SOP Objective
To ensure all relevant clinical staff are aware of the risks associated with Respiratory Tract Infections

This SOP applies to all staff employed by NHS Greater Glasgow & Clyde and locum staff on fixed term contracts.

KEY CHANGES FROM THE PREVIOUS VERSION OF THIS SOP
- Added link to A-Z in National Infection Prevention and Control Manual
- Update on when to remove FFP3 masks
- Modification to the Appendix 2 algorithm

Document Control Summary

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<th>Approved by and date</th>
<th>Board Infection Control Committee 29th July 2019</th>
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<tr>
<td>Date of Publication</td>
<td>28th August 2019</td>
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<tr>
<td>Developed by</td>
<td>Infection Prevention Control SOP Sub-Group</td>
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<td>Related Documents</td>
<td>National Infection prevention and Control Manual</td>
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<td>Lead Manager</td>
<td>Board Infection Control Manager</td>
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<tr>
<td>Responsible Director</td>
<td>Board Medical Director</td>
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The most up-to-date version of this SOP can be viewed at the following website: www.nhsggc.org.uk/your-health/infection-prevention-and-control/
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Appendix 1: Influenza Aide Memoire

Follow this algorithm if you have a patient with suspected or confirmed Influenza

Consult SOP and Isolate in a single room with:
- ensuite / own commode
- door closed
- IPC yellow sign on door
- dedicated equipment
- Influenza Care Checklist completed daily

Patient is asymptomatic of coryzal symptoms/back to their normal respiratory function for at least 24 hours?
Or
Patient has completed a course of antiviral treatment?
(e.g. Usually 5 days for Tamiflu)

YES

Is the patient severely immunocompromised?

YES

NO

Patient is asymptomatic of coryzal symptoms/back to their normal respiratory function for at least 24 hours?
Or
Patient has completed a course of antiviral treatment?
(e.g. Usually 5 days for Tamiflu)

YES

NO

Clinical team must assess risk of ongoing transmission of influenza in their patient. When no longer considered infectious

- Stop transmission based precautions
- Undertake terminal clean of room

Influenza SOP - Guidelines for patients in isolation:

Hand Hygiene: Liquid Soap and Water or alcohol hand rub

PPE: Disposable gloves and yellow apron, fluid resistant surgical mask (FRSM) and goggles if within 1m of patient. FFP3 respirator for Aerosol Generating Procedures. (AGPs)

Patient Environment: Twice daily clean with chlorine based detergent

Patient Equipment: Twice daily chlorine clean

Laundry: Treat as infected

Waste: Dispose of as Clinical / Healthcare waste

Incubation Period: 1 – 4 days

Period of Communicability: Patient is asymptomatic of coryzal symptoms/back to their normal respiratory function for at least 24 hours? Or, patient has completed a course of antiviral treatment (e.g. Usually 5 days for Tamiflu)

Notifiable disease: Yes

Transmission route: droplet

Coryzal Symptoms: inflammation of the mucosa of the respiratory tract, causing nasal discharge and congestion, sneezing, sore throat and cough.

The most up-to-date version of this SOP can be viewed at the following website: www.nhsggc.org.uk/your-health/infection-prevention-and-control/
1. Responsibilities:

**Healthcare Workers (HCWs) must:**
- Follow this SOP.
- Inform a member of the Infection Prevention Control Team (IPCT) if this SOP cannot be followed.
- Must ensure care checklists are implemented and up to date.

**Senior Charge Nurses (SCNs) / Managers must:**
- Support HCWs in following this SOP.
- Cascade new policies/SOPs to clinical staff after approval by the Board Infection Control Committee (BICC).
- Ensure HCW are aware how to use respiratory protection and have access to appropriate PPE including fit testing for FFP3 masks.
- Provide staff the opportunity to receive the staff flu vaccination each year.

**IPCTs must:**
- Keep this SOP up-to-date.
- Support the clinical team to undertake a risk assessment where this SOP cannot be followed.
- Provide education opportunities on this SOP.

