical barrier and minimise contamination of the nose and mouth by droplets
- When influenza patients are cohorted in one area and several patients must be visited over a short time or in rapid sequence, it may be more practical for staff to put on a surgical mask on entry to the area and to keep it on for the duration of the activity or until the surgical mask requires replacement (i.e. when it becomes wet or damaged)

- Surgical masks should:
  - Cover both nose and mouth
  - Not be allowed to dangle around the neck after or between each use
  - Not be touched once put on
6.1.6 Aerosol-generating procedures (AGP)

The following procedures when undertaken on patients with influenza are considered likely to generate aerosols capable of transmitting influenza:

- Intubation, extubation and related procedures e.g. manual ventilation and open suctioning
- Cardiopulmonary resuscitation
- Bronchoscopy (unless carried out through a closed circuit ventilation system)
- Surgery and post-mortem procedures in which high-speed devices are used
- Dental procedures
- Non-invasive ventilation (NIV)
- High-frequency oscillating ventilation (HFOV)
- Induction of sputum

AGPs should only be carried out only when essential. Where possible, these procedures should be carried out in well-ventilated single rooms with the doors shut. Only those healthcare workers who are needed to undertake the procedure should be present.

FFP3 respirators

For all AGPs (and those in the same room) an FFP3 respirator, fluid repellent gown, gloves and eye protection should be worn. It is a legal requirement that any HCW required to wear an FFP3 respirator should have undertaken FIT testing prior to using it (HSE 2010). Fitting the respirator correctly and training is critical for the provision of proper protection.

As aerosols may still be present in the environment health care staff must wear a FFP3 respirator when entering a room within one hour of this procedure taking place.

Disposable respirators should be replaced after each use and changed if:

- Breathing becomes difficult
- The respirator is damaged or distorted
- The respirator becomes obviously contaminated by respiratory secretions or other body fluids
- A proper face fit cannot be maintained

Respirators should be disposed of as hazardous (orange bag) waste. In the community setting (patients own home) respirators can be disposed of in the domestic waste stream.

FIT Testing

When should a repeat fit test be conducted?

When the wearer:

- Loses or gains weight
- Undergoes any substantial dental work
- Develops any facial changes (scars, moles etc) around the face seal area

Staff providing Fit Test training must be deemed competent as per the Trust Fit Testing Guidelines (see Appendix C)

Visitors to patients ventilated with non-invasive ventilation (NIV) or high-frequency oscillating ventilation (HFOV) may be exposed to potentially infectious aerosols. The number of such
visitors should be limited where possible. Visitors should be made aware of the risks and be offered PPE as recommended for staff.

Certain other procedures may generate an aerosol from material other than patient’s secretions but are NOT considered to represent a significant infection

- Obtaining diagnostic nose and throat swabs
- Administration of pressurised humidified oxygen
- Administration of medication via nebulisation

During nebulisation, the aerosol derives from a non-patient source (the fluid in the nebuliser chamber) and does not carry patient-derived viral particles (PHE 2016).

For such procedures, gloves, an apron and a surgical mask (plus eye protection if there is a risk of splashes to the eyes) are recommended as per standard infection control and droplet precautions. Staff should use appropriate hand hygiene when helping patients to remove nebulisers and/or oxygen masks.

6.1.7 Putting on and removing Personal Protective Equipment (PPE)

Putting on PPE:
The level of PPE used will vary according to the procedure being carried out, and not all items will always be required – see 6.1.15. PPE should be put on before entering a side room or cohorted area / patient area if at home. For AGPs all staff entering the room for the procedure and within one hour of the procedure will need to wear full PPE.

PPE should be put on in the following order:

1. Gown OR apron if not undertaking AGP
2. FFP3 respirator OR surgical mask if not undertaking AGP
3. Eye protection, i.e. goggles or face shield for AGPs and as appropriate after risk assessment
4. Disposable gloves

Removal of PPE:
PPE should be removed in an order that minimises the potential for cross-contamination. Before leaving the side room or cohorted area, gloves gown and eye protection should be removed. The respirator or surgical mask should be removed after leaving the side room / cohorted area. PPE should be removed in the following order:

1. Remove gloves – before leaving the isolation room
2. Remove gown or apron – before leaving the isolation room
3. Remove eye protection – before leaving the isolation room (if worn)
4. Clean hands and leave the isolation room
5. Respirator or surgical mask – remove once outside the isolation room
6. Clean hands

6.1.8 Environmental Infection Control

Linen and laundry
Linen used during the patient’s care should be managed safely as per Standard Infection Control precautions. Linen should be categorized as ‘infected’.

- In hospital -linen should be placed in appropriate receptacles immediately after use and bagged at the point of use (see isolation policy)
• In hospital - linen bags must be tied and sealed before removal from the influenza patient care area
• Gloves and aprons should be worn for handling all contaminated linen
• Hand hygiene should be performed after removing gloves that have been in contact with soiled linen and laundry.

Bed curtains should be changed following patient discharge / end of the outbreak as part of the infectious terminal clean.

Rugs and carpets should be washed / steamed following discharge / end of the outbreak as part of the infectious terminal clean.

Crockery and utensils
No special precautions, beyond those for Standard Infection Control Precautions, are recommended for dishes and eating utensils used by a patient with influenza.

The combination of hot water and detergent used in dishwashers is sufficient to decontaminate dishes and eating utensils used by patients with influenza. Washing up by hand using household detergent and hand hot water is also sufficient. There is no need to use disposable plates and cutlery.

