



Medway Community Health Care

**Infection Prevention and Control Policy for
Pandemic Influenza: PCT and Provider Services**

Version:	1.0
Ratified by:	
Date ratified:	
Name of originator/author:	Infection Control Advisor
Name of responsible committee/individual:	Pandemic Influenza Committee
Date issued:	
Review date:	
Target audience:	PCT Commissioning Provider Services Local Authority Agencies Primary Care

Document Status	Approved
Policy ref / Version (if appropriate)	Version 2.

DOCUMENT CHANGE HISTORY		
Version	Date	Comments (i.e. viewed, or reviews, amended, approved by person or committee)
2.0		New Policy

Groups or individuals who have been consulted with in production of document:

Pandemic Flu Committee
Director of Provider Services
Assistant Director for Clinical Standards
Assistant Directors
Heads of Services
Operational Managers
Infection Control Link Practitioners

Document reference:

Review date for approved document:

December 2009

Contents

Paragraph		Page
1	Policy Statement	6
	1.1 Scope and Purpose	6
	1.2 Responsibilities	6
2	Overview of Pandemic Influenza Infection Prevention and Control	7
	2.1 Key Points	7
	2.2 Influenza Clinical Features and Transmission	8
3	Principles of Containment and Infection Prevention and Control	9
	3.1 Occupational Health and Deployment of Staff – Key Points	9
	3.2 Staff Deployment	10
	3.3 Bank and Agency Staff	11
	3.4 Workers at Risk of Complications	11
	3.5 Infection Control Precautions	11
	3.6 Droplet Precautions	11
	3.7 Patient Placement, Segregation and Cohorting	
	3.7.1 Inpatient	12
	3.7.2 PCT Health Care Clinics and Primary Care Clinics	12
	3.8 Management of a Coughing and Sneezing Patient	12
	3.9 Hand Hygiene	13
	3.10 Personal Protective Equipment (PPE)	
	3.10.1 Aprons	18
	3.10.2 Gowns	18
	3.10.3 Eye Protection	19
	3.10.4 Fluid Repellent Surgical Masks	19
	3.10.5 Putting on and Removing PPE	20
4	Aerosol Generating Procedures	22
5	Environmental Infection Control	
	5.1 Clinical and Non-clinical Waste	24
	5.2 Linen and Laundry	24
	5.3 Staff Uniforms	25
	5.4 Crockery and Utensils	25

Paragraph		Page
	5.5 Environmental Cleaning and Disinfection	25
	5.6 Medical and Nursing Equipment	26
	5.7 Furnishings	26
Appendices		
Appendix A	National Patient Safety agency Cleanyourhands Poster	15
Appendix B	Pandemic Flu Personal Protective Equipment Poster	16

1 POLICY STATEMENT

1.1 SCOPE AND PURPOSE

This policy forms part of the Medway PCT Pandemic Influenza Policy and should be read in conjunction with the operational plans and Human Resources Policy for a Major Incident.

The policy will provide guidance and information on Infection Prevention and Control (IPC) procedures for PCT and Provider Services staff, Local Authority partners, Independent Contractors, patients, relatives and visitors.

This policy is based on the Department of Health Pandemic Influenza: Guidance for Infection Control in Hospitals and Primary Care (November 2007).

1.2 RESPONSIBILITIES

The Director of Public Health is responsible for the co-ordinated, multi-agency Pandemic Influenza Plan.

The Emergency Planning Committee is responsible to ensure that the preparation, plans and policies are in place.

The PCT Board is responsible to ratify and issue The Pandemic Influenza Plan and policies.

Heads of Services and Operational Managers are responsible to ensure that staff have access to the IPC Policy, training and communication.

PCT and Provider Services staff have a responsibility to understand this policy and be aware of the implications to their area of responsibility.

The Lead for IPC during the Pandemic is the Director of Infection Prevention and Control (DIPC)

The Infection Control Advisor (ICA)/Team (Provider and Commissioning) will be responsible for the annual review of the policy annually, to provide advice, support and training to Provider services and PCT staff.

2 OVERVIEW OF PANDEMIC INFLUENZA AND INFECTION PREVENTION AND CONTROL

2.1 Key points

Health impacts of an influenza pandemic in the UK

- All age groups are likely to be affected, but children and otherwise fit adults could be at relatively greater risk.
- Clinical attack rate may be of the order of 25% to 35%, but up to 50% is possible.
- Between 55,000 and 750,000 deaths are possible.
- Substantial demand for healthcare services is likely, in both primary care and hospital settings.

