

SEASONAL INFLUENZA POLICY

(To be read in conjunction with the Isolation Policy and
Standard IPC Precautions including Blood and Body Fluid Spillages Policy)

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1 INTRODUCTION

- 1.1 Influenza or 'flu' is an acute viral infection of the respiratory tract. There are three types of influenza virus: A, B and C. Influenza A and B are responsible for most clinical illness.
- 1.2 For otherwise healthy individuals, influenza is an unpleasant but usually self-limiting disease with recovery usually within two to seven days. The risk of complicated influenza is higher amongst children under six months of age, older people and those with underlying health conditions such as respiratory or cardiac disease or immunosuppression and pregnant women. Influenza during pregnancy may also be associated with perinatal mortality, prematurity, smaller neonatal size and lower birth weight.
- 1.3 Most cases in the UK tend to occur during an eight to ten-week period during the winter. Transmission is by aerosol, droplets or through direct contact with respiratory secretions of someone with the infection. The incubation period of influenza is 1 to 4 days. The infectious period for influenza is usually 5 days (although may be up to 7 days) from onset of symptoms. Immunocompromised individuals may remain infectious for a much longer period. Influenza spreads rapidly, especially in closed communities.
- 1.4 To help avoid complications, reduce mortality and limit spread in the wider community, Seasonal 'Flu' vaccines are offered to all individuals, at high risk of complicated Influenza, by their General Practitioner and to help protect patients and staff, the Department of Health recommends annual immunisation against influenza for all health care workers

2 PURPOSE AND RATIONALE

- 2.1 The purpose of this policy is to provide clear guidance on the recognition, care and management of patients with Seasonal Influenza and ensure all actions are taken to limit the transmission of the infection to others.
- 2.2 This policy applies to all clinical staff (including Temporary, Locum, Bank, Agency, Contracted staff as appropriate).

3 POLICY STATEMENT

- 3.1 Influenza is a communicable viral illness and can be transmitted through airborne spread or through direct contact of throat and nasal secretions of infected individuals. Seasonal Influenza is particularly problematic for the very young, the elderly, the immunocompromised and those with chronic health conditions. Annual vaccination is provided by the NHS to provide protection for these 'at risk' groups and for healthcare professionals to help reduce further spread. Effective management of known or suspected cases of Seasonal Influenza is vital to ensure the safety of vulnerable patient groups.

4 DEFINITIONS

- 4.1 **Aerosol Generating Procedures (AGP's)** - are procedures which generate an aerosol from the patients' secretions and include:

- Intubation, extubation and related procedures, for example manual ventilation and open suctioning
- Cardiopulmonary resuscitation
- Bronchoscopy
- Surgery and post mortem procedures in which high-speed devices are used
- Non Invasive Ventilation (NIV) e.g. Bilevel Positive Airway Pressure
- Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- High Frequency Oscillatory Ventilation (HFOV)
- Induction of sputum
- Dental Procedures

The following procedures may generate an aerosol from material other than patients' secretions but are NOT considered to represent a significant infectious risk:

- Administration of pressurised humidified O₂
- Administration of medication via nebulisation

4.2 **Close Contacts (patients)** – are defined as those who have:

- A patient who has been in the same bay as an infectious influenza patient for a period of 4 hours or more OR any time period if the infectious patient has undergone an AGP in the bay

4.3 **Close Contacts (staff)** – are defined as those who have:

- Has been within 2 metres with a confirmed infectious case of influenza without wearing a fluid repellent mask OR been within the same room or bay without an FFP3 respirator or eye protection whilst AGPs have been performed

4.4 **Immunosuppressed patients** – these include:

- patients with evidence of severe primary immunodeficiency, for example, severe combined immunodeficiency, Wiskott-Aldrich syndrome and other combined immunodeficiency syndromes
- patients currently being treated for malignant disease with immunosuppressive chemotherapy or radiotherapy, or who have terminated such treatment within at least the last six months
- patients who have received a solid organ transplant and are currently on immunosuppressive treatment
- patients who have received a bone marrow transplant, until at least 12 months after finishing all immunosuppressive treatment, or longer where the patient has developed graft-versus-host disease
- patients receiving systemic high-dose steroids, until at least three months after treatment has stopped

- patients receiving other types of immunosuppressive drugs (e.g. azathioprine, cyclosporin, methotrexate, cyclophosphamide, leflunomide and the newer cytokine inhibitors) alone or in combination with lower doses of steroids, until at least six months after terminating such treatment
- patients with immunosuppression due to human immunodeficiency virus (HIV) infection.

4.5 **Incubation** - the time between exposure to a pathogen and developing symptoms of infection.