Environmental cleaning and disinfection (refer to Isolation policy)
• Patient cohort areas / isolation rooms and clinical rooms should be cleaned daily as a minimum with Actichlor plus
• Frequently touched surfaces (e.g., over-bed tables, lockers, lavatory surfaces, door knobs, keyboards and equipment in the immediate vicinity of the patient) should be cleaned at least three times daily and immediately if visibly contaminated.
• In addition it is essential that all frequently touched surfaces and all horizontal surfaces are decontaminated after any AGP
• Freshly prepared detergent and chlorine should be used.
• Keep the environment clean and clutter free
• Damp rather than dry dusting should be performed to avoid generating dust particles.
• The use of vacuum cleaners should be avoided if possible
• Dedicated or single-use/disposable equipment should be used. Non-disposable equipment, including mop heads, should be laundered after use.
• Any spillage or contamination of the environment with secretions, excretions or body fluids should be treated in line with the local spillage policy.
• On patient discharge / resolution of outbreak a full infectious terminal clean must be undertaken.
• Any soft furnishings / carpets in isolated areas that cannot be removed and washed must be steam cleaned as part of the terminal clean

Housekeeping staff
• Should be allocated to specific areas and not moved between influenza and non-influenza areas.
• Must be trained in the correct methods of wearing PPE and the precautions to be taken when cleaning cohorted areas.
• Should wear gloves and aprons; in addition a surgical mask should be worn when cleaning in the immediate patient environment in cohorted areas.

6.1.9 Hazardous and non-clinical waste
No special handling procedures beyond those for Standard Infection Control Precautions are recommended for hazardous and non-clinical waste that may be contaminated with influenza virus.
Waste from suspected / known cases of flu should be treated as ‘infectious’ waste (orange bags)
Liquid waste such as urine and faeces can be safely disposed of into the sewerage system.
All waste collection bags should be tied and sealed before removal from the patient area.
Gloves should be worn when handling ALL waste and hand hygiene performed after removal of gloves.
In the community setting (patients own home) PPE should be discarded into a bag, sealed, and then disposed of into the patients own domestic waste stream (with their permission).

6.1.10 Patient care equipment

- Equipment should as far as possible be allocated to each individual patient or cohort of patients
- Reusable equipment (e.g., stethoscopes, patient couch in treatment and consulting rooms) must be scrupulously decontaminated between each patient with clinell sanitizing wipes
- Equipment that is visibly soiled should be cleaned immediately. If applicable, follow local and manufacturers recommendations for cleaning and disinfection or sterilization of reusable patient-care equipment
- Wipe external surfaces of portable equipment for performing x-rays and other procedures in the patient’s room with detergent and chlorine or a clinell wipe upon removal from the patient’s room or consulting room.
- Use of equipment that re-circulates air (e.g. fans,) should be avoided.
- Cleaning of patient care equipment is essential prior to both disinfection and sterilisation.
- Hands must be cleaned following the decontamination of equipment

Furnishings
During a pandemic all non-essential furniture must be removed, especially soft furnishings from reception and waiting areas in hospitals, day rooms and clinic locations. The remaining furniture should be easy to clean and should not conceal or retain dirt and moisture. Toys, books, newspapers and magazines should be removed from the waiting areas. The Infection Prevention and Control team will inform staff when a pandemic situation has been declared.

6.1.11 Patient movement / transport

- The movement and transport of patients from their room or the cohorted area should be limited to essential purposes only
- Staff at the destination must be informed that the patient has, or is suspected to have, influenza
- Limit transport and movement of patients outside of their room to medically necessary purposes. If patient movement or transport is necessary, then if possible the patient should wear a surgical face mask to minimise the dispersal of respiratory secretions and reduce environmental contamination.
- If the patient is wearing a face mask during transport, then no mask is required by the HCW transporting or accompanying patients for whom droplet precautions are indicated. If the patient is unable to wear a mask for any reason, then HCWs transporting or accompanying the patient who will be required to come within two metres of the patient should wear a surgical face mask
- Good respiratory hygiene should be encouraged – ‘Catch it, bin it, kill it’
- Staff involved in transfers should practice good hand hygiene, and hand hygiene facilities should be available to patients when feasible
6.1.12 Patient Discharge

- Flu positive patients can go home at any stage when medically fit
- Flu positive patients can be discharged to a nursing / residential home when asymptomatic AND if on treatment / or treatment is completed
- Symptomatic contacts – should be managed as per Flu positive patients
- Asymptomatic contacts – there is no restriction of the transfer or discharge of contacts

6.1.13 Staff

- Staff are encouraged to have the seasonal flu vaccine on a yearly basis. This is provided free of charge for all Trust staff
- Providing you are well you will not require isolation or removal from duty following contact
- Staff who have worn the correct PPE do not routinely require antiviral treatment
- It is recommended that pregnant or ‘at risk’ staff avoid contact with flu if possible. At risk groups include: those with long term lung, kidney, neurological, liver or heart disease; children under 5; people over 65; those with diabetes mellitus; the immunosuppressed – whether caused by disease or treatment.
- The appropriate use of PPE will protect uniforms from contamination in most circumstances. During a pandemic, healthcare workers should not wear their uniform when travelling to and from work
- Hospital/facility laundry services should be used to launder uniforms if they are available. If there are no laundry facilities available then uniforms should be laundered in a domestic washing machine in water as hot as the fabric will tolerate, then ironed or tumbled-dried. Uniforms must be machine washed, and if transported dirty, transport them home in a sealed plastic bag

6.1.11 Visitors

- Visitors to areas of the hospital which are closed due to flu, should be kept to a minimum
- All visitors entering cohorted areas must be instructed on hand hygiene practice and the use and removal of appropriate PPE
- Visitors with influenza symptoms should not enter the healthcare facility and should be encouraged to return home

7. Surveillance

The Infection Prevention and Control Team will advise Public Health England South East (0344 225 3861 or HIOW@phe.gov.uk) about any cases of suspected flu.

