



PANDEMIC FLU : INTERIM GUIDANCE

INFECTION CONTROL FOR GENERAL MEDICAL PRACTICES

*The Royal College of General Practitioners and the General Practitioners Committee of the
British Medical Association gratefully acknowledge this work by
Dr Hilary Pickles, Director Public Health & Medical Director, Hillingdon PCT*

Contents

<u>1.</u>	<u>INTRODUCTION</u>	<u>3</u>
<u>2.</u>	<u>KEEPING THIS IN PROPORTION</u>	<u>3</u>
<u>3.</u>	<u>PHYSICAL SEPARATION IN THE SURGERY</u>	<u>4</u>
<u>4.</u>	<u>GENERAL WORKING PROCEDURES</u>	<u>4</u>
<u>5.</u>	<u>INFECTION CONTROL PRECAUTIONS</u>	<u>5</u>
<u>6.</u>	<u>ENVIRONMENTAL INFECTION CONTROL</u>	<u>6</u>
<u>7.</u>	<u>HOME VISITING TEAMS</u>	<u>7</u>
<u>8.</u>	<u>IMMUNE STAFF</u>	<u>7</u>
<u>9.</u>	<u>SUPPLIES</u>	<u>7</u>
<u>10.</u>	<u>CHECKLIST OF ADDITIONAL REQUIREMENTS FOR INFECTION CONTROL MATERIALS</u>	<u>8</u>
<u>11.</u>	<u>CHECKLIST FOR PRACTICES ON CURRENT PANDEMIC PLANNING</u>	<u>9</u>
<u>12.</u>	<u>FURTHER READING</u>	<u>10</u>

1. Introduction

This is a practical guide for general medical practices on the infection control aspects of how to plan for and respond to the threat of pandemic flu. It may also be of value to others involved in primary health care, like community pharmacists. The aim will be for practices to continue to function during the extreme pressures of a flu pandemic, reconciling the dual responsibilities to continue to provide adequate clinical care for patients and as employer to ensure that staff are not put at avoidable risk. This guidance is interim and will be revised as further guidance – which is expected – is released by the Health Departments. For other aspects of the organisation of primary care in a pandemic, please see the plans from the local Primary Care Organisation (PCO). For more general aspects of dealing with pandemic flu, follow national guidance as available through the Health Departments' websites.

This guidance is based on the following principles :

- It comes into force when WHO Pandemic Alert Phase 6 is declared and the DH indicates that pandemic flu cases are now occurring in the UK (UK Pandemic Alert Level 2)
- Wherever possible, those known to be or likely to be infected with flu should be kept physically apart from those without flu
- Wherever possible, working practices and procedures which risk enhancing transmission of flu should be avoided
- Sensible barrier precautions should be used when close contact with a flu-infected patient is inevitable or likely
- There should be no compromise in infection control standards when dealing with other serious transmissible infections (e.g. blood borne viruses)
- High standards of patient care should be maintained throughout, for those with flu and for those with other conditions
- Primary Care Professionals, as leaders in their local communities, should act as role models for others in dealing with the tensions and fears that will arise around the prevention and management of pandemic flu.

2. Keeping this in Proportion

If the pandemic strain of influenza is as highly infectious as some claim, it may be inevitable that up to 25-50% of the population, including some practice staff, will become infected with symptoms at some point during the pandemic. Even if the pandemic proves as dangerous as that in 1918/9, the vast majority will recover without any physical sequelae. For every symptomatic infection there may be roughly one more asymptomatic infection. Good infection control practice will be important in minimising the risk of healthcare workers being infected at work. However, protection measures at work have to be proportionate to the risks of infection with influenza faced by healthcare professionals away from work (e.g. caring contact with children in the family home).

3. Physical Separation in the Surgery

National guidance, reinforced by local Primary Care Organisations, is that, in general, patients ill with pandemic flu should not attend the GP surgery. However it is likely that primary care staff will be deployed to provide care to patients with influenza-like illness in other settings. Alternative pathways are being established for providing rapid access to antiviral treatment to those who present with influenza-like illness, including out of hours. The majority will be expected to self-manage their illness at home, after having received antivirals from local distribution mechanisms yet to be confirmed. Small practices with single entrances may need to remind patients they should not attend the surgery for flu treatment, with notices on the door indicating the alternatives.