**OHS (Occupational Health Service)**
- Public Health and OHS will plan and promote the uptake of staff seasonal flu vaccination
- OHS will provide opportunity for staff to receive their flu vaccination during working hours

The most up-to-date version of this SOP can be viewed at the following website: [www.nhsggc.org.uk/your-health/infection-prevention-and-control/]
Influenza

Infections with a particular strain of influenza (type A or B) occur every year and are referred to as seasonal influenza. Pandemic influenza occurs when a new influenza sub-type appears that is different to previous sub-types and can:

- infect humans
- spread effectively from human to human
- causes significant clinical illness in a high proportion of those who acquire the virus

Primary strategies for preventing influenza are:

- **VACCINATION** - the most effective way of preventing the spread of influenza
- early detection and treatment
- standard infection control precautions and transmission based precautions must be followed, to prevent transmission during patient care

2. Symptoms of Influenza

Influenza is a respiratory illness characterised by coryzal symptoms including fever, cough, 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. Adults can be infectious from the day before symptoms begin to approximately five days after illness onset. Children can be infectious for seven or more days, and young children can shed virus for several days before their illness onset. Severely immunocompromised persons can shed virus for weeks or months.

Routes of Transmission

There are three main routes of transmissions:

i. **Droplet Transmission**

Large droplets (greater than 5 microns in size) may be generated from a person with clinical disease during coughing or sneezing and may land directly on the conjunctiva, or mucous membranes of the nose and mouth of a susceptible person. Large droplets are heavy and do not remain suspended in the air for long periods of time and only travel for up to 1 metre, so close contact is required for transmission.
ii. Direct / Indirect Contact Transmission

Direct contact transmission is when the virus is spread person to person either by contact with the infectious person skin or droplet transmission, e.g. symptomatic patient to a HCW, from a sneeze or cough directly onto the nose or mouth.

Indirect contact transmission is the transfer of an infectious agent through a contaminated intermediate object or person, e.g. from a contaminated surface, bed table, to the hands of another person who then transfers the virus to their nose, mouth or eyes. Influenza virus is known to survive well in the environment; up to 24 hours.

iii. By the Airborne Route during and after Aerosol Generating Procedures (AGPs)

Transmission may occur at short distances through inhalation of small particle aerosols which are produced during Aerosol Generating Procedures (AGPs).
(See section 5 below)

Smaller droplets or aerosol produced during these types of procedures can be inhaled and cause infection. They may also remain in the air for a prolonged period and travel over distances.

3. Aerosol Generating Procedures (AGPs)

Healthcare staff that perform AGPs on patients with confirmed or suspected influenza should don additional protective clothing (see Section 5E Personal Protective Equipment).

Where possible, AGPs should be avoided or alternative methods considered. Only essential staff should be present.

Aerosol Generating Procedures (AGPs) are defined as:

- 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
- Some Dental procedures (e.g drilling)
- Non Invasive Ventilation (NIV) e.g. Bilevel Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP).

The most up-to-date version of this SOP can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control/
• High Frequency Oscillatory Ventilation (HFOV).
• Induction of sputum (not including chest physiotherapy)

4. Testing for Influenza
• Patients who present to hospital with flu-like illness should be tested if clinically relevant.
• Repeat testing to confirm clearance of influenza is not required.

Anti-viral Prescribing for patients with flu-like illness

Treatment and prophylaxis
Please contact microbiologist, infectious disease consultant or virologist to obtain advice regarding treatment of suspected or known cases of influenza and/or prophylaxis of specific vulnerable groups. The most up-to-date information on treatment issued by the Scottish Government Health Directorates (SGHD) can be viewed at https://www.hps.scot.nhs.uk/a-to-z-of-topics/influenza/