4.6 **Infectious Period** - the time period over which an infected person can spread the infection to someone else. For Influenza, this is until 24 hours after symptoms have resolved or 7 days, whichever is earlier, unless the patient is severely immunocompromised.

4.7 **Influenza Season** – Usually for an 8 to 10 week period during the winter months. This is triggered when the a letter from the CMO/CPhO is sent notifying prescribers that surveillance indicators are at a level to indicate flu circulating in the community and that antivirals may be prescribed.

4.8 **Notifiable Diseases** - an infectious disease requiring notification to Public health England (PHE) under Health Protection Legislation Guidance 2010.

4.9 **High Risk Groups (patients and staff)** - those at risk from complicated influenza, as identified by Department of Health / PHE. The current list includes:

- over 65 years of age
- under 6 months of age
- chronic respiratory disease (including asthma that requires continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission)
- heart disease
- chronic kidney disease
- chronic liver disease
- chronic neurological disease
- immunosuppression due to disease or treatment
- diabetes mellitus
- pregnant women
- morbid obesity (BMI \geq 40)

5 DUTIES AND RESPONSIBILITIES

5.1 **The Trust Board, via the Chief Executive will:**

- ensure there are effective and adequately resourced arrangements for the detection and management of infection within the Trust;
- identify a board level lead for infection prevention and control;

ensure that the role and functions of the Director of Infection Prevention and Control are satisfactorily fulfilled.

5.2 Director of Infection Prevention and Control (DIPC):

- is responsible for providing assurance to Trust Board in relation to Seasonal Influenza and associated practices across the Trust;
- the Infection Prevention and Control Group will ensure that procedures for the implementation of the policy for the detection and management of infection are continually reviewed and improved within the Trust.

5.3 Infection Prevention and Control (IPC) Team will:

- provide advice to ward staff in the infection control management of a case of influenza, including source isolation;
- liaise with the nurse in charge of the ward to ensure that patients who have had 'close contact' with a confirmed infectious case are appropriately identified.

5.4 Consultant Microbiologists (CMM) will:

- provide advice to clinical teams on the diagnosis and management of patients with suspected or confirmed influenza as required;
- provide advice on post exposure prophylaxis for at risk patients who have had 'close contact' with a confirmed infectious case;
- provide additional advice regarding the clinical management of patients with influenza not covered in this policy.

5.5 Ward/Team Managers are responsible for:

- ensuring all staff working in that area understand and implement the infection prevention and control precautions outlined in this policy;
- ensuring that appropriate and sufficient Personal Protective Equipment is available in their ward or department;
- ensuring that staff are aware of the policy and requirements for attending training as identified in the Training Needs Analysis. Managers will ensure that staff have attended all relevant training and have current updates;
- ensuring that staff are released to attend relevant Training and for recording attendance at training in local training records. All non-attendance at training will be followed up by managers;
- ensuring individual staff and team's training needs are met through appraisal and in line with the Training Needs Analysis. Training information should be passed to the Learning and Development Department who will update the electronic staff record.

5.6 **All Healthcare Staff** - involved in care of patients or their environment are responsible for:

- the implementation of, and compliance, with this policy;
- ensuring appropriate diagnostic testing is undertaken for patients with suspected influenza;
- following the advice of the CMMs and IP&C Team relating to care of will
- maintaining a list of patients who have had 'close contact' with a confirmed infectious case to the appropriate clinical teams so that their risk status can be checked and influenza prophylaxis given as appropriate;
- reporting to ward/department manager when there are insufficient facilities available to ensure compliance with the policy;
- booking themselves onto initial and update mandatory training and for attending mandatory training.

5.7 **Occupational Health Department will:**

- Provide advice on post exposure prophylaxis for staff falling into one of the defined risk groups who have had 'close contact' with a confirmed infectious case;
- Give advice to staff with influenza who contact the Occupational Health department, including advice on when they may return to work.

6 DIAGNOSIS AND TESTING

6.1 Symptoms of influenza include the sudden onset of fever, chills, headache, myalgia and extreme fatigue. Other common symptoms include a dry cough, sore throat and stuffy nose. The illness may also be complicated by (and may present as) bronchitis, secondary bacterial pneumonia or, in children, otitis media. Influenza can rarely be complicated by meningitis, encephalitis or meningoencephalitis.

6.2 Influenza should be suspected in all patients admitted with a flu-like illness with an onset within 7 days and fitting the following criteria:

- fever ≥ 38 °C, or history of fever AND two or more symptoms - cough, sore-throat, rhinorrhoea, limb / joint pain, headache.
- up to one third of patients (especially the elderly) will not present with a fever therefore also suspect patients with three of the above symptoms if no fever present.