When SHFT is alerted to an influenza pandemic the IPC team will contribute to the local surveillance of the influenza pandemic.

The clinical diagnostic criteria will depend on the pandemic influenza virus. The following clinical diagnostic criteria are being used in the UK for H1N1 (2009) swine flu pandemic influenza:

- Fever (pyrexia 38°C) or a history of fever

And

- Influenza-like illness (two or more of the following symptoms: cough, sore throat, rhinorrhoea (runny nose), limb or joint pain, headache, vomiting or diarrhoea)
8. **Action Cards**

If staff become aware of any suspected cases they will advise their Line Manager, arrange for the patient to be isolated and seek advice from the Infection Prevention and Control Team. Staff will follow either:

**Influenza Action Card 1 – Staff caring for a patient with clinically presumed influenza in their home**

Or

**Influenza Action Card 2 – Infection Prevention Precautions when Managing Suspected or Known Flu Cases**

Or

**Influenza Action Card 3 – How to use full personal protective equipment (PPE)**

Or

**Influenza Action Card 4 – Specific advice for domestic staff cleaning a hospital isolation room**

Or

**Influenza Action Card 5 – Specific advice for domestic staff cleaning a hospital isolation room / cohort bay**

9. **Establishing Anti-viral Collection Points**

In response to a request by NHS England (Area Teams), SHFT may be required to establish Anti-viral Collection Points (ACPs). The ACPs will distribute anti-viral medications to patients who have been referred by the National Pandemic Flu Service, have a unique reference number, and identification with their name, date of birth, and address. NHS England will be responsible for the provision of pharmaceutical support to the ACP, for the supply and storage of anti-viral medications, and for the supply of consumables and signposting.

SHFT have identified the following potential locations for the establishment of ACPs:

- Aldershot
- Andover
- Basingstoke
- Eastleigh
- Gosport
- Havant Health Centre
- Lymington
- Lymington
- Winchester

If a request is received from NHS England to establish an ACP a manager will be appointed by the Incident Management Team.

The ACP manager will follow:
Anti-viral collection point manager action card

Staff will refer to Public Health England website for up to date information on the distribution of anti-viral medications available at www.HIOW@phe.gov.uk

10. References

Department of Health (2009) Pandemic (H1N1) 2009 Influenza – A summary of guidance for infection control in healthcare settings. Available at: www.dh.gov.uk/publications

Department of Health (2011) UK Influenza Pandemic Preparedness Strategy 2011 Available at: www.dh.gov.uk/publications


Bournemouth, Dorset And Poole, and Hampshire and Isle of Wight LRFs Pandemic Influenza Framework v0.05 June 2015.

Public Health England (2016) Infection control precautions to minimise transmission of acute respiratory tract infections in healthcare settings

Appendix A

Medical patient with symptoms suggestive of respiratory virus

- Isolate immediately if possible. If isolation not possible, leave patient in existing bed space
- Perform combined viral nose/throat swab (green top) Request viral PCR not MC&S
  Treat empirically for influenza using PHE flu antiviral treatment guidelines (2016)

Positive viral swab result

Influenza Virus A/B

Isolate in side room
Or
Transfer to flu cohort bay until:
- Asymptomatic AND 5 days minimum from onset of symptoms

Treat with Oseltamivir 75mg BD for 5 days for uncomplicated influenza. As per PHE flu antiviral guidelines.

If flu case not isolated from admission:
- Isolate or remove patient to flu positive cohort bay or form new cohort bay
- Contacts who are symptomatic: isolate, take viral screen & offer treatment with Oseltamivir 75mg BD 5 days
- Contacts who are not symptomatic: offer prophylaxis of Oseltamivir 75mg OD 10 days if within 48hrs of exposure. A contact viral screen is not required unless symptoms develop

Discharge & Transfer:
- Flu positive patients can go home at any stage when medically fit
- Flu positive patients can be discharged to a nursing home when asymptomatic and on treatment / treatment completed
- Symptomatic contacts: manage as per Flu positive until viral screen is known
- Asymptomatic contacts: no restriction to transfer/discharge of contacts on prophylaxis. In Lymington New Forest Hospital, patients will be tracked internally

Other virus

Eg RSV, Human meta-pneumonvirus, Para-influenza virus

Isolate in side room until:
- Asymptomatic or 5 days from onset of symptoms

- Stop antiviral treatment
- No specific treatment required

If index case not isolated from admission:
- Isolate index case
- No specific prophylaxis required for contacts
- Isolation/cohorting of contacts is not required
- If contact becomes symptomatic, isolate and viral swab for flu

- Discharge to home when medically fit
- Discharge to nursing home when asymptomatic

Addendum to SHFT Incident Response Plan
Seasonal Influenza Management and Pandemic Influenza Plan & Action Cards
Version 3
Feb 2017
Community hospital wards
Infection Control Actions for Confirmed Respiratory Viruses

Confirmed seasonal influenza
- Patients with confirmed influenza are isolated until asymptomatic AND for 5 days from onset of symptoms, whichever is longer. Isolation of patients with prolonged symptoms should be discussed with senior medical staff. If patient is febrile, assume they are still infectious.
- Isolation may be in a side room or in a cohort bay with other confirmed influenza cases.
- If a symptomatic influenza positive patient has been in a bay with other contacts, assess whether the contact is symptomatic with respiratory symptoms or asymptomatic and manage as below:
  - **Symptomatic contact:** of confirmed case in the same bay require: isolation, viral screening and treatment with Oseltamivir 75mg BD for 5 days
  - **Asymptomatic contacts:** of a confirmed case: do not require isolation but should be offered prophylaxis and screened only if symptoms of flu develop
- Once the index Flu positive patient has been removed from the bay, the bed space can be cleaned and another patient admitted. The bay does not need to be closed and staff should follow excellent hand hygiene and standard infection prevention precautions.
- Patients with confirmed flu who are medically fit for discharge can be discharged home.
- Confirmed Flu positive patients can be transferred to nursing homes when on Oseltamivir treatment or completed, and when asymptomatic.
- Symptomatic contacts: should be managed as Flu positive until flu results are known.
- Asymptomatic contacts: receiving Oseltamivir prophylaxis can be discharged / transferred at any point when medically fit.