Clinical features of influenza

- The most significant features are rapid onset of cough and fever.
- Headache, sore throat, a runny or stuffy nose, aching muscles and joints, and extreme tiredness are other symptoms.
- People are most infectious soon after they develop symptoms, although typically they can continue to excrete viruses for up to five days (seven days in children).

How influenza is spread

- The virus is transmitted from person to person through close contact.
- The balance of evidence points to transmission by droplet and through direct and indirect contact as the most important routes.
- Aerosol transmission may occur in certain situations, e.g. during aerosol generating procedures.

Prevention of influenza transmission

Transmission of the influenza virus can be prevented through:

- Strict adherence to infection control practices, especially hand hygiene, containment of respiratory secretions and the use of PPE.
- Adherence to standard infection control principles and droplet precautions.
- Administrative controls such as separation or cohorting of patients with influenza.
- Instructing staff members with respiratory symptoms to stay at home and not come in to work.
- Restriction of symptomatic visitors.
- Environmental cleaning.
- Education of staff, patients and visitors.

2.2 Influenza Clinical Features and Transmission

Influenza is a respiratory illness characterised by sudden onset of fever and cough, with other possible symptoms being chills, headache, sore throat and 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.

The typical incubation period for non-pandemic influenza is one to four days, with an average of two to three days.

People are most infectious soon after they develop symptoms, although they can continue to excrete viruses for up to five days (although longer periods have been found).

The period of communicability is longer in children – typically seven days.

It is well established that influenza is transmitted from person to person through close contact with an infected coughing or sneezing person.

Transmission almost certainly occurs through multiple routes, including droplets and direct and indirect contact.

Aerosol transmission may also occur in certain situations.

Droplet and contact transmission is the most important and likely route.

Experimental studies of survival of the influenza virus suggest that it can survive for limited periods of time in the environment, depending on the surface contaminated.

It can be transferred from contaminated surfaces onto hands, and is easily inactivated by commercially available alcohol handrub.

Influenza viruses are easily deactivated by washing with soap and water or alcohol handrub and by cleaning surfaces with normal household detergents and cleaners.

Careful and frequent hand hygiene and environmental cleaning are important to help control spread through contact.

3 PRINCIPLES OF CONTAINMENT AND INFECTION PREVENTION AND CONTROL

Limiting the transmission of influenza in the healthcare setting requires:

- Timely recognition of influenza cases.
- Instructing staff members with respiratory symptoms to stay at home and not come in to work.
- Segregating staff into those who are dealing with influenza patients and those who are not.
- Consistently and correctly implementing appropriate infection control precautions to limit transmission (standard infection control principles and droplet precautions).
- Using PPE appropriately, according to risk of exposure to the virus.
- Maintaining separation in space and/or time between influenza and non-influenza Patients.
- Restricting access of ill visitors to the facility and posting pertinent signage in clear and unambiguous language (including in languages other than English).
- Environmental cleaning and disinfection.
- Educating staff, patients and visitors about the transmission and prevention of influenza.
- Treating patients and staff with antiviral drugs that can reduce infectivity and the duration of illness.
- Vaccinating patients and staff.

3.1 OCCUPATIONAL HEALTH AND DEPLOYMENT OF STAFF

Refer to the PCT *Human Resources Policy in the case of a Major Incident* for full guidance.

Key points

Prompt recognition of cases of influenza among healthcare workers is essential to limit the spread of the pandemic.

- Healthcare workers with influenza should not come to work.
- As a general principle, healthcare workers who provide care in areas for pandemic influenza patients should not care for other patients, although exceptions may be necessary.

- Healthcare workers at high risk of complications from influenza should not provide direct patient care.
- Bank and agency staff should follow the same deployment advice as permanent staff.
- The PCT Human Resources Department will lead on the implementation of systems to monitor staff illness and absence.
- The PCT will facilitate staff access to antiviral treatment where necessary and implement vaccination of the healthcare workforce when required.

3.2 Staff Deployment

Healthcare workers who are assigned to care for patients with influenza or who work in areas of a facility that have been segregated for patients with influenza should not be assigned to care for non-influenza patients or work in non-influenza areas.