5. Limiting the Spread of Influenza

A. Patient Placement
• All patients with confirmed or suspected influenza should be nursed in a single room with en suite facilities. If a single room is not available staff must contact a member of the local IPCT for further advice.
• A yellow IPC isolation sign should be clearly visible on the door.
• Patients should be considered infectious until patient is asymptomatic / back to their normal respiratory function for at least 24 hours OR patient has completed a course of antiviral treatment.
• Patients who are diagnosed as having influenza but are asymptomatic are unlikely to spread the virus and can be regarded as non-infectious.
• PCR tests can remain positive for considerable periods and should not be used to determine infectivity.
• Patients with underlying medical conditions or patients who have gone on to develop a secondary complication as a result of infection should be considered infectious until they return to their previous health state.
• Patients who are immunocompromised or with prolonged illness or complications should be assessed by clinical staff and the IPCT, and isolation precautions discontinued if deemed appropriate. Patients who fall into this category must be assessed individually.
In the event of an increase in the number of patients with influenza requiring admittance to hospital, in conjunction with the IPCT, an influenza cohort bay or ward can be considered. Please see Appendix 2 for IPC guidance.

B. Patient Movement / Inter-Hospital Transfers

Influenza patients who are still infectious must not leave the area unless there is an urgent clinical need. If a patient has to leave the single room while symptomatic, they should wear a fluid-resistant surgical mask (FRSM) if possible to minimise the dispersal of respiratory secretions and prevent environmental contamination. The FRSM should be worn until the patient is returned to the single room / cohort area. On removal of the FRSM, the patient should be offered the opportunity to undertake hand hygiene.

If a patient requires transfer to another department the following procedures must be followed:

- The department must be informed in advance.
- HCWs transporting the patient do not need to wear PPE if the patient is wearing an FRSM but must undertake hand hygiene.
- The patient must be taken straight to and returned from the department and must not wait in a communal area.
- If possible patients should be placed at the end of a list, to allow appropriate decontamination after any procedure.
- If the patient requires oxygen via a mask, then the patient need not wear the FRSM however, if nasal prongs are used to deliver oxygen then the patient should also wear an FRSM over the prongs.

Hospital Transfers and Discharges

Patients must not be transferred from one hospital to another for routine care however some patients may require specialist care, e.g. renal dialysis. If a patient has to be transferred this MUST be discussed with the local IPCT who will alert the IPCT at the receiving hospital. It will be the responsibility of the clinical area that the patient is being discharged from to alert the Scottish Ambulance Service.

Discharge to residential care:
If a patient remains symptomatic or has not completed 5 days of appropriate antiviral treatment, this must be communicated to those receiving the patient, and appropriate IPC measures put in place prior to the transfer of the patient.
C. Visitor Restrictions

- Visiting in hospital should be restricted to 1-2 visitors only in order to reduce the risk of influenza transmission to visitors. Only close relations or a partner should be allowed to visit.

- All visitors must be free of flu-like symptoms, however in exceptional circumstances, e.g. when a patient is critically ill, then advice should be sought from the IPCT and a risk assessment will be undertaken.

- Visitors must speak to a member of staff and be instructed on hand hygiene practice and the wearing of protective clothing as appropriate prior to visiting the patient, such as a surgical mask, apron and gloves.

- Visitors to patients ventilated with NIV or HFOV may be exposed to potentially infectious aerosols. The number of such visitors should be limited to two unless there are exceptional circumstances. Visitors should be made aware of the risks and be offered PPE as recommended for staff.

D. Hand Hygiene

Hand hygiene remains the single most important measure to take against the spread of influenza. Effective hand hygiene with plain liquid soap and running water or alcohol based hand rub on visibly clean hands is effective.

E. Personal Protective Equipment (PPE)

PPE is worn to protect staff from body fluids to reduce the risk of transmission of influenza between patients and staff and from one patient to another. The level of PPE used will vary based on the procedures being carried out and not all items of PPE will always be required. Appropriate PPE for care of patients who are suspected or confirmed to have influenza is summarised in Table 2.

Table 2

<table>
<thead>
<tr>
<th>PPE</th>
<th>Close patient contact (&lt; 1 metre)</th>
<th>Aerosol Generating Procedures (AGP)</th>
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<td>Gloves</td>
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<tr>
<td>Plastic Aprons</td>
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<tr>
<td>Fluid-Resistant Surgical Mask</td>
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<tr>
<td>FFP3 Respirator</td>
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</tr>
<tr>
<td>Eye Protection</td>
<td>Risk Assessment</td>
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</table>
**Fluid resistant surgical mask (FRSM)**

Fluid resistant surgical masks (FRSM) should be worn by HCWs for contact with patients suspected or known to have influenza. The mask provides a physical barrier which becomes ineffective once wet. As masks themselves may become a reservoir for the virus great care should be taken during their removal and disposal.