Depending on local arrangements, larger group practices may be expected to arrange for treatment of influenza-like illness via separate 'flu routes' within the surgery, where those with flu can be seen by dedicated teams. In some local plans, whole GP surgeries may be allocated to dealing only with flu patients, with dedicated staff.

4. General Working Procedures

Inevitably there will be many patients and significant numbers of staff who develop influenza-like illness. Staff who become unwell must be sent home during the period when they may be infectious to others (from as soon as they are aware of the infection until their symptoms resolve), unless staff shortages are extreme and they volunteer and are well enough to work in settings caring only for those with flu. Congestion in the surgery, for example in waiting areas, needs to be minimised, which may necessitate a rethink in surgery layout and/or clinic times and possibly even asking patients to wait in their cars until ready to be seen. The balance between open and on-the-day access and advance booking may need to be revisited, as well as the length of consultations. Practices should consider instituting telephone triage services, so that they are better able to manage the flow of patients.

Droplets are generated from the source patient primarily during coughing and sneezing. Respiratory droplets do not remain suspended in the air and generally only travel short distances, usually a metre or less, through the air. However, some medical procedures involving the respiratory tract can lead to the generation of aerosols, which can spread the airborne risk much further. Most of these procedures are unlikely to take place in primary care, but some practices may wish to continue to be able to offer procedures such as nebulisation and chest physiotherapy. This would require a dedicated room with suitable ventilation.

There may be shortages in personal protective equipment, and available stocks will need to be used sensibly. In practice, this means that in primary care such equipment cannot be used for all patient contacts and must only be used in managing those suspected to have flu symptoms or known to have flu. Supplies must also be reserved for dealing with patients known to have other serious transmissible infections and especially for standard universal precautions for handling blood and body fluids.

As with other infections, sensible choice of work attire may help to reduce the spread of infection, and ties should be discouraged.

5. Infection Control Precautions

5.1. Hand Hygiene

Frequent hand-washing, and at least once between each patient, is good practice in any case and should continue whether or not the patient is thought to have possible flu. If there are delays in the installation of adequate washbasins in areas adapted for clinical care, wall dispensers for alcohol-based hand rubs/gels are an adequate substitute, though vulnerable to shortages in rub/gel. Staff from the practice involved in home visits need to have personal alcohol hand rub, and know how to use it correctly.

5.2. The Coughing and Sneezing Patient

During the pandemic, there will be nationally promulgated messages about the importance of covering the nose during sneezing, the safe disposal of tissues and other aspects of containing respiratory secretions, and the associated hand hygiene. If patients with symptoms of cough and sneezing attend a practice, they should be given a surgical face mask. Adults accompanying children and babies should be instructed on respiratory hygiene – single use tissues and hand hygiene.

5.3. Personal Protective Equipment

PPE such as gowns, masks, gloves should continue to be used as normal with patients not thought to have flu when the exposure justifies this. Supplies within the practice may need to be rationed so this standard use is not compromised. If supplies become unavailable, a judgment will need to be taken within the practice whether some high risk procedures are best postponed.

Those that are within a metre of a patient known or thought to be ill with flu should wear a fluid repellent **surgical face mask**. A surgical face mask will provide a physical barrier and minimise contamination of the facial mucosa by large particle droplets, one of the principle ways influenza is transmitted. In the practice setting, face masks are likely to be needed by healthcare workers only, with receptionists for example ensuring they keep the distance from any relevant patients. National guidance is that this mask should be changed when moving between areas where flu and non-flu patients are cared for, or when they become moist.

Those practices that want to be prepared to tackle aerosol-generating procedures in those with flu, such as nebulisation, and have the physical layout that would permit this, should prepare to use FFP3 respirators. Expert advice will be needed on personalised fit testing and training undertaken in FFP3 use.

Gloves are not strictly needed for the routine care of patients with pandemic flu, but are advised in national guidance provided sufficient supplies are available. However in primary care their use should be prioritised towards standard universal precautions for procedures such as dressing wounds and other activity that risks direct contact with excretions, body fluids etc. They need to be discarded after each patient use, and hands then washed and dried using paper towels. Alcohol hand-rub can also be used for decontamination of socially clean hands.