Exceptions to this include:

- In community hospitals, hospice and nursing home, workers in occupations with a limited number of staff, e.g. medical staff and AHPs, although segregation of staff should be maintained as much as is practically possible.
- Situations in which the care and management of the patient would be compromised.
- Staff who have fully recovered from pandemic influenza.

In some work settings in primary care such staff segregation may not be feasible.

Consideration should be given to developing approaches that are similar to those in hospital settings; for example, one general practitioner (GP) or district nurse could be designated to see all the patients with symptoms of influenza in a session.

In PCT in patient/residential areas, healthcare workers from a non-influenza area may be redeployed in an area that is segregated for the care of influenza patients. However, once redeployed, such workers cannot return to their original non-influenza area for the duration of the pandemic, apart from the exceptions listed above.

Healthcare workers who have recovered from influenza, or who have received a full course of vaccination against the pandemic strain and are therefore considered unlikely to develop or transmit influenza, should be prioritised for the care of patients with influenza.

In exceptional circumstances these workers may be moved within a period of duty, but this is not desirable.

3.3 Bank and Agency Staff

Bank and agency staff must not work across different clinical environments. **Bank and agency staff should follow the same deployment advice as permanent staff.**

3.4 Workers at risk of complications from pandemic influenza

Healthcare workers who are at high risk of complications of influenza (e.g. pregnant women and immunocompromised workers) should be considered for alternate work assignments, away from the direct care of patients, for the duration of the pandemic or until they have been vaccinated if it is clinically appropriate for them to be vaccinated.

They should not provide care to patients who are known to have influenza, and neither should they enter parts of the facility segregated for the treatment of patients with influenza.

3.5 Infection Control Precautions

Infection Control precautions will minimise exposure to and transmission of micro-organisms.

Infection control precautions should be applied by **all** healthcare practitioners to the care of **all** patients **all** of the time.

Infection Controls precautions are:

- Hand Hygiene
- Use of Personal Protective Equipment (PPE)
 - Gloves
 - Masks
 - Aprons and gowns
 - Eye protection
- Safe use and disposal of sharps
- Disposal of clinical waste
- Safe handling of linen
- Placement of patients
- Transport of patients
- Managing coughing and sneezing

3.6 Droplet Precautions required for pandemic influenza

In addition to the standard infection control principles, droplet precautions should be used if a patient is known or suspected to be infected with influenza and is at risk of transmitting droplets while coughing, sneezing or talking and during some procedures. These are segregation/cohorting and the management of coughing and sneezing patients.

3.7 Patient placement, segregation and cohorting

3.7.1 In patient

Ideally patients with influenza should be placed in single rooms, but during a pandemic this will not be possible.

Therefore patients should be 'cohorted' (grouped together with other patients who have influenza and no other infection) in a segregated area.

Where patients are cohorted on the basis of epidemiological and clinical information rather than on laboratory-confirmed diagnosis, beds should be at least one metre apart.

Special ventilation is not necessary, and the doors of segregated areas can remain open (unless a patient is being isolated for another reason in addition to influenza that requires the doors to be shut).

3.7.2 PCT health care clinics and primary care clinics

Patients with influenza from those without should be separated within a designated self-contained area.

The area should:

- Be fully self-contained
- Include reception and waiting areas that are separated from non-influenza patients
- Have a separate entrance/exit door
- Not be used as a thoroughfare by other patients, visitors or staff.

To control entry, signage should be displayed warning of the segregated influenza area.

3.8 Management of a coughing and sneezing patient

Patients, staff and visitors should be encouraged to minimise potential influenza transmission through good hygiene measures. These will be advertised by the DH through a media campaign:

Cover nose and mouth with disposable, single – use tissues when sneezing, coughing, wiping and blowing noses.

Dispose of use tissue in a lined, lidded waste bin.

Wash hands after coughing, sneezing, using tissues or contact with respiratory secretions and contaminated objects.

Keep hands away from the eyes, mouth and nose.

Assist patients with the management and containment of used tissues by supplying a plastic bag and hand wipes.

In common waiting areas, coughing and sneezing patients should wear a surgical mask.

3.9 Hand Hygiene

Hand hygiene is the single most important practice needed to reduce the transmission of infection in healthcare and patients home settings.