**When to remove the FRSM**

When visiting a number of patients within an influenza cohort, clinic or A&E department, it is acceptable to wear the same mask and change it at the end of the session and if it gets wet. Great care must be taken not to contaminate the hands during this time by touching the mask. HCW/ Visitors must removal all PPE before leaving a patient care area (single room/ cohort area), FRSM or FFP3 respirators should be removed last. **Hand hygiene must be performed after removal of all PPE.**

**When to wear an FFP3 respirator**

FFP3 respirators should be worn only by those staff carrying out AGPs. To be effective, individual users must be trained to fit the respirator properly to their face.

**When to remove the FFP3**

The FFP3 mask must be worn for up to 2 hours following an AGP, during which time the aerosols will have either been removed through the ventilation system or allowed to settle. If staff wish to leave the patient room within the two hour period, gloves and aprons should be removed in the room and hand hygiene performed. The FFP3 mask should be removed on leaving the room, placed in the nearest clinical waste receptacle and hand hygiene performed.

**F. Decontamination of Patient Equipment**

Where practicable, the patient should be designated their own equipment. See [SOP Cleaning of Near Patient Equipment](#).

**G. Decontamination of the Environment**

Domestic staff must follow the SOP for Twice Daily Clean of Isolation Rooms. Cleans should be undertaken at least four hours apart. See [NHSGGC Twice Daily Clean of Isolation Rooms SOP](#).

All frequently touched surfaces should be decontaminated after any AGP using chlorine based detergent. Limit the amount of equipment in the room as far as possible.

The most up-to-date version of this SOP can be viewed at the following website: [www.nhsggc.org.uk/your-health/infection-prevention-and-control/](http://www.nhsggc.org.uk/your-health/infection-prevention-and-control/)
H. Clinical/ Healthcare Waste
Waste should be designated as clinical / healthcare waste and placed in an orange bag. Please refer to the NHSGCC Waste Management Policy.

I. Laundry
Discard linen as fouled/ infected, i.e. in a water soluble bag then a secondary bag, tied and then placed into a laundry bag.

Please refer to National guidance of the safe management of linen

Sending Laundry Home
If relatives or carers wish to take patients clothing home, staff must place clothing into a domestic alginate bag and staff must ensure that a Home Laundry Information Leaflet is issued.

NB Nursing staff in the ward should record in the nursing notes that both the advice and information leaflet has been issued.

J. Respiratory Hygiene / Cough Etiquette (Catch it, Bin it, Kill it)
Patients, staff and visitors should be encouraged to minimise potential influenza transmission by:

- Covering the nose and mouth with disposable single-use tissues when sneezing, coughing, wiping and blowing noses.
- Disposing of used tissues in nearest clinical/ healthcare waste bin, washing hands after coughing, and sneezing using tissues.
- Avoid touching eyes, mouth and nose.

Some patients may need assistance with containment of respiratory secretions, e.g. older people and children. Those who are immobile may need a personal waste bag readily at hand for immediate disposal of tissues. They should also have a supply of hand wipes and tissues.
6. Evidence Base

Health Protection Scotland. Guidance on use of antiviral agents for the treatment and prophylaxis of influenza
HPS Website - Influenza

Health Protection Scotland Infection Prevention and Control Guidance;
Planning and communications

On each hospital site, wards and wards with suitable bed bays will be identified and a respiratory pathway agreed from ED to discharge. This will be communicated to the appropriate staff at huddles/briefs to support patient/bed management. Daily updates on bed spaces on cohort wards/bays should be available to support patient transfers from ED and acute receiving. Wards with cohort bays will not be closed to other admissions.

Definition of a cohort ward or bay

A cohort area is a bay/ward in which a group of patients (cohort) with the same infection are placed together. Patient cohorting may be appropriate when single rooms are not available and there is more than one patient with the same confirmed infection.