Aprons will be required as usual if there is a risk of soiling or splashing. If a patient with flu symptoms is being examined, the national guidance recommends the wearing of an apron to reduce the risk of contamination of personal clothing. If supplies are sufficient, this should be used once only, and then discarded. When supplies are limited, a single apron may be needed for a whole session seeing flu patients.

Eye protection will be needed in accordance with existing practice, when undertaking procedures where there is a risk of splashing on the face. The ocular route of inoculation is not regarded as a major route of transmission for normal human influenza viruses, but is nevertheless biologically plausible.

6. Environmental Infection Control

Although the influenza virus can survive on hard surfaces for several hours, fortunately it is readily destroyed by cleaning with standard detergents and disinfectants. Practices will need to have an **enhanced cleaning** programme throughout all clinical areas, at least daily or after a session when a flu patient has been seen before the next non-flu patient. Frequently touched surfaces such as door knobs will need cleaning more often, and freshly prepared neutral detergent and hot water should be used for this purpose. Common diagnostic instruments, like stethoscopes, should be cleaned frequently, and always between use on flu and non-flu patients. **Soft furnishings** will be difficult to clean, and should be removed and stored where possible, together with books, **magazines and toys**, until the pandemic is over. **Carpets** are unlikely to present a transmission risk.

No special procedures will be needed for **clinical waste**, and gloves should be used for handling waste, with hands washed after gloves are removed as usual. Similarly, no special arrangements are needed for patient care equipment, other than more scrupulous care than usual to clean and if appropriate decontaminate between patients.

HIGHLIGHTS

- **Planning and preparation needed now for :**
 - **Separation of flu and non-flu patients**
 - **Surgical masks for flu patients and those examining them**
 - **Frequent hand washing**
 - **Increased cleaning**
 - **Extra consumables**

7. Home Visiting Teams

7.1 Visiting Regular Patients

Because of flu-related pressures, other home visiting will need to be kept to a minimum, and the possibility of the visiting health worker introducing flu to the housebound and vulnerable should be part of the risk assessment before deciding to visit. When a visit is unavoidable, then a face mask should be to hand in case the person visited turns out to have symptoms of cough and sneezing. Otherwise, usual infection control procedures should be employed.

7.2 Visiting Flu Patients

When persons with flu, or suspected flu, are to be visited at home, a face mask should be donned on entering the premises, and other protective equipment such as gowns and gloves used as necessary according to the procedures being undertaken. On leaving, all such equipment should then be discarded (the normal domestic waste system will do), and hands washed, using a personal hand gel dispenser if no wash-hand basin and soap are available. Alcohol rub can also be employed again after finally leaving the premises, say on returning to the car.

8. Immune Staff

Some staff may fall ill with flu early on, yet recover and be fit enough to return to work with presumed immunity. Diagnostic tests to confirm past infection may become available. Such staff should be posted in the front line of dealing with flu patients. Whilst there will be no need for them to take added personal precautions against flu infection, they will still need to be wary of other potential infectious diseases and take the standard precautions as the situation requires. There must also continue to be care to avoid carrying flu from an infected to an uninfected patient, so there can be no relaxation in hand hygiene standards, for example. The same will apply to staff who have been successfully vaccinated against the pandemic strain, when this becomes available.

9. Supplies

There are likely to be problems with the supply chain during the pandemic, and immediately prior to the pandemic, i.e. in WHO periods 4 and 5 when human to human spread is mounting overseas, it may be impossible to get orders accepted and honoured. That means there needs to be advance planning for the clinical and non-clinical supplies needed by the practice, at least for the duration of the first pandemic wave. Some of these supplies will need to be held in the practice, and there needs to be a clear understanding of what reserves are being held on behalf of the practice at PCO / Health Board / regional or national level. In the absence of further guidance, practices could consider stockpiling at least 50% of their estimated total pandemic needs.