Hands must be decontaminated immediately before each and every episode of direct patient contact or care and after any activity or contact that potentially results in hands becoming contaminated, e.g. contact with the patient's immediate environment, handling of linen or waste.

Hands that are visibly soiled or potentially grossly contaminated with dirt or organic material, e.g. after removal of gloves, must be washed with liquid soap and water.

Hands should be decontaminated between caring for different patients and between different care activities for the same patient. For convenience and efficacy, an alcohol handrub is preferable unless hands are visibly soiled.

Hands should be washed with soap and water after several consecutive applications of alcohol handrub.

Before a shift of clinical work begins, all wrist and, ideally, hand jewellery (stoned rings) should be removed. Plain wedding bands are permitted.

All staff working in a clinical area will be bare below the elbows to ensure effective hand hygiene.

Cuts and abrasions must be covered with waterproof dressings.

Fingernails should be kept short, clean and free of nail polish. False nails and nail extensions must not be worn by clinical staff.

An effective hand washing technique involves three stages: preparation, washing and rinsing, and drying.

Wet hands under tepid running water **before** applying the recommended amount of liquid soap.

The hand wash solution must come into contact with all the surfaces of the hand.

The hands must be rubbed together vigorously for a minimum of 10–15 seconds, and particular attention should be paid to the tips of the fingers, the thumbs and the areas between the fingers.

Hands should be rinsed thoroughly prior to drying with good-quality paper towels.

When an alcohol handrub is used to decontaminate hands, hands should be free of dirt and organic material.

The handrub solution must come into contact with all surfaces of the hand. The hands must be rubbed together vigorously, with particular attention paid to the tips of the fingers, the thumbs and the areas between the fingers, until the solution has evaporated and the hands are dry.

Clinical staff should be aware of the potentially damaging effects of hand decontamination products. They should be encouraged to use an emollient hand cream regularly, e.g. after washing hands before a break, or when going off duty and when off duty, to maintain the integrity of the skin.

If a particular soap, antimicrobial hand wash or alcohol-based product causes skin irritation, review the methods described above before consulting the occupational health team.

Alcohol handrub should be made available at the point of care in all healthcare facilities or carried personally by staff.

See Appendix A.

See Appendix B.

3.10 PERSONAL PROTECTIVE EQUIPMENT (PPE)

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.

Care must be taken to ensure that PPE is worn and removed correctly, in order to avoid inadvertent contamination.

All staff must remove contaminated clothing – surgical masks or respirators being removed last – and dispose of it appropriately as clinical waste, also known as infectious waste, before staff leave a patient care area.

Appropriate PPE for staff who care for patients with pandemic influenza is summarised in Table 1.

Table 1: Personal protective equipment for staff who care for patients with pandemic influenza

	ENTRY TO COHORTED AREA BUT NO CONTACT WITH PATIENTS	CLOSE PATIENT CONTACT (WITHIN ONE METRE)	AEROSOL-GENERATING PROCEDURES ^a
Hand hygiene	✓	✓	✓
Gloves	x ^b	✓ ^c	✓
Plastic apron	x ^b	✓	x
Gown	x	x ^{d,e}	✓ ^e
Surgical mask	✓ ^f	✓	x
FFP3 respirator	x	x	✓
Eye protection	x	Risk assessment	

- A Wherever possible, aerosol-generating procedures should be performed in side rooms or other closed single patient areas with minimal staff present (see section 4).
- B Gloves and apron should be worn during certain cleaning procedures (see section 5.5).
- C Gloves should be worn in accordance with standard infection control principles. If glove supplies become limited or come under pressure, this recommendation may need to be relaxed. Glove use should be prioritised for contact with blood and body fluids, invasive procedures and contact with sterile sites.
- D Consider a gown in place of an apron if extensive soiling of clothing or contact of skin with blood or other body fluids is anticipated (e.g. during intubation or when caring for babies).
- E If non-fluid-repellent gowns are used, a plastic apron should be worn underneath.
- F Surgical masks (fluid repellent) are recommended for use at all times in cohorted areas for practical purposes.
If mask supplies become limited or come under pressure, then in cohorted areas their use should be limited to close contact with a symptomatic patient (within one metre)

3.10.1 Aprons

Disposable plastic aprons should be worn whenever there is a risk of personal clothes or a uniform coming into contact with a patient's

blood, body fluids, secretions (including respiratory secretions) or excretions or during activities that involve close contact with the patient (e.g. examining the patient).