Other respiratory viruses (including RSV parainfluenza virus and human meta-pneumovirus)
- Confirmed patients require isolation until asymptomatic or for 5 days from onset of symptoms whichever is shorter. Usually this will be in a side room unless there are sufficient cases of any individual virus to cohort.
- Contacts do not require isolation / cohorting or prophylaxis.

For Lymington New Forest Hospital
- For any patient admitted with confirmed or suspected flu who is not isolated on admission: complete a contact tracing form to identify all contacts of the index case so that contacts can be followed up if the patient tests Flu positive.
Appendix B

**Lymington New Forest Hospital Only: Contact Tracing List Of A Suspected Flu Patient (Index) Not Isolated on Admission:**

This form must be completed for any suspected flu patient who has not been isolated on admission. Following completion it must be kept in the notes of the suspected flu patient (Index). If the patient screens positive to Flu, please assess all contacts with a view to starting either treatment of prophylaxis.

<table>
<thead>
<tr>
<th>Name of Suspected Flu Case (Index):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Number:</td>
<td></td>
</tr>
<tr>
<td>Ward:</td>
<td></td>
</tr>
<tr>
<td>Date Viral Screen Taken:</td>
<td></td>
</tr>
<tr>
<td>Date Isolated (if applicable)</td>
<td></td>
</tr>
<tr>
<td>Date and Result of Screen:</td>
<td>Flu Positive – YES, follow up as per flu chart</td>
</tr>
<tr>
<td></td>
<td>Flu Negative – no further actions required – continue with clinical plan</td>
</tr>
</tbody>
</table>

Please record below the names of any contacts of a suspected flu case (who have been in the same bay of the index patient named above) and the name of the ward if they have been transferred:

- If any contacts of a confirmed case are symptomatic treat as per Flu flow chart (isolate, screen and treat)
- If any contacts of a confirmed flu case are asymptomatic offer prophylaxis as per flow chart

<table>
<thead>
<tr>
<th>No</th>
<th>Name of Contacts</th>
<th>Hospital Number</th>
<th>Ward Transferred to</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3</td>
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<td>4</td>
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<td>5</td>
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<td>6</td>
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<td>7</td>
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<tr>
<td>8</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix C

FFP3 FIT Testing

What competencies are required for fit testers?

According to guidelines issues from the Health and Safety Executive fit testing should be conducted by a competent person. [www.hse.gov.uk](http://www.hse.gov.uk) (search for 282/28)

A competent fit tester can demonstrate

- A knowledge that FFP3 respirators are recommended for aerosol generated procedures on patients with influenza and that these may be re-usable or disposable and the benefits of each (If re-usable FFP3 respirator they should have knowledge regarding cleaning, storage and frequency of filter change)

- An ability to correctly fit the FFP3 respirator in accordance with manufacturers instructions and perform pre-use checks

- An ability to recognise poor fit and help with respirator fitting solutions

- Ability to fit test the FFP3 respirator ensuring manufacturers guidelines are followed

- Fit Test Trainers must complete a Qualitative Fit Test Record for each staff member they Fit Test. This record must be forwarded to HR dept at Moorgreen hospital. HR will input this information onto the staff members ESR. This is a legal requirement.
**APPENDIX D: STAFF HEALTH AND ILLNESS RELATING TO INFECTION CONTROL**

<table>
<thead>
<tr>
<th>Illness</th>
<th>Advice</th>
<th>Comment</th>
<th><a href="http://www.rcplondon.ac.uk">www.rcplondon.ac.uk</a></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diarrhoea/vomiting illness</strong></td>
<td>Staff working in any setting must refrain from duty, until 48 hours after symptoms have resolved. No clearance stool required</td>
<td>More stringent guidance applies if a food handler has an infection with salmonella typhi, verotoxigenic escherichia coli (VTEC) O157 and hepatitis A (Royal College of Physicians 2008)</td>
<td></td>
</tr>
<tr>
<td><em>eg Viral gastroenteritis</em></td>
<td></td>
<td>(Royal College of Physicians 2008)</td>
<td></td>
</tr>
<tr>
<td><em>norovirus</em>, food poisoning,</td>
<td></td>
<td>(Royal College of Physicians 2008)</td>
<td></td>
</tr>
<tr>
<td><strong>Cold</strong></td>
<td>In all settings staff should risk assess the immune status of their service users and judge the impact that catching a cold would have.</td>
<td>Help prevent a cold spreading by taking the following preventative steps:</td>
<td></td>
</tr>
<tr>
<td><em>A stuffy or runny nose, sore throat, sneezing and sometimes a cough and a mild fever.</em></td>
<td></td>
<td>• wash/sanitise your hands regularly and properly, particularly after touching your nose or mouth and before handling food</td>
<td></td>
</tr>
<tr>
<td><strong>Lower risk environments</strong></td>
<td>(eg Outpatient areas, office areas, mental health community care teams) Staff may work continue to work if they don’t have a fever and feel well enough to work Follow the preventive steps indicated in column to the right.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medium risk environments</strong></td>
<td>(eg in-patient areas) If staff don’t have a fever and feel well enough to work they should continue to do so providing they practise preventative steps indicated in column to the right. Exclude staff member from clinical duties if they uncontrolled coughing/sneezing and runny nose which cannot be managed by periodic wiping</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>High risk environments</strong></td>
<td>Symptomatic staff must avoid face to face contact with neonates, patients with chronic respiratory problems, or those on chemotherapy or otherwise severely compromised by age or disease.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Uncomplicated influenza illness | Staff with probable/suspected ‘flu or ‘flu like symptoms, (fever of $>38^\circ C$ or history of fever **plus** two or more of cough or other respiratory symptoms, chills, sore throat, headache, muscle aches) should stay away from work and contact their manager. They should ask their GP for advice if necessary.  
Staff unwell with ‘flu like symptoms should stay off work until acute symptoms resolve. Usually for 7 days or longer if they remain unwell. | Flu symptoms are more severe and usually peak after two to three days, and an individual with ‘flu, will usually feel too unwell to attend work. However, they should begin to feel much better within five to eight days and then be able to return to work.  
Some symptoms such as a cough and general tiredness may last for two to three weeks.  
Flu vaccination takes place October –Feb make sure staff get protected |
INFECTION PREVENTION ALERT