10. Checklist of Additional Requirements for Infection Control Materials

What	Guide to Assumed Usage <i>each practice to form judgments based on list size and local arrangements</i>	Total for this Practice Per Pandemic / Week	Supplies Available and their Shortfall
Within Surgery			
Disposable gloves	3x current usage		
Alcohol hand gel	150ml bottle per clinician every 2 days and non-clinician every 15 days		
Surgical masks	8 per worker per day		
Detergent wipes	150 per practice per day		
Alcohol wipes	3 x current stocks		
Clinical waste bags	1 ½ x current usage		
Aprons	A roll per day		
Gowns	3 per clinician per day		
FFP3 masks, eye protection	Limited reserves only, unless special circumstances and the staff are appropriately trained		
Paper towels	1 ½ x current usage		
Face tissues for any sneezing patients	3 x current usage		
Liquid soap	1 ½ x current usage		
General cleaning materials	3 x current usage		
What else?			
Home Visiting			
Disposable gloves	Pair per flu patient		
Alcohol hand gel	As above, 150ml per clinician per day		
Surgical masks	One per patient		
Aprons	30% of home visits		
Gowns	1 ½ x current usage		
Small clinical waste bags	1 ½ x current usage		
Eye protection	Probably none		
What else?			

Note 1 : Calculations from the HA / PCO / Health Board / HPA on the pandemic load for the practice is up to X ill patients and X deaths for the first wave lasting 9 weeks [Each practice to add in their own figures according to local advice from the PCO]

Note 2 : This is not a comprehensive checklist for the extra requirements for practices in relation to a flu pandemic, since it deals only with infection control items. Other consumables, like throat spatulas and thermometers, leaflets and information sheets, must be included on additional checklists.

11. Checklist for Practices on Current Pandemic Planning

Action	Yes	No	Comments
Infection control- lead for the practice. Who has got to grips with the national and local guidance?			Who?
PCO (Health Board) / Practice plans avoid flu-ill patients attending surgery?			Are the alternatives for them clearly identified and robust?
Surgery plans for a ' flu layout '?			Dummy run tried? Signage ready?
COSHH ¹ assessment and discussion of proposed arrangements with all practice staff and subcontractors e.g. cleaners?			Written note of meeting?
Aerosol-generating procedures still to be undertaken in the practice?			If so, ensure the precautions taken mean this can be squared with COSHH
Adequate hand basins / hand gel dispensers for all clinical areas?			Needed anyway, so no excuse for not resolving now.
Agreement on enhanced cleaning and staff and / or subcontractor resilience for this?			And adequate cleaning materials in stock?
Plans to strip out spare soft furnishings , toys, magazines etc.			Who will do this and where will be the storage?
Adequate stocks of the usual non-medical disposables e.g. paper sheeting, rubbish bags?			Replenishing during the pandemic could get difficult.
Any unmet infection control training needs?			Plans for quick training for volunteers allocated to the practice?
Clear practice procedures for exclusion of ill staff ?			And plans for coping without them?
Estimates of extra requirements for face masks , gowns, gloves, personal hand gel etc?			Understanding with the local PCO / Health Board over how these requirements will be met?
Essential practice-based stockpile ?			With calculations of how long it might last.
Personal protective equipment kept in reserve in the practice for essential non-flu uses e.g. with AIDS or HepB patients?			
Note there are lots of other pandemic flu related items that practices need to plan for, which are not included here since they fall outside the 'infection control' heading, e.g. more general business continuity planning.			Make sure these are identified and dealt with on a separate checklist.
Especially for small and single-handed practices, are you familiar with the proposed arrangements for your ' buddy ' practices, and them with yours?			The PCO / Health Board plan should deal with support to small practices, including those unable to function because of illness, but check it does.

¹ Control of Substances Hazardous to Health Regulations 2002, as required for all employers

12. Further Reading

- Guidelines for Pandemic Influenza : Infection Control in Hospitals and primary care Settings. DH and HPA October 2005 on :
www.dh.gov.uk/assetRoot/04/12/17/54/04121754.pdf
- The pandemic flu plan from the local PCO / Health Board
- Check on DH website for any updates on :
www.dh.gov.uk/PolicyAndGuidance/PandemicFlu/fs/en
- World Health Organisation's revised guidelines on the pharmacological management of humans infected with avian influenza :
http://www.who.int/csr/disease/avian_influenza/guidelines/en/