Plastic aprons should be worn as single-use items for one procedure or episode of patient care and then discarded and disposed of as clinical waste.

In cohorted areas, aprons must be changed between patients.

3.10.2 **Gowns**

Gowns are not required for the routine care of patients with influenza.

Healthcare workers should wear gowns if they anticipate extensive soiling of their personal clothing or uniform with respiratory secretions, or if there is risk of extensive splashing of blood, body fluids, secretions or excretions onto their skin.

Aerosol-generating procedures such as intubation and activities that involve holding the patient close (such as in paediatric settings) are examples of when a gown may be needed.

Fluid repellent gowns are preferable, but if non-fluid repellent gowns are used a plastic apron should be worn beneath.

Gowns should:

- Fully cover the area to be protected
- Be worn only once and then placed in a clinical waste or laundry receptacle, as appropriate.

Hand hygiene should be performed immediately after removal of the gown.

3.10.3 **Eye protection**

Eye protection should be worn when there is a risk of contamination of the eyes by splashes and droplets, e.g. by blood, body fluids, secretions or excretions.

Individual risk assessments should be carried out at the time of providing care to patients to identify those at risk and decide on reasonable precautions to reduce the risk.

Eye protection should always be worn during aerosol-generating procedures. This requirement extends to all those present in the room during a procedure that has the potential to produce an aerosol.

Eye protection can be achieved by using any one of:

- a surgical mask with integrated visor
- a full-face visor
- polycarbonate safety spectacles or equivalent.

Disposable single-use eye protection is recommended.

If non disposable eye protection is used it must be decontaminated after each use following the manufacturers instructions.

3.10.4 **Fluid repellent surgical masks**

Surgical masks should be fluid repellent and should be worn by healthcare workers for any close contact with patients (i.e. within one metre).

The mask will provide a physical barrier and minimise contamination of the nose and mouth by droplets.

Surgical masks should:

- Cover both the nose and the mouth
- Not be allowed to dangle around the neck after or between each use
- Not be touched once put on
- Be changed when they become moist
- Be worn once only and then discarded in an appropriate receptacle as clinical waste.

Hand hygiene must be performed after disposal is complete.

When influenza patients are cohorted in one area and several patients must be visited over a short time or in rapid sequence (e.g. in cohorted areas of a hospital or nursing home, an “influenza clinic’ or a GP surgery session for influenza patients), healthcare workers are to wear a single surgical mask upon entry to the area and to keep it on for the duration of the activity or until the surgical mask requires replacement.

This also minimises hand-to-face contact and reminds healthcare workers that they are working in a high-risk area.

However, other PPE (e.g. gloves and apron) must be changed between patients and hand hygiene performed.

Although it may be more practical to wear a surgical mask at all times in a cohorted area, if surgical mask supplies become limited during a pandemic, surgical masks will be prioritised for use when healthcare workers are in close contact (within one metre) with a symptomatic influenza patient.

All contaminated PPE must be removed before leaving a patient care area.

Surgical masks or FFP3 respirators should be removed last, and removal should be followed by thorough hand hygiene.

3.10.5 Respirators

A disposable respirator that provides the highest possible protection factor available (i.e. an EN149:2001 FFP3 disposable respirator, (FFP3) should be worn by healthcare workers when they perform procedures that have the potential to generate aerosols.

If an FFP3 disposable respirator is not immediately available, the next highest category of respirator available should be worn (i.e. FFP2).

Every user should be fit tested and trained in the use of the respirator. In addition to the initial fit test carried out by a trained fitter, a fit check should be carried out each time a respirator is worn.

The respirator must seal tightly to the face, or air will enter from the sides.

A good fit can be achieved only if the area where the respirator seals against the skin is clean shaven. Beards, long moustaches, and stubble may cause leaks around the respirator.

FFP3 respirators should be replaced after each use and changed if breathing becomes difficult, if the respirator becomes damaged, distorted or obviously contaminated by respiratory secretions or other body fluids, or if a proper fit to the face cannot be maintained.

Respirators should be disposed of as clinical waste.

Putting on and removing PPE

The level of PPE used will vary according to the procedure being carried out, and not all items of PPE will always be required.

Standard infection control principles apply at all times.

Putting on PPE

Healthcare workers should put on PPE before they enter a single room or cohorted area.