All visitors must use alcohol sanitising foam on arrival

FLU SYMPTOMS?

If you have flu symptoms do not visit until your symptoms have resolved (usually 5-7 days)

DIARRHOEA & VOMITING?

If you have diarrhoea and vomiting symptoms do not visit. Please stay away until you have been symptom free for at least 48 hours

Thank you for your help in preventing the spread of infection
Appendix F

Seasonal influenza (flu) information for patients

**What is flu?**
It is a respiratory illness associated with infection by the influenza virus. Symptoms include headache, fever, cough, sore throat and aching muscles and joints. It can affect different people in a variety of ways, ranging from minor symptoms through to pneumonia and in very rare cases death.

**How serious is flu infection?**
Flu usually makes people feel worse than an ordinary cold. For most people flu infection is just a nasty experience but for some it can lead to illnesses that are more serious. The most common complications of flu are bronchitis and pneumonia, which in some cases may require treatment in hospital. Some types of flu, such as the swine flu strain, can cause serious illness in young, otherwise healthy individuals.

**What are the symptoms of flu?**
The most common symptoms of flu are a rapid onset of fever, shivering, headache, muscle aches and dry cough. Most people confuse flu with a heavy cold; however, flu is usually a more severe illness than the common cold, which is caused by other respiratory viruses.

**What are the symptoms of the common cold?**
Cold symptoms generally include a runny nose, sneezing, watery eyes and throat irritation. The symptoms usually occur gradually and do not generally cause a fever or body aches.

**When does flu occur?**
Flu occurs most often in the winter months and usually peaks between December and March. Illnesses resembling flu may occur in the summer months but they are usually due to other viruses.

**How is flu diagnosed?**
Usually, a doctor will diagnose a case of the flu based on typical symptoms of fever, chills, headache, cough and body aches. Sometimes throat and nose swabs are taken to confirm the diagnosis.

**How is flu spread?**
The flu virus is highly infectious and is easily passed from person to person when an infected person coughs or sneezes. Transmission can also occur by touching a surface contaminated with respiratory secretions and then putting the fingers in the mouth or nose or near the eyes. The flu virus can live on a hard surface such as a door knob or telephone for up to 24 hours and soft surfaces such as carpets and curtains for around 20 minutes.
To reduce spread of the virus
It is important if someone has a respiratory infection that they cover their nose and mouth, preferably with a tissue, when they cough and sneeze and wash their hands straight afterwards. Used tissues should be disposed of immediately after use.

Isolation areas on the ward will be cleaned using chlorine based disinfection products, such as Actichlor Plus. These can be used to clean the room of someone who has flu as the virus can easily be destroyed. Hard surfaces including telephones door knobs and light switches may also be wiped with Clinell wipes.

The incubation period – the period between infection and the appearance of symptoms – is about one to three days. Although the virus is present before symptoms appear, adults are usually considered infectious once symptoms appear and for about 7 days afterwards. This period is longer in children and the immunocompromised.

What should I do if I get flu?
Rest, drink plenty of fluids you will be offered painkillers such as paracetamol if necessary and follow any medical advice.

Who is most at risk from the complications of flu?
The young, and the elderly are more at risk of infection generally and also with respect to flu.
Other high-risk groups include individuals who have ongoing respiratory (lung), cardiac (heart) or immune conditions that make them more vulnerable to flu and more likely to suffer severe illness.

When in hospital
When caring for patients with suspected or confirmed infectious respiratory viruses health care workers may need to assess the infectious risk posed to themselves and, where appropriate, personal protective equipment to minimize that risk. Your health care worker may be required to wear a face mask and you may also be asked to wear a face mask to minimize risk of transmission.

Other sources of information
The Health Protection Agency
www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/SeasonalInfluenza/

How do I find out more?
More information is available from your doctor or nurse.
## Index

<table>
<thead>
<tr>
<th>Action Card</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Staff caring for a patient with clinically presumed influenza in their home</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>Infection Prevention Precautions when Managing Suspected or Known Flu cases</td>
<td>5</td>
</tr>
<tr>
<td>3.</td>
<td>How to use full personal protective equipment (PPE)</td>
<td>7</td>
</tr>
<tr>
<td>4.</td>
<td>How to take a specimen</td>
<td>9</td>
</tr>
<tr>
<td>5.</td>
<td>Specific advise for domestic staff cleaning a hospital isolation room</td>
<td>11</td>
</tr>
<tr>
<td>6.</td>
<td>Anti-viral Collection Point Manager</td>
<td>12</td>
</tr>
</tbody>
</table>
**Action Card 1: Staff Caring For A Patient With Clinically Presumed Influenza In Their Home**