Decision to create a Flu cohort

If a ward has bed bays and a number of confirmed FLU patients, those patients should be nursed in a single bay as a cohort. If there are empty beds in that cohort, they can be used for FLU patients from other areas. The decision to set up a cohort should be discussed with local IPCT/on call Microbiologist prior to being implemented.

Setting up the cohort

The cohort bay should have dedicated equipment as far as possible such as blood pressure, oxygen saturation and temperature recording devices within the cohort bay. A trolley with fresh linen, tissues, waste bags and commonly used disposable equipment such as oxygen tubing and masks will be useful for staff working in cohort.

Staffing (cohort nursing)

Cohort nursing (dedicated teams) should be implemented to minimise the risk of contamination between groups of symptomatic and non-symptomatic patients if staff resource allows. If not, contact the local IPCT who will help to undertake a risk assessment.

Bed spacing

Patients should be separated by at least 3 feet (1m) from each other in a cohort area, and bed curtains can be drawn as an additional physical barrier if required.

Cohort patients

Patients who have confirmed Influenza can be nursed in an influenza cohort until they have been asymptomatic / returned to normal respiratory function for at least 24 hours OR received 5 days of antiviral therapy. However, It should be noted that patients being nursed together in a cohort should all have the same type of FLU. e.g. Influenza A.

Patients who remain symptomatic but are well enough to be discharged can be sent home. Patients who have FLU and another infection e.g. diarrhoea or MRSA, should be nursed in a single room.

Testing for influenza

Either laboratory or POCT testing is sufficient to identify patients with influenza. It is not necessary to test prior to discharge. Patients who are asymptomatic should not be tested.

PPE

For entering the cohort ward / bay, it is not necessary to wear PPE unless about to undertake patient care. For all direct care or contact with the patients environment (within 1m of the patient) staff should don a disposable plastic yellow apron, disposable gloves and a surgical face mask. For AGP, an FFP3 mask should be worn. If patients require routine AGPs, consider placing this patient in a single room.

Equipment

As far as possible, dedicated equipment should remain in the cohort bay for use on cohort patients only. For equipment that cannot be dedicated, items should be cleaned with a chlorine based solution containing 1,000 ppm active chlorine.

Ward rounds

Ward rounds within a cohort will consist of 1 member of medical team entering the cohort in appropriate PPE to examine the patient only. Once exam completed, removal of PPE and hand hygiene should be performed. Any equipment used may either stay in the cohort or be decontaminated before removal.
The most up-to-date version of this SOP can be viewed at the following website: [www.nhsggc.org.uk/your-health/infection-prevention-and-control/](http://www.nhsggc.org.uk/your-health/infection-prevention-and-control/)

<table>
<thead>
<tr>
<th>Linen</th>
<th>Bed linen should be managed as infected linen</th>
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<tr>
<td>Waste</td>
<td>Waste should be managed as healthcare waste</td>
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<tr>
<td>Cleaning of</td>
<td>Domestic services should clean the cohort bed bay/ward daily with a solution containing 1,000 ppm active chlorine e.g. Actichlor Plus. (Consideration should be given to a dedicated cleaning team on each site).</td>
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<tr>
<td>Environment</td>
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<tr>
<td>Visitors</td>
<td>Visitors are allowed but no more than two per bed space. It may be necessary to stop visiting temporarily if the situation warrants this.</td>
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</table>

The most up-to-date version of this SOP can be viewed at the following website: [www.nhsggc.org.uk/your-health/infection-prevention-and-control/](http://www.nhsggc.org.uk/your-health/infection-prevention-and-control/)
Patient presents with respiratory symptoms in ward or in ED

High suspicion of FLU

Confirmed FLU

Patient requires admission

Patient into a Single Side Room (SSR)

Patient into FLU cohort

Patient confirmed FLU

Patient asymptomatic or normal respiratory function > 24 hours OR completed 5 days of antiviral therapy

Stop isolation / discharge

Patient symptomatic but well enough to be discharged home. (not to a care home)

Discharge