The order given here for putting on PPE is practical, but the order for putting on is less critical than the order of removal.

1. Gown or apron if it is not an aerosol-generating procedure

- Fully cover the torso from the neck to knees and the arms to the end of the wrists, and wrap around the back.
- Fasten at back of neck and waist.

2. Surgical mask (or FFP3 respirator if it is an aerosol-generating procedure)

- Secure ties or elastic bands at middle of head and neck.
- Fit flexible band to nose bridge.
- Fit snug to face and below chin.
- Fit check the respirator.

3. Goggles or face shield (in aerosol-generating procedures and as appropriate after risk assessment)

- Place over face and eyes and adjust to fit.

4. Disposable gloves

- Extend to cover wrist of gown if a gown is worn.

Removing PPE

Healthcare workers should remove PPE upon leaving the room or cohorted area in an order that minimises the potential for cross-contamination

If a single room has been used for an aerosol-generating procedure, those involved in the procedure should, **before** leaving the room, remove their gloves, gown and eye goggles (in that order) and dispose of them as clinical waste.

After they leave the room they can remove the respirator and dispose of it as clinical waste.

Hand hygiene should be performed after all PPE has been removed.

The order for removing PPE is important to reduce cross-contamination. The order outlined as follows always applies, even if not all items of PPE have been used.

1. Gloves

Assume that the outside of the glove is contaminated.

- Grasp the outside of the glove with the opposite gloved hand; peel off.
- Hold the removed glove in gloved hand.
- Slide the fingers of the ungloved hand under the remaining glove at the wrist.
- Peel off second glove over first glove.
- Discard appropriately.

2. Gown or apron

Assume that the front and sleeves of the gown or apron are contaminated.

- Unfasten or break the ties.
- Pull the gown or apron away from the neck and shoulders, touching the inside of the gown only.
- Turn the gown inside out.
- Fold or roll it into a bundle and discard appropriately.

3. Goggles or face shield

Assume that the outside of the goggles or face shield is contaminated.

- To remove, handle by head band or ear pieces.
- Discard appropriately.

4. Respirator or surgical mask

Assume that the front of the respirator or surgical mask is contaminated.

- Untie or break the bottom ties, followed by the top ties or elastic, and remove the respirator or mask by handling the ties only.
- Discard appropriately.

Perform hand hygiene immediately after removing all PPE.

4 Aerosol generating procedures

Several medical procedures have been reported to generate aerosols, and it has been suggested that some of these are associated with an increased risk of pathogen transmission.

The risk associated with many aerosol-generating procedures is not yet well defined, and the understanding of the aerobiology involved in such procedures may change as further studies in this area are carried out. In a recent (2007) revised WHO document, *Infection prevention and control of epidemic-and pandemic-prone acute respiratory diseases in healthcare*, based on epidemiological studies on tuberculosis (TB) and/or SARS, the following aerosol-generating procedures were considered to be associated with a documented increase in risk of pathogen transmission in patients with acute respiratory disease

- Intubation and related procedures, eg manual ventilation and suctioning
- Cardiopulmonary resuscitation
- Bronchoscopy
- Surgery and post-mortem procedures in which high-speed devices are used.

Other controversial/possible procedures that may be associated with an increased risk of pathogen transmission are non-invasive positive pressure ventilation, bi-level positive airway pressure, high frequency oscillating ventilation and nebulisation.

Infection control and personal protective equipment in aerosol-generating procedures

Only essential aerosol-generating procedures should be carried out.

Aerosol-generating procedures should be carried out in well-ventilated single rooms with the doors shut.

Only those healthcare workers who are needed to perform the procedure should be present.

A gown, gloves and eye protection must be worn during such procedures.

An FFP3 respirator should be worn for:

- Intubation and related procedures, e.g. manual ventilation and suctioning.
- Cardiopulmonary resuscitation.
- Bronchoscopy.

For procedures with only a 'controversial/possible' increase in risk of pathogen transmission, use of an FFP3 respirator instead of a surgical mask may be considered prudent until data are available that allow better assessment of the risk associated with different procedures.

These include nebulisation and chest physiotherapy and emergency dental procedures.

5 Environmental Infection Control

5.1 Clinical and non clinical waste

The Department of Health has published guidance on the safe disposal of healthcare waste: *Health Technical Memorandum 07-01: Safe management of healthcare waste*.