For advice on treatment and reporting check: [www.HIOW@phe.gov.uk](http://www.HIOW@phe.gov.uk)

On entering the home put on your personal protective clothing (PPE) as follows:

- Plastic disposable apron
- Surgical face mask - (fluid repellent) -these masks are stored in community hospitals
- Eye protection if there is a risk of a splash
- Disposable gloves

**REMEMBER VACCINATION IS THE BEST FORM OF PROTECTION**

**STOP**

Planning to:

a) perform an aerosol generating procedure? e.g. Intubation, nasopharyngeal aspiration, tracheostomy care, chest physio, you will need full PPE including a FFP3 respirator - **go to action card action card 3.**

**Once inside the patient’s room**

Keep your hands way from your face
Limit the number of surfaces you touch
Change gloves when gloves are torn or heavily contaminated
**Regularly perform hand hygiene with soap and water or alcohol gel**
Always perform hand hygiene immediately after removing PPE

**On leaving the patient’s room remove protective clothing in this order:**

- **Remove your gloves** without allowing the outside of the glove to touch your skin and discard*
- **Remove your apron** (break ties, pull apron away from neck/shoulders, touching insides only roll into a bundle and discard*) - next remove eye protection if worn
- **Remove your surgical mask**- untie the ties (first the bottom, then top, pull away without touching the front of the mask and discard*)

*discard into a bag, seal bag and discard in patient’s waste bin

**Before leaving ensure your equipment is cleaned. Wear fresh PPE as above for the cleaning, use usual cleaning agent eg clinell sanitising wipe. Wash/clean hands after removing PPE and discard***
Advice to give to patient carers:

- Good tissue hygiene - Catch it bin it kill it Wash Hands
- Restrict visiting and number of carers
- Wash patient’s crockery/cutlery before use by others (ideally in dishwasher).
- Keep regularly touched surfaces clean – detergent and water disposable cloth or regular household cleaner e.g. Dettox
- Wash linen on hottest wash that fabric will tolerate - don’t hug used linen, wash hands after contact with linen
- Keep patient home, isolated until asymptomatic and the antiviral course is completed
- Avoid close contact with others be watchful for emergency signs in patient
- Patient to wear surgical mask when in contact with visiting carers

Call for Emergency Care if the patient:

- has difficulty breathing or chest pain
- has purple or blue discoloration of the lips
- is vomiting and unable to keep liquids down
- has signs of dehydration such as dizziness when standing, absence of urination, or in infants, a lack of tears when they cry
- has seizures (for example, uncontrolled convulsions)
- is less responsive than normal or becomes confused

Staff Health
Providing you are well you will not require isolation or removal from duty following contact. Staff who have worn the correct PPE do not routinely require antiviral treatment. It is recommended that pregnant or ‘at risk’** staff avoid contact with flu where possible please contact your Occupational Health Department for advice.

** those with long-term lung, kidney, neurological, liver or heart disease; children under five; people over 65; those with diabetes mellitus; the immunosuppressed (whether caused by disease or treatment); patients who have had drug treatment for asthma within the past three years; and pregnant women.

Contact numbers

PHE on 0344 225 3861

Infection Prevention and Control Team – Office 02380 874291
Theresa Lewis (Lead IP&CN) - 07500 975960
Jacky Hunt (North) – 07500 975962
Angela Roberts (West) – 07500 975961
Louise Piper- (East) – 07717 714894
Addendum to SHFT Incident Response Plan
Seasonal Influenza Management and Pandemic Influenza Plan & Action Cards
Version 3 Feb 2017

Card 1: Caring For A Patient Clinically
Presumed Influenza In The Home

Infectious Period
The infectious period for influenza is greatest in the first 48hrs after the onset of symptoms and can last up to 7 days. Children, immunocompromised individuals and seriously ill people may remain infectious for a longer period, and action should be considered to minimise prolonged shedding of influenza virus by patients with risk factors. The incubation period for influenza is 1-3 days.

Method of spread
3 main routes namely
1) **Droplet transmission**: If droplets from an infected person come into contact with the mucous membranes (mouth or nose) or surface of the eye of a recipient, they can transmit infection. These droplets remain in the air for a short period and travel one to two metres, so physical closeness is required for transmission.
2) **Aerosol transmission** during aerosol generating procedures
3) **Contact transmission** may be direct or indirect. Infectious agents can be inadvertently passed directly from an infected person (for example after coughing into their hands) to a recipient who, in the absence of correct hand hygiene, may then transfer the organism to the mucous membranes of their mouth, nose or eyes. Indirect contact transmission takes place when a recipient has contact with a contaminated object, such as furniture or equipment that an infected person may have coughed or sneezed on.

Isolation Precautions
Patients clinically presumed flu should be nursed in a side room, whilst in hospital, until the patient is asymptomatic **AND** 5 days from onset of symptoms – whichever is longer. If febrile assume infectious. Ensure an isolation sign on the door, disposable apron, gloves and surgical mask and clinical waste foot operated bin (orange bag) outside of the room.

Before entering the room wash your hands and put on your personal protective clothing (PPE) as follows:
- Plastic disposable apron
- Surgical Mask
- Eye protection if there is a risk of an eye splash
- Disposable gloves

**STOP**
If you are going to do an aerosol generating procedure e.g. Intubation, nasopharyngeal aspiration, trachyostomy care, physio sputum induction, then you will need full PPE including a FFP3 respirator. Only people who have been fit tested can wear a FFP3 mask.