6.3 During the "Influenza season", patients suspected of having Influenza, based on the above criteria, should have virology swabs from nose and throat for laboratory confirmation.

6.4 Nose and throat swabs should be taken using specific, green top, virology swabs (for areas using Taunton Labs – colours for other labs may differ, please refer to local virology swabbing guidance). The nasal swab should be taken from deep inside the nasal cavity (not just anterior nares as in MRSA). For the throat swab, the tongue should be depressed with a spatula and the

swab rubbed up and down against the back of the throat and the tonsils, avoiding the tongue and cheeks. When taking the swabs, which could induce coughing, a surgical mask, gloves and a plastic apron should be worn. If the patient is already coughing violently you should also eye protection should also be worn.

- 6.5 Outside the influenza season swabbing patients for influenza should be discussed with the Consultant Microbiologist.

7 INFECTION CONTROL PRECAUTIONS

- 7.1 Isolation - patients with suspected or confirmed Influenza should be source isolated as per the Isolation policy. In addition
- 7.2 Pregnant Staff - should not care for patients with suspected or confirmed influenza during the infectious stage.
- 7.3 Respiratory Protective Equipment
- Fluid Repellent Surgical Masks - should be worn for all activities carried out within 2 metres of the patient. In practice this will mean donning prior to entering the room.
 - FFP3 Respirator masks should be worn when undertaking AGPs (as defined in Section 4).
 - Eye Protection should be worn if there is a risk of splash and for all AGPs.
- 7.4 Visitors – These should be limited to essential visiting only during the infectious stage, and, if not a household contact, should be advised to wear a fluid repellent mask.
- 7.5 Transportation – Transportation of patients during the infectious stage of influenza should be limited to essential purposes only (i.e. clinical need). During transfers the patient should wear a fluid repellent surgical mask. If the patient is using an oxygen mask a surgical mask should be fitted over the oxygen mask.
- 7.6 Routine inter-healthcare transfers (in to or out of Somerset Partnership managed in-patient units) – should be delayed until 24 hours after symptoms have resolved or 7 days, whichever is earlier. If the transferring area is under restriction due to an outbreak of Influenza, routine inter-healthcare transfers can still occur where the patient has had laboratory confirmed Influenza and is no longer in the infectious period.
- 7.7 Emergency transfers from Somerset Partnership managed areas on the basis of patient deterioration must continue but the receiving hospital and ambulance crew must be informed of the known/potential infection.

8 DISCONTINUATION OF ISOLATION PRECAUTIONS

- 8.1 Isolation precautions can be discontinued 24 hours after the resolution of fever and respiratory symptoms. This is usually within 5-7 days from onset of symptoms. If symptoms persist, isolation precautions can be discontinued 7 days after onset unless the patient is immunosuppressed.
- 8.2 Immunosuppressed patients may remain infectious for a longer time period and should be discussed with the IP&CT team. If immunosuppressed patients remain symptomatic after 7 days of onset, they should have two sets of negative influenza swabs (nose and throat) at least 24 hours apart before isolation restrictions are lifted.
- 8.3 On discharge of the patient or discontinuation of source isolation a terminal clean of the room must be carried out, as per the isolation policy.

9 NOTIFICATION

- 9.1 Influenza is a notifiable disease under the Health Protection Legislation (England) Guidance 2010 if there is a new sub-type of the virus, or if the patient is a resident of an institution such as a care home, school or prison, or is thought to be part of an outbreak. Notification should be made by the medical team caring for the patient to the Consultant in Communicable Disease Control (CCDC) at the Devon, Cornwall and Somerset Public Health Centre, PHE, on 0300 303 8162 , and fulfils the clinician's responsibility to notify the Local Authority Proper Officer.

10 CONTACTS (PATIENTS)

- 10.1 If a patient is confirmed as having infectious influenza and has not been nursed in source isolation, other 'close contact' patients (as defined in section 4) should be identified. Close contacts falling into one of the defined risk groups should be offered post exposure prophylaxis if not already adequately protected by the seasonal influenza vaccination, that is:
- They have not been vaccinated OR
 - There has been less than 14 days between their vaccination and date of first contact with influenza OR
 - PHE have informed the trust that the vaccination is not well matched to the circulating strain OR
 - They have been vaccinated but are unlikely to have developed or maintained adequate antibody levels e.g. on treatment for ALL within and until at least 6 months after completion of chemo; lymphoproliferative disorders under follow up; are receiving, or have received in past 6 months, immunosuppressive treatment for solid organ transplant; severe primary immunodeficiency; have received a haematopoietic stem cell transplant until at least 24 months post-transplant and at least 12 months off immunosuppressive treatment; have graft versus host disease.

- 10.2 Post exposure prophylaxis should be started within 48 hours of the last contact. If therapy cannot be started within 48 hours of the last contact further advice should be sought from the Consultant Microbiologist.
- 10.3 The choice of prophylactic antiviral agent should be according to the most up to date 'PHE guidance on use of antiviral agents for the treatment and prophylaxis of influenza'.
- 10.4 Prophylaxis should be prescribed by the clinical team looking after the at risk patient.
- 10.5 Susceptible close contacts may be incubating infection and if likely to remain in hospital must be monitored closely for early signs of infection. The need for isolation should be considered if the contact begins to develop upper respiratory tract symptoms such as rhinorrhoea, cough or sneezing.

11 CONTACTS (HEALTHCARE WORKERS [HCW])

- 11.1 HCWs providing direct care for an influenza case should wear respiratory protection as set out in section 7 of this policy.
- 11.2 Any staff who fit the criteria as a close contact (as defined in section 4) and who also fall into one of the defined risk groups and have not had their annual influenza vaccination or have only had it in the 14 days prior to exposure should contact Occupational Health to discuss the possible need for prophylaxis. Out of hours staff should contact the on call GP service.

12 SYMPTOMATIC HEALTHCARE WORKERS (HCW)

- 12.1 Staff with laboratory conformed Influenza should be excluded from work until symptom free (up to a maximum of 7 days) after which time they may return to work. Immunocompromised staff should take GP and occupational health advice if symptoms extend further than 7 days.
- 12.2 Staff with flu like illness but no laboratory confirmation should be excluded from work whilst they have a fever and/or are unable to contain sneezing/ coughing or respiratory secretions in a tissue.

13 MONITORING COMPLIANCE AND EFFECTIVENESS

13.1 Monitoring arrangements for compliance and effectiveness

- Overall monitoring will be by the Infection Prevention and Control Assurance Group.

13.2 Responsibilities for conducting the monitoring

- The Infection Prevention and Control Assurance Group will monitor procedural document compliance and effectiveness where they relate to clinical areas.

13.3 **Methodology to be used for monitoring**

- The Infection Prevention and Control report at the conclusion of an outbreak should include comment as to whether the procedure within this policy has been followed. Any actions identified will be implemented and monitored via the Infection Prevention and Control Assurance Group.
- Quarterly audit of Isolation facilities and practice undertaken by the Infection Prevention and Control Team.

13.4 **Frequency of monitoring**

- The Infection Prevention and Control Assurance Group reports to the Quality Assurance Group twice yearly.

13.5 **Process for reviewing results and ensuring improvements in performance occur**

- Audit results will be presented to the Senior Managers Operational Group for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring improvements, where necessary, are implemented.

14 **TRAINING AND COMPETENCY REQUIREMENTS**

14.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix (training needs analysis) (where mandatory training is indicated). Where no mandatory training is indicated please specify how training will be provided for this policy (e.g. local induction, recommended training, etc). All training document referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

- Trust Induction Training
- Hand Hygiene Training
- Infection Prevention and Control Training
- Untoward Event Training

15 **REFERENCES AND ASSOCIATED DOCUMENTS**

References

- 15.1 Public Health England (2013, updated 2018) Influenza: the Green Book, chapter 19. Immunisation against infectious disease: the green book. Available at: <https://www.gov.uk/government/publications/influenza-the-green-book-chapter-19>.
- 15.2 Public Health England (2013, updated 2017) Contraindications and special considerations; the Green Book, chapter 6. Immunisation against infectious

disease: the green book. Available at:
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- 15.3 Public Health England (2016). Infection control precautions to minimise transmission of acute Respiratory Tract Infections in healthcare settings. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585584/RTI_infection_control_guidance.pdf.
- 15.4 Public Health England (2017) . PHE guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/648758/PHE_guidance_antivirals_influenza_201718_FINAL.pdf.

Cross reference to other procedural documents

- All other Infection Prevention and Control Policies
- Consent to Examination and Treatment Policy
- Consent and Capacity to Consent and Treatment Policy
- Hand Hygiene Policy
- Infection Prevention Control Policy
- Learning Development and Mandatory Training Policy
- Record Keeping and Records Management Policy
- Risk Management Policy and Procedure
- Staff Mandatory Training Matrix (Training Needs Analysis)
- Untoward Event Policy
- Serious Incidents Requiring Investigation
- Pandemic Influenza Policy.

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.