No special procedures beyond those required to conform with standard infection control principles are recommended for handling clinical waste (also known as infectious waste) and non-clinical waste that may be contaminated with influenza virus.

All items contaminated with secretions or sputum e.g. paper tissues and surgical masks, will be treated as infectious clinical waste.

Gloves and aprons will be worn to remove waste bags.

All waste collection bags should be tied and sealed before removal from the patient area.

Hand hygiene will be performed after removing the apron and gloves.

5.2 Linen and laundry

Linen used during care of patients should be managed safely to reduce the risk of contamination to staff, the environment and patients.

Linen should be categorised as 'used' or 'infected' as per the NHS Executive's *Health Service Guideline (95) 18: Hospital laundry arrangements for used and infected linen*

Both used and infected linen must be handled, transported and processed in a manner that prevents exposure to the skin and mucous membranes of staff, contamination of their clothing and the environment, and infection of other patients.

Linen should be placed in appropriate receptacles immediately after use and bagged at the point of use.

If linen appears to be heavily soiled with body fluids, including respiratory secretions, it should be treated as potentially infected and put into alginate bags.

Linen bags must be closed before removal from the influenza patient care area.

Gloves and aprons should be worn when handling all contaminated linen

Hand hygiene should be performed after removal of gloves that have been in contact with used linen and laundry.

Paper sheeting should be used on patient examination couches. It should be changed after each patient has been examined and the couch cleaned with detergent.

5.3 Staff Uniforms

During a pandemic, healthcare workers should not travel to and from work or between remote hospital residences and places of duty in uniform.

Community staff will be required to use PPE at the entrance to each patients home and remove before leaving the property. At the end of the shift staff will be required to change out of their uniform and transported as detailed below.

Changing rooms or areas where staff can change into uniforms upon arrival at work will be provided.

Uniforms should be laundered in a domestic washing machine at the optimum temperature recommended by the detergent manufacturers that is appropriate to the maximum temperature the fabric can tolerate, then ironed or tumbled dried.

Uniforms should be transported home in a tied plastic bag and washed separately from other linen in a load not more than half the machine's capacity, in order to ensure adequate rinsing and dilution.

5.4 Crockery and utensils

The usual mode of cleaning with detergents and hot water is appropriate.

5.5 Environmental Cleaning and disinfection

Freshly prepared neutral detergent and warm water should be used for cleaning the hospital or other healthcare environment.

As a minimum, areas used for cohorted patients should be cleaned daily. This includes surfaces and patient bed area equipment.

Clinical rooms should be cleaned at least daily and also between clinical sessions for patients with influenza and those for patients not infected with influenza, if the same clinical room is used.

Frequently touched surfaces such as medical equipment and door handles should be cleaned at least twice daily and when known to be contaminated with secretions, excretions or body fluids.

Domestic staff should be allocated to specific areas and not moved between influenza and non-influenza areas.

Domestic staff should wear gloves and aprons when cleaning general areas.

Domestic staff should wear gloves, aprons and masks when cleaning the immediate patient environment in cohorted areas

Dedicated or single-use/disposable equipment should be used when possible.

Non-disposable equipment should be decontaminated or laundered after use in line with the manufacturers instructions.

Any spillage or contamination of the environment with secretions, excretions or body fluids should be treated in line with the PCT spillage policy.

5.6 Medical and nursing equipment

Gloves should be worn when handling and transporting used patient care equipment.

Heavily soiled equipment should be cleaned with neutral detergent and warm water before being removed from the patient's room or consulting room.

Reusable equipment (eg stethoscopes and patient couches in treatment and consulting rooms) must be scrupulously decontaminated between each patient; equipment that is visibly soiled should be cleaned promptly. Where applicable, follow local and manufacturers' recommendations for cleaning and disinfection or sterilisation of reusable patient care equipment.

External surfaces of portable equipment used for procedures in the patient's room or consulting room should be cleaned with neutral detergent and warm water upon removal from the room.

In addition to these standard practices, non-critical patient equipment should, whenever possible, be dedicated to the use of influenza patients only.

Use of equipment that re-circulates air (such as fans) should be avoided.

5.7 Furnishings

All non-essential furniture, especially soft furnishings, should be removed from reception and waiting areas in hospitals, clinic rooms and GP consulting and treatment rooms.

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 area.