Once inside the patients room
- Keep your hands way from your face
- Limit the number of surfaces you touch
- Change gloves when gloves are torn or heavily contaminated
- **Regularly perform hand hygiene with soap and water or alcohol gel**
- Always perform hand hygiene immediately after removing PPE
Cleaning requirements

Ensure that the room/bays of patients with infection are cleaned daily, and are prioritised for frequently-touched surface cleaning (eg over-bed tables, lockers, lavatory surfaces in patient bathrooms, door knobs and equipment in the immediate vicinity of the patient) three times a day and immediately if visibly contaminated with a chlorine based product (Actichlor) including wash hand basins, door handles, toilet /commode (the latter should be identified for the isolated patients use only) and frequently touched areas.

All supplies of liquid soap, paper hand towels and alcohol gel in the room should be checked daily and replaced as required.

All waste should be placed in the orange (clinical waste) bags and disposed at regular intervals

All linen should be treated as ‘infectious’, ‘bagged and disposed of in a timely manner

Dedicate equipment to this patient only where possible eg bp cuff.

Decontaminate re-useable equipment as per manufacturer’s instructions before use on another person.

On patient discharge / end of outbreak rooms affected must undergo a full infectious terminal clean

Staff Health

Providing you are well you will not require isolation or removal from duty following contact. Staff who have worn the correct PPE do not routinely require antiviral treatment.

It is recommended that pregnant or ‘at risk’* staff avoid contact with flu where possible please contact your Occupational Health Department for advice.

* those with long-term lung, kidney, neurological, liver or heart disease; children under five; people over 65; those with diabetes mellitus; the immunosuppressed (whether caused by disease or treatment); and pregnant women.

For further advice please contact a member of the Infection Control Team
Infection Prevention and Control Team – office 02380 874291
Theresa Lewis (Lead IP&CN) 07500 975960
Jacky Hunt (North) – 07500 975962
Angela Roberts (West) – 07500 975961
Louise Piper (East) 07717 714894
Action Card 3 –
How to use Full Personal Protective Equipment (PPE)

For treatment /reporting please check PHE website for latest advice before taking action
www.HIOW@phe.gov.uk

What does ‘Full PPE’ consist of?
- disposable gown
- disposable gloves
- disposable eye protection
- Correctly fitted FFP3 respirator mask (staff members must have undergone fit testing in advance)

When is ‘Full PPE’ required?
b) When performing an aerosol generating procedure? e.g. Intubation, nasopharyngeal aspiration, tracheostomy care, chest physio, certain dental procedures

Putting on personal protective equipment (PPE)
The order for putting on PPE is gown, FFP3 mask, eye protection and gloves

Gown- Pull over head and fasten at back of waist,
FFP3 Respirator -
- Secure elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin (make sure no hair is caught)
- Check fit of respirator mask by breathing in and out to ensure snug fit to face. No air should escape from the mask

Eye protection (disposable goggles/face shield) Place over face and eyes and adjust to fit (if not part) of FFP3 mask
Gloves Extend to cover wrist of gown
Removing personal protective equipment (PPE)
The order for removing PPE is gloves, apron, eye protection and finally FFP3 mask.
Gloves Grasp the outside of the glove with the opposite gloved hand and peel off
Hold the removed glove in the gloved hand slide the fingers of the un gloved hand under the
remaining hand at the wrist of the glove. Peel the second glove off over the first and discard both
in the lined waste bin.
Gown Un fasten or break ties, pull gown away from neck fold into bundle and discard*
Eye Protection (goggles/face shield) Handle only by the headband or the sides discard*
FFP3 Mask- Un fasten ties/remove bands first the bottom and then the top
Pull away from the face without touching front of mask/respirator and discard *

*Discard PPE in a lidded clinical orange bag waste bin (hospital) or in a bag in household waste
if at home.

Perform hand hygiene immediately after removing all PPE

Remember if performing a procedure which generates aerosols:
- Try and perform procedure in an area segregated from others (avoid aerosol generating
  procedures in communal area).
- Clean hard surfaces in the immediate area (whilst wearing PPE) with usual disinfectant
e.g. Clinell Sanitizing wipes (whilst wearing fresh disposable gloves and apron and
surgical mask, clean hands after removing PPE)

Contact numbers
PHE on 0344 225 3861
Infection Prevention and Control Team – office 02380 874291
Theresa Lewis (Lead IP&CN) 07500 975960
Jacky Hunt (North) – 07500 975962
Angela Roberts (West) – 07500 975961
Louise Piper (East) 07717 714894
Action Card 4 –
How to Take a Specimen

For treatment/reporting please check PHE website for latest advice before taking action
www.HIOW@phe.gov.uk

Influenza Specimen Collection:
Ideally all patients admitted to hospital with influenza-type illness should be tested for flu in order to facilitate appropriate treatment and infection control precautions.
Before entering the patient’s room gather all equipment you will need:
- 2 dry sterile polyester swabs
- Viral transport media tube (green lidded*). This should contain 1-3mls of sterile viral transport medium
  *contact the lab at your local acute trust if you need supplies of these

PPE Required:
Before entering the isolation room clean your hands and put on personal protective clothing (PPE) as follows:

- Plastic disposable apron
- Surgical face mask - (fluid repellent) -these masks are stored in community hospitals
- Eye protection if there is a risk of a splash
- Disposable gloves

**REMEMBER VACCINATION IS THE BEST FORM OF PROTECTION**

Taking the Specimen:
Nose Swab:
Tilt patient’s head back 70 degrees (if safe to do so)
While gently rotating the swab, insert swab less than one inch into nostril until resistance is met at the turbinate
Rotate the swab several times against the nasal wall and repeat in other nostril using the same swab
Place tip of the swab into sterile viral transport media

Throat swab:
Take a second dry polyester swab and insert into the mouth, swab the posterior pharynx and tonsillar areas (avoid the tongue)
Place tip of swab into the same viral transport media tube
Before leaving the patients room the following should be undertaken in this order:

Remove your gloves without allowing the outside of the glove to touch your skin and discard*
Remove your apron (break ties, pull apron away from neck/shoulders, touching insides only roll into a bundle and discard*-next remove eye protection if worn.
Clean hands
*discard into a bag, seal bag and discard in patient’s infectious waste bin (orange bag)

After leaving the room
Remove your surgical mask- untie the ties (first the bottom, then top, pull away without touching the front of the mask and discard in clinical waste bag outside of the side room
Clean hands

Packaging and Processing:
Complete the specimen request documentation as normal indicating ‘suspected influenza’ on the request form and include any prescribed treatment started
Package the specimen as normal and take to your nearest specimen collection point
Document your actions

Contact numbers
PHE on 0344 225 3861

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The flu virus can live on a hard surface for up to 24 hours and a soft surface for approx 20 minutes. The virus can be transferred to hands where infection can be spread by putting fingers into mouth/nose or touching eyes. Therefore the importance of hand hygiene (i.e. Use of soap and water or alcohol gel) and good personal hygiene is essential.

Cleaning requirements:
Damp rather than dry dusting should be carried out to avoid the generation of dust particles. Cleaning of surfaces should be carried out using a freshly prepared cleaning solution/detergent and warm water and disposable cloths/paper roll. (HSE 2008)

Action Card 5
Specific Advice for Domestic Staff Cleaning a Hospital Isolation Room.

Before commencing the cleaning process:-
Wash/Alcohol gel your hands and put on your personal protective clothing (PPE) as follows:
Plastic disposable apron
**Surgical face mask** (will be required in a hospital setting, as advised by the nurse in charge, if you are about to clean a room of a suspected or confirmed flu case).
Disposable gloves

Once cleaning has commenced:-
Keep your hands away from your face
Change gloves when they are torn or heavily contaminated
Always perform hand hygiene immediately after removing PPE.
Hospital Isolation room:

- **Minimum daily clean**, and following visible contamination, use a chlorine based product (Actichlor Plus) include wash hand basins, toilets / commode.
- Dissolve 1 Actichlor plus tablet in 1 litre cold water for a daily isolation room clean and a terminal clean – follow COSHH. Refer to Actichlor Plus poster.

  - Use disposable cloth/paper roll
  - Use equipment colour coded yellow for infected areas and dedicated to the specific isolation room.
  - Change curtains as part of terminal clean.
  - All supplies of liquid soap, paper hand towels and alcohol gel in the room should be checked daily and replaced as required.
  - All waste should be placed in an orange bag and disposed of at regular intervals, followed by hand hygiene.
  - All linen should be bagged as infectious and disposed of in a timely manner followed by hand hygiene.

Before leaving the patients’ isolation room remove PPE in this order:

- **Remove your gloves** without allowing the outside of the glove to touch your skin and discard*
- **Remove your apron** (break ties at waist then neck and pull apron away from neck/shoulders, touching inside only, roll into a bundle and discard*
- **Clean hands**

  * discard into patient’s orange bag waste bin.

After leaving the isolation room:

- **Remove your surgical mask**- untie the ties (the bottom then top), pull mask away from the face without touching the front of the mask and discard in clinical waste bag outside of the side room.
- **Clean hands**

Staff Health

Providing you are well you will not require removal from duty.

- If you are in a vulnerable group e.g. asthma/immuno-suppressed contact your Occupational Health dept. before working in clinical environments with flu patients.
- If you are pregnant contact your Occupational Health Department before working in clinical environments with flu patients.

Contact numbers

- PHE – 0344 225 3861
- Infection Prevention and Control Team – office 02380 874291
- Theresa Lewis (Lead IP&CN) 07500 975960
- Jacky Hunt (North) – 07500 975962
- Angela Roberts (West) – 07500 975961
- Louise Piper (East) 07717 714894
1. **The Anti-viral Collection Point (ACP) manager should be:**
   - Band 6 or above (no upper band limit)

2. **The role of the ACP manager is to:**
   - Mobilise and manage the ACP
   - Provide guidance, support and leadership to ACP staff
   - Liaise with the NHS England or SHFT pharmacist to manage the anti viral supply and ensure demand is met
   - Ensure that the ACP premises meet health, safety and security requirements
   - Ensure that the ACP entry and exit points, opening and closing times, directions and general information is clearly signposted at all times (using signage provided by NHS England)
   - Ensure that there is an adequate stock of consumables, stationery, cleaning equipment etc
   - Co-ordinate communications and reporting to all relevant stakeholders
   - Meet and greet those attending the ACP
   - Manage the flow of people within the ACP, managing queues and any conflicts or aggressive behaviour, providing support as and when required
   - Consider need for a security presence to manage people attending en-masse
   - Advise those attending the ACP as appropriate
   - Manage any complaints about the ACP

3. **The ACP manager will:**
   - Ensure that the staff register is maintained and attendance is recorded
   - Create and manage a staff rota ensuring sufficient staff are available
   - Generally manage all resource requirements
   - Ensure that new staff are trained and provided with information packs
   - Hold a daily briefing meeting to update staff of any changes to policy and procedure
   - Ensure that a deputy ACP manager is identified, trained and if appropriate in possession of spare set of keys to the ACP
   - Liaise with the premise security manager to ensure that security arrangements are in place (personnel, alarm systems, lockable storage for records and stockpile)
   - Notify the SHFT Incident Management Team immediately of any issues or emergencies
   - Notify the SHFT Incident Management Team of immediately any changes to the ACP arrangements
   - Ensure compliance with standard infection prevention and health and safety procedures
   - Complete reporting requirements, including daily stock usage reports and delivery error reports