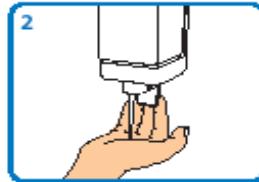
Appendix A



Hand-washing technique with soap and water



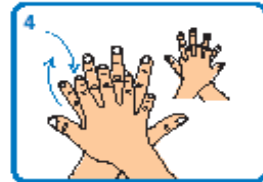
1 Wet hands with water



2 Apply enough soap to cover all hand surfaces



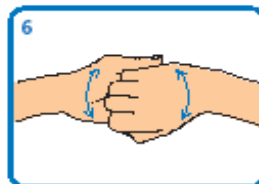
3 Rub hands palm to palm



4 Rub back of each hand with palm of other hand with fingers interlaced



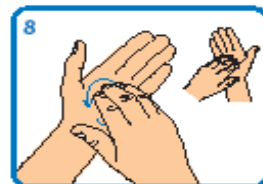
5 Rub palm to palm with fingers interlaced



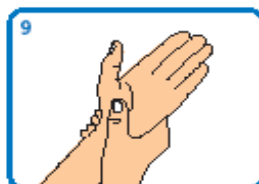
6 Rub with back of fingers to opposing palms with fingers interlocked



7 Rub each thumb clasped in opposite hand using a rotational movement



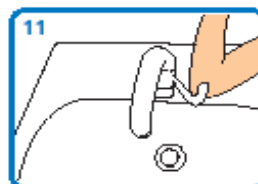
8 Rub tips of fingers in opposite palm in a circular motion



9 Rub each wrist with opposite hand



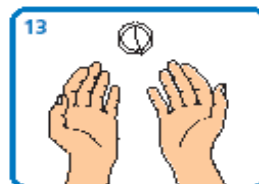
10 Rinse hands with water



11 Use elbow to turn off tap



12 Dry thoroughly with a single-use towel



13 Hand washing should take 15-30 seconds



© Crown copyright 2007 283373 1p 1k Sep07

Adapted from World Health Organization *Guidelines on Hand Hygiene in Health Care*



PANDEMIC FLU

PREPARE & PROTECT Guidance for healthcare staff



PUTTING ON personal protective equipment (PPE)

The type of PPE used will vary based on the type of exposure anticipated, and not all items of PPE will be required.

The order for putting on PPE is APRON, SURGICAL MASK, EYE PROTECTION and GLOVES.



APRON (OR GOWN)
 • Pull over head and fasten at back of waist



SURGICAL MASK (OR RESPIRATOR)
 • Secure ties or elastic bands at middle of head and neck
 • Fit flexible band to nose bridge
 • Fit snug to face and below chin
 • Fit/check respirator



EYE PROTECTION (GOGGLES/FACE SHIELD)
 • Place over face and eyes and adjust to fit



GLOVES
 • Extend to cover wrist

REMOVING personal protective equipment (PPE)

PPE should be removed in an order that minimises the potential for cross-contamination.

The order for removing PPE is GLOVES, APRON, EYE PROTECTION and SURGICAL MASK.



GLOVES
 • Grasp the outside of the glove with the opposite gloved hand; peel off
 • Hold the removed glove in the gloved hand
 • Slide the fingers of the ungloved hand under the remaining glove at the wrist
 • Peel the second glove off over the first glove
 • Discard in a lined waste bin



APRON (OR GOWN)
 • Unfasten or break ties
 • Pull apron away from neck and shoulders lifting over head, touching inside only
 • Fold or roll into a bundle
 • Discard in a lined waste bin



EYE PROTECTION (GOGGLES/FACE SHIELD)
 • Handle only by the headband or the sides
 • Discard in a lined waste bin



SURGICAL MASK (OR RESPIRATOR)
 • Unfasten the ties – first the bottom, then the top
 • Pull away from the face without touching front of mask/respirator
 • Discard in a lined waste bin

EXAMPLE FOR TRAINING USE

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF INFECTION

- Keep hands away from face
- Change gloves when torn or heavily contaminated
- Limit surfaces touched
- Regularly perform hand hygiene

PERFORM HAND HYGIENE IMMEDIATELY AFTER REMOVING ALL PPE

All PPE should be removed before leaving the area and disposed of as clinical (infectious) waste.

FOR MORE INFORMATION CONTACT: