# Guidance for the Management of Suspected Cases of Severe Imported Respiratory Virus Infections Including Avian Influenza and MERS Cov.

*(Note this does not include pandemic Influenza)*

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Full History

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Associated Trust Policies/ Procedural documents:

Trust VHF policy

In consultation with and date:

- Infection Control Operational Group: 10th August 2015
- PEP: 7th October 2015
- Consultant Paediatricians: 7th October 2015
- Infection Control & Decontamination Assurance Group: 20th October 2015

Contact for Review:

Infection Control Doctor
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1. INTRODUCTION

1.1 Travellers returning to the UK may present to hospital, either through primary care or directly, with febrile respiratory illness. A range of potential infections need to be considered, which include all those normally encountered in the UK, but also additional pathogens peculiar to travellers which have the potential to cause serious, life threatening disease, and infect contacts including healthcare workers. Examples include, but are not limited to, some coronavirus and avian influenza A infections.

1.2 Coronaviruses. Coronaviruses cause many infections including the common cold in humans. Some coronaviruses, which have a reservoir in animal hosts, are able to infect people and spread from person to person. They mainly cause respiratory tract infections and are transmitted by large respiratory droplets and direct or indirect contact with infected secretions. In 2003 a worldwide outbreak of Severe Acute Respiratory Syndrome (SARS), a coronavirus, spread from China via Hong Kong. The outbreak was controlled and cases have not been seen since. The Middle East respiratory syndrome coronavirus (MERS CoV) was first recognised in 2012 and is focused in the Arabian Peninsula. It has a mortality rate of about 30%. MERS-CoV has a reservoir in camels and infection may follow contact with camels or consumption of camel milk or undercooked meat.

1.3 Influenza A. Some subtypes of ‘flu A naturally circulate in wild and domestic birds. Some strains cause little or no disease but sometimes outbreaks with high mortality in birds are due to “highly pathogenic avian influenza” (HPAI) strains. Some avian strains have the potential to affect humans, examples include H5N1, H7N9, H10N8. Human infection from birds is rare and follows direct or very close contact with infected birds or their excretions. Such contact may occur in live poultry markets, common in some parts of the world, or where domestic poultry is kept in intimate proximity to human accommodation. Human symptoms vary from mild conjunctivitis to serious, life threatening pneumonia. Although the mortality rate is high in human H5N1 pneumonia (about 50%), infection is rare and human to human spread is very limited. Avian ‘flu is different from “pandemic ‘flu”.

1.4 The key to recognising the possibility of serious travel associated respiratory infections is the taking of an accurate travel history from anyone presenting to hospital with a fever and respiratory symptoms. This allows potential cases to be managed appropriately, which includes the use of isolation and personal protective equipment to prevent spread of infection.

1.5 Currently this guideline primarily targets MERS CoV and Avian Influenza. However other infections will be added should the risk be identified. The initial management, especially containment methods to protect staff and other patients from infection are appropriate for all serious infections transmitted via the respiratory route.

2. PURPOSE

2.1 The purpose of this guideline it to ensure that patients who may have infectious travel associated respiratory infections are promptly identified and managed correctly in order to:

- Ensure measures are taken to prevent transmission to healthcare workers (HCW), and other patients
- Direct optimal medical management including use where appropriate of antibiotics and antivirals
- Alert Public Health Agencies for surveillance purposes to ensure potential contacts out of hospital are monitored
3. DEFINITIONS

3.1 Severe travel associated respiratory infection
This is an infection of the respiratory tract that is severe enough to result in an infected patient being admitted to hospital and which occurs in a person who has travelled outside the UK in the 14 days prior to being seen. It may be of known or unknown cause.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 The Chief Executive and Board of Directors are responsible for ensuring the provision of suitable and sufficient resources and facilities to enable effective management of a patient admitted with a severe travel associated respiratory infection.

4.2 The Directors of Infection Prevention and Control (DsIPC) are responsible for: Providing expert guidance and advice to the Infection Prevention and Control Team, clinical and managerial staff about measures needed to protect staff, patients and members of the public from infection by severe travel associated respiratory infection.

4.3 The Duty medical and nursing staff in the Emergency Department, Acute Medical Unit or clinical area / ward in which a patient who may have severe travel associated respiratory infection is recognised, are responsible for: ensuring that any patients have a risk assessment and that appropriate actions are taken on the result of the risk assessment, with the support of the Microbiologists and Infection Prevention and Control Team.

4.4 Infection Prevention & Control Team (with support from the DsIPC) are responsible for advising on infection control measures required for severe travel associated respiratory infection cases. Especially on the correct use and where necessary fitting of personal protective equipment including FFP3 standard respirators.

4.5 The Infection Control Doctor and Consultant Microbiologists are responsible for providing advice on the diagnosis of severe travel associated respiratory infection and use of antibiotics or antivirals. Where appropriate they will liaise with specialist reference diagnostic laboratories.

4.6 Patient Flow Manager and Site Management Team are responsible for organising patient movements to negative pressure isolation rooms on the isolation ward (Torridge ward) if this is assessed as necessary.

4.7 The Security and Portering Teams are responsible assisting in the movement of patients with suspected severe travel associated respiratory infection to isolation facilities if required.

4.8 Isolation Ward (Torridge Ward) staff are responsible for the area in which patients with a severe travel associated respiratory infection will be cared for at least until the infective agent identified and the level of infectious risk confirmed. Torridge staff supplemented as necessary will provide the nucleus of nurses and doctors caring for these patients initially.
4.9 **Diagnostic Laboratory Staff**

- **Microbiology Consultant and Biomedical Scientist** staff are responsible for providing services to diagnose respiratory infections, and to direct specimens to reference and specialist laboratories when appropriate
- **Clinical Chemistry & Haematology Consultant and Biomedical Scientist** staff are responsible for providing a routine diagnostic service for patients with severe travel associated respiratory infection

4.10 Should an incident involving severe travel associated respiratory infection become the subject of press attention the **Trust Communications Team** are responsible for providing the necessary reports and press releases for the public and local and national press. This includes appropriate liaison with NHS England and Public Health England communications functions.

4.11 **The Consultant in Communicable Disease Control** (CCDC) and Public Health England (PHE) are responsible for the public health response in cases where an infectious agent may have the potential to spread in the community. This includes identifying and following up potential contacts.

4.12 **Occupational Health Department** in liaison with PHE are responsible for following up staff that are contacts of a confirmed case a severe travel associated respiratory infection.

5. **IDENTIFYING PATIENTS AT RISK OF HAVING A SEVERE TRAVEL ASSOCIATED RESPIRATORY INFECTION**

5.1 All patients who present to primary or secondary care with a fever should be asked about a travel history to determine whether they are at risk of an imported infectious disease. The key aim is that patients should receive an appropriate risk assessment in a safe environment, minimising the risk of transmission to contacts, including healthcare staff. This allows the patient to be managed appropriately.

5.2 In patients with a recent history of travel, respiratory tract infection may be caused by any of the pathogens normally found in non-travellers. However there may be increased risk of some infections such as Legionnaires’ Disease for example. In addition there are some potentially serious infections with a high risk of mortality in which there is also a risk of infection in contacts, including health carers.

5.3 Examples of serious travel associated infections which fall into this category include **MERS CoV**, and **Avian Influenza** (bird flu). However there may occasionally be alerts of other potential threats. Alerts and updates to current threats are issued by Public Health England (PHE) from time to time and when necessary these will be cascaded to appropriate departments by Microbiology or Infection Prevention and Control.

5.4 **Case Definition**

The **case definition** (PHE 2015) used currently to identify patients in need of a risk assessment depends on two elements, 1) the presenting **clinical features** and 2) the risk of **exposure** to agents. It aims to identify patients at risk of MERS CoV or Avian Influenza as these are the main recognised threats. For a suspect case patients must fulfil the conditions in both the clinical and the exposure categories.
1) **Clinical**

   Fever $\geq 38^\circ C$  
   **AND**
   Lower respiratory tract symptoms (cough or shortness of breath) or clinical signs of lower respiratory tract infection  
   **OR**
   Other severe/life-threatening illness suggestive of an infectious process

2) **Exposure**

   History of travel to, or residence in an area where infection with MERS-CoV (see 5.5) or Avian Influenza (see 5.6) could have been acquired in the 14 days before symptom onset  
   **OR**
   Close contact during the 14 days before onset of illness with a confirmed case of MERS-CoV or Avian Influenza-CoV infection while the case was symptomatic  
   **OR**
   Healthcare worker based in ICU caring for patients with severe acute respiratory infection, regardless of history of travel or use of PPE  
   **OR**
   Part of a cluster of two or more epidemiologically linked cases within a two-week period requiring ICU admission, regardless of history of travel

   (Note: two weeks has been chosen as the longest period of incubation recognised for current threats and is an indication for risk assessment, but for H5N1 ‘flu the period is seven days, H7N9 ‘flu 10 days and MERS-CoV 14 days)

5.5 MERS CoV exposure may occur in the Arabian peninsula:- Bahrain, Jordan, Iraq, Iran, Kingdom of Saudi Arabia, Kuwait, Oman, Qatar, United Arab Emirates, Yemen, ([PHE 2015 case algorithm](#)).

5.6 Avian influenza A/H7N9 exposure may occur in travellers from China. Avian Influenza A/H5N1 may occur in travellers from China, other parts of Asia and Egypt. In both cases close exposure to ducks or chickens in markets, live, dying or dead birds. ([PHE Avian flu data guidance and analysis](#))

5.7 If MERS CoV, Avian Influenza or another infectious respiratory disease is considered a possible diagnosis then before continuing with the initial assessment:
   - In the Emergency Department patients should be directed to a designated single room as soon as possible.
   - In other parts of the hospital patients should be isolated in a single room as soon after they are identified as possible.
   - The patient should be asked to wear a surgical mask.
   - Clinical staff assessing the patient should don personal protective equipment. This should be as advised for Viral Haemorrhagic Fever ([See Trust VHF Guideline, Appendix 4](#)) as this equipment is available and contains all the essential elements and key staff are trained in its use. However the wearer should be fit tested for a FFP3 respirator.
   - Infection control or the on call medical microbiologist should be called to assist in the assessment.
6. MANAGEMENT OF CASES OF SEVERE TRAVEL ASSOCIATED RESPIRATORY INFECTION

6.1 Admission of possible severe travel associated respiratory infection cases to hospital

6.1.1 Cases should only be managed in hospital if their current clinical condition warrants it. Therefore patients identified in primary care, including a walk in centres, should only be admitted if the clinical condition warrants it. Otherwise cases should be managed in their own homes and followed up by Primary Care / Health Protection Teams. (PHE 2015 primary care)

6.1.2 Patients to be admitted who are identified as possible cases before admission will be admitted directly to a negative pressure room either on Torridge Ward or the Intensive Care Unit (ICU) depending on whether ventilation support is necessary. This includes paediatric patients. It is essential that patients are only transported to hospital by an appropriate Hazard Area Response Team (HART) ambulance and that the receiving ward (Torridge or ITU) is prepared to receive the patient. It is appropriate to use the same communication and admission pathways for these patients as those contained in the Trust VHF Guideline, although the infective agents and risk assessments are different.

6.1.2 Public Health England if not already informed should be notified immediately. PHE is responsible for identification and management of contacts outside the hospital.

6.2 Patients identified as possible severe travel associated respiratory infection cases after admission

6.2.1 These patients, including paediatric cases, should be transferred to a negative pressure room either on Torridge or ICU as soon as possible. The patient should be given a surgical mask to wear until transferred to a single room.

6.2.3 Infection Control, site management, portering teams and the receiving ward will coordinate to ensure that the patient is moved safely when the receiving ward is ready. The patient should wear a surgical mask and those moving the patient PPE as for VHF (See Trust VHF Guideline, Appendix 3).

6.2.4 The area vacated by a patient identified after admission will require thorough decontamination and treatment with hydrogen peroxide vapour before being used for other patients.

6.2.5 The infection control team should advise on identifying patient contacts. Occupational health should identify and follow up staff contacts.

6.2.6 PHE should be notified, and will be responsible for identification and management of contacts outside the hospital.

6.3 Patients identified as possible severe travel associated respiratory infection cases in the Emergency Department or Walk-In Centre

6.3.1 As soon as the potential for avian ‘flu case is recognised, the patient should be moved to a cubicle room with the door closed. If the patient’s condition allows it he/she should wear an ordinary surgical mask. Oxygen may be given by nasal prongs. Attending staff should put on PPE (See Trust VHF Guideline, Appendix 4 and Ebola PPE training video) before any further action is taken.
6.3.2 If assessment shows he/she possibly has a risk of a severe travel associated respiratory infection such as MERS CoV or avian ‘flu, and that admission is indicated, then he/she must be admitted to a negative pressure room on Torridge Ward or ICU if respiratory support is required as soon as assessment is complete and the receiving ward is ready. Paediatric patients will also be admitted to Torridge or ICU with appropriate paediatric nursing support.

6.3.3 Infection Control, site management, portering teams and the receiving ward will coordinate to ensure that the patient is moved safely when the receiving ward is ready. The patient should wear a surgical mask and those moving the patient PPE as for VHF (see Trust VHF Guideline).

6.3.4 The area vacated by a patient identified after admission will require thorough decontamination and treatment with hydrogen peroxide vapour before being used for other patients.

6.3.5 The infection control team should advise on identifying patient contacts. Occupational health should identify and follow up staff contacts.

6.3.6 PHE should be notified, and will be responsible for identification and management of contacts outside the hospital.

6.3.7 If admission is not indicated but the patient is thought to have avian ‘flu, there must be extensive liaison between hospital staff, the GP and Consultant in Communicable Disease Control (CCDC) before the patient is sent home. Written as well as verbal advice must be given to the patient.

7 DIAGNOSTIC INVESTIGATIONS

7.1 Diagnostic investigations are those necessary to manage a severe respiratory tract infection. Special arrangements and sampling are required for respiratory pathogens.

7.2 Radiological investigation includes a Chest X-ray. This is best done with a portable machine that can be decontaminated and a machine should be designated for the patient until the infectious risk is over. The Radiographer will wear full PPE Trust VHF Guideline. Should departmental investigation be essential, arrangements must be discussed with infection prevention and control.

7.3 Microbiological investigation includes tests appropriate to the normal investigation of severe respiratory tract infection and specific investigations which will be referred to specialised laboratories.

- Blood culture
- Viral Swabs
  - Duplicate nose and throat swabs in viral transport media
- Sputum if produced
- Invasive respiratory samples if ventilated
  - Nasopharyngeal aspirate, Endotracheal aspirate or Bronchial lavage
- Blood
  - Clotted and EDTA samples for serology and PCR investigation
- Urine for pneumococcal and legionella antigens

Obtaining invasive respiratory specimens requires great care as aerosols may be generated. They should only be taken if the investigation is essential and protective full protective clothing must be worn.
7.4 Haematology and Biochemistry samples can be processed using normal precautions without special containment precautions.
   - FBC
   - Liver and Renal function tests
   - Blood gasses

7.4 All specimens and request forms for Microbiology, Biochemistry and Haematology must have “Risk of Infection” and severe travel associated respiratory infection included in the clinical details. Microbiological specimens will be transported directly to the laboratory and NOT the vacuum tube system.

7.5 Other essential investigations which require the patient to visit a department need to be organised in consultation with infection prevention and control to ensure that appropriate precautions and decontamination arrangements are in place.

8. INFECTION CONTROL

8.1 Isolation

8.1.1 Patients with a suspected or confirmed infectious travel associated respiratory tract infection will be admitted to a negative pressure isolation room with a lobby on Torridge Ward. If they require ventilatory support, a negative pressure room on ICU should be used instead.

8.1.2 Paediatric patients will be isolated on Torridge or ICU with appropriate paediatric support.

8.2 Personal Protective Equipment (PPE)

8.2.1 MERS CoV and Avian influenza are both transmitted by droplets and fine droplet nuclei - airborne - and also by direct and indirect contact. Other imported respiratory pathogens are likely to be transmitted by the same routes. During the 1997 outbreak of influenza A H5N1 in Hong Kong, contact and droplet precautions prevented nosocomial spread of the disease. Rigorous contact and droplet precautions in the 2003 SARS epidemic also prevented infection.

8.2.2 Although there is little evidence to support airborne transmission from human to human in the outbreaks of avian ‘flu A H5N1 there is good evidence of human to human infection with animal coronaviruses. Because of the high mortality of these infections and the difficulty in initially providing a definitive diagnosis until specific investigations can be completed, it is appropriate to use full personal protective equipment (PPE).

8.2.3 The trust has developed PPE and training in PPE use for potential viral haemorrhagic cases, and this provides the high level of protection required in potentially fatal transmissible respiratory diseases. For this reason the PPE used should be as for VHF (VHF policy). **However for severe travel associated respiratory infections, staff must be fit tested for the FFP3 respirators.**

8.2.4 The period of infectivity will vary for different infections, and may be longer in children and in patients with a degree of immune compromise. For this reason Microbiology will advise on the length of the likely infectious period on a case by case basis.
8.3 Hand hygiene

8.3.1 The infective agents likely to be encountered in severe travel associated respiratory infections include bacteria and enveloped viruses (coronaviruses and influenza viruses for example). These agents are susceptible to alcohol. Hand hygiene must be performed using soap and water if visible soiling is present or there is contamination with body fluids and secretions. Otherwise alcohol hand rub is appropriate.

8.3.2 Hand hygiene must be performed after removing protective clothing and prior to leaving the isolation room. Hands must then be further cleaned, using alcohol hand rub after exiting the isolation room. Hand hygiene must also be performed after cleaning of contaminated equipment.

8.4 Waste

8.4.1 Infected patients may excrete viruses in respiratory secretions and in faeces. En suite facilities in the isolation rooms should be used if possible. If unable to use the en suite the patient should use a disposable bedpan / urinal. Urine can then be poured carefully down the en suite toilet. Faeces and the receptacle should be disposed of in a clinical waste sack.

8.4.2 All clinical waste must be placed in clinical waste bags and bags sealed in the normal way AND KEPT WITHIN THE ISOLATION ROOM. Double bagging is not necessary. Waste will be collected by the porters wearing appropriate PPE and taken for disposal by incineration.

8.5 Laundry

8.5.1 Laundry should be placed in water-soluble bags and then into a red outer bag. This bag must be labelled as INFECTED. Contact the Porters to arrange for separate collection of the laundry bag for transportation to the Laundry Department.

8.6 Cutlery and crockery

8.6.1 Disposable cutlery and crockery is not necessary for infection control purposes. However for small numbers of patients the use of disposable cutlery and crockery may well be administratively easier. If used it should be disposed of in clinical waste.

8.7 Domestic issues

8.7.2 Daily cleaning of isolation rooms with Chlorclean will initially be a nursing responsibility as staff in contact with the isolation room should be minimised and protective clothing needs to be worn. Frequent cleaning of ward areas, door knobs, staff toilets, sluice etc. is also essential. Damp dusting should be performed wherever possible to avoid aerosolisation of virus. It is important that all areas are allocated and none missed. This should be monitored by infection control staff or ward managers.

8.7.2 Terminal cleaning is the responsibility of Housekeeping and Nursing. Surfaces within the room must be disinfected using Chlorclean solution 1000ppm. A terminal clean should include hydrogen peroxide vapour. Curtains must be changed and washed as infected linen. Specific advice on the terminal clean is likely to be needed depending on the infective agent identified in a particular case.
9 OCCUPATIONAL HEALTH & MANAGEMENT OF CONTACTS

9.1 MERS CoV and Avian influenza may be transmitted from human to human, but transmissibility is variable for different agents. Never the less these pathogens may have a high risk of mortality and therefore potential contacts should be monitored closely.

9.2 Household or other close contacts out of hospital should be monitored for evidence of infection. Contact tracing and monitoring in the community is a role of Public Health England.

9.3 Staff contacts.

9.3.1 Only essential HCW should have access to the isolation room. Nursing and junior medical staff should be dedicated, and trained in infection control procedures and use of PPE including fit tested for FFP3 respirators. Other staff, e.g. Consultant Medical Staff should ensure that they have protected time for these patients, to ensure that they can concentrate on infection control issues. If avian ‘flu is confirmed by the specialist Laboratory, then all HCW in contact with a patient with avian ‘flu should take prophylaxis if recommended by the PHE. This is likely to include immunisation with current influenza vaccines and taking oseltamivir.

9.3.2 A visitors book system will be maintained to record the names and times that staff and visitors have contact with severe travel associated respiratory infections. The names of staff attending suspected or probable cases must be documented and a list sent to the Occupational Health Department who will monitor them for the appropriate period during and after exposure.

9.3.3 Staff contacts who develop a fever >38 °C or respiratory symptoms should stay at home. They should contact their GP informing him/her of the organism they have been exposure to. They should also contact the duty manager in the hospital (via the switchboard), who will liaise with PHE, Occupational Health and Microbiology.

9.4 Visitors

9.4.1 Any visitors must be advised of the risks of infection and preferably not visit. Until a definitive diagnosis has been made it is not possible to give precise advise on risk of infection. However after a diagnosis has been made, or high risk pathogens have been excluded, good advice on risks and precautions necessary can be given to visitors. The infection control team should be involved in advising the appropriate precautions, and if indicated protective equipment.

9.4.2 Those visitors that have been close contacts may be incubating the disease or already be infectious due to common exposure. They must be advised not to come to the hospital if they have a fever or feel unwell and to contact their GP, informing the GP that they are unwell and have had contact with avian influenza. PHE should also be informed.

10. DISCHARGE OF PATIENTS

10.1 All suspected or probable cases of a severe travel associated respiratory infection who are admitted must remain in appropriate isolation until discharge, or until the appropriate period after resolution of fever as advised by Microbiology. This will vary for the infecting agent, the age and immune status of the patient.
10.2 Staff who become infected should not return to work until advised by Occupational Health in liaison with Microbiology.

11. CARE OF THE DECEASED

11.1 Standard precautions should be followed when caring for a person who dies of a travel associated severe respiratory pathogen. If they die during the infectious period full PPE should also be worn for last offices. The body should be placed in an impermeable bag prior to transfer to the mortuary.

11.2 Family should be able to view the body if they wish. If the person died during the infectious period they should wear gloves and gowns.

11.3 If a full or limited post mortem examination should be performed, this must be discussed first with Infection Control and a Consultant Microbiologist and PHE. This is to allow appropriate precautions to be undertaken and to make arrangements for specialist diagnostic services.

12. COMMUNICATION

12.1 Good communication is essential to ensure that the risks posed by possible avian ‘flu, coronavirus and other imported respiratory infections are reduced to the minimum possible. This should start as soon as a possible patient is identified.

12.2 Staff, patients and visitors to the hospital are likely to be worried. There is also likely to be media interest, possibly excessive. A co-ordinated and effective response should achieve a safe outcome.

12.3 Identification of a suspected or probable case must be reported to the Infection Control Team and/or on-call Consultant Microbiologist immediately and the Consultant Physician/Paediatrician on call. The Consultant in charge of the ICU should also be informed if respiratory support is likely to be needed. The senior manager on duty must also be informed.

12.4 The duty Consultant Microbiologist and Senior Infection Control Nurse can be contacted via the hospital switchboard. They will advise on infection control precautions, microbial investigation and treatment. They will also inform the PHE.

12.5 Useful Contacts

- Duty Consultant Microbiologist: Page via switchboard
- Senior Nurse Infection Control: Page #6579 or via switchboard
- Infection Control Nurses’ Office: Ext. 2355 (Mon-Fri 08.30 – 16.30hrs)
- Bed Manager: Bleep 273
- Senior Nurse on-call: Page via switchboard
- Matron general medicine: #6490 or via switchboard
- Senior Paediatric Nurse on-call: Page via switchboard
- Night Manager: Bleep 217 (9pm – 8pm)
- Senior Manager on-call: Page via switchboard
- AMU Admissions Co-ordinator: Bleep 513
- PHE: 0300 303 8162
13. **ARCHIVING ARRANGEMENTS**
The original of this SOP/guideline will remain with the author, who is the Infection Control Doctor (ICD) / Director for Infection Prevention and Control (DIPC). An electronic copy will be maintained on the Trust intranet, P – Policies – R - Severe Imported Respiratory Virus Infections. Archived electronic copies will be stored on the Trust's “archived policies” shared drive, and will be held indefinitely. A paper copy (where one exists) will be retained for 10 years.

14. **PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE GUIDELINE**

14.1 To monitor compliance with this SOP/guideline, the auditable standards will be monitored as follows:

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<tr>
<th>No</th>
<th>Minimum Requirements</th>
<th>Evidenced by</th>
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<tr>
<td>1.</td>
<td>Patients with possible or probable severe imported respiratory viral infections will be reviewed by the IPCT</td>
<td>Case records and laboratory records</td>
</tr>
<tr>
<td>2.</td>
<td>Patients with confirmed severe imported respiratory infections will be reviewed and reported to the ICOG</td>
<td>ICOG report</td>
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14.2 **Frequency**
Any cases where possibility or high possibility of severe imported respiratory viral infections where a risk assessment has been undertaken will be discussed by the IPCT at routine meetings and if relevant reported to ICOG. Significant incidents will be included in the DIPC annual report.

14.3 **Undertaken by**
ICD / Joint IPCD

14.4 **Dissemination of Results**
At the Infection Control Operational Group which is held 6 weekly and at the Infection Control and Decontamination Assurance Group and the relevant Divisional Governance Groups if there is failure to comply with the policy.

14.5 **Recommendations/ Action Plans**
Implementation of the recommendations and action plans will be monitored by the Infection Control and Decontamination Assurance Group, which meets quarterly. Any barriers to implementation will be risk-assessed and added to the risk register. Any changes in practice needed will be highlighted to Trust staff via the Governance Managers’ cascade system.

15 **REFERENCES**

1) PHE 2013 Infection Control Advice Middle East respiratory syndrome coronavirus (MERS-CoV)  
Accessed September 2015

2) The Referral of Samples to a PHE Public Health Laboratory for Testing for the Middle East Respiratory Syndrome Coronavirus (MERS-CoV) in England

Guidance for the Management of Suspected Cases of Severe Imported Respiratory Virus Infections Including Avian Influenza and MERS Cov
Ratified by: Infection Control & Decontamination Assurance Group: 20th October 2015
Review date: August 2017
Accessed September 2015

3) PHE 2015 MERS-CoV Case Algorithm
Accessed September 2015

4) WHO 2015 Fact sheet Middle East respiratory syndrome coronavirus (MERS-CoV)
http://www.who.int/mediacentre/factsheets/mers-cov/en/
Accessed September 2015

5) WHO 2003 Case Definitions for Surveillance of Severe Acute Respiratory Syndrome (SARS) http://www.who.int/csr/sars/casedefinition/en/
Accessed September 2015

6) RD&E 2015 Viral Haemorrhagic Fever - Guideline for Risk Assessment and Management of Patients
http://ian.exe.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=58530
Accessed September 2015
### APPENDIX 1: COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

<table>
<thead>
<tr>
<th>Staff groups that need to have knowledge of the guideline/SOP</th>
<th>Clinical staff in admission ward, Emergency Department, Torridge Ward; Site Management Team; Infection prevention and Control team; Portering Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>The key changes if a revised document</td>
<td>This Guideline replaces that for Avian Influenza in order to provide guidance for a wider range of infections, however infection control management is largely identical in this group of infections</td>
</tr>
<tr>
<td>The key objectives</td>
<td>The purpose of this guideline it to ensure that patients who may have infectious travel associated respiratory infections are promptly identified and managed correctly.</td>
</tr>
<tr>
<td>How new staff will be made aware of the procedure/guideline and manager action</td>
<td>New staff should be informed in general about infection prevention control and where to find specific guidelines and policies. In relevant departments (see above) the guideline should be highlighted appropriately</td>
</tr>
<tr>
<td>Specific Issues to be raised with staff</td>
<td>Staff in front line admitting departments should be aware of the importance of taking a travel history in patients with a fever and signs of infection</td>
</tr>
<tr>
<td>Training available to staff</td>
<td>Support is available from the IPC team and microbiology</td>
</tr>
<tr>
<td>Any other requirements</td>
<td>No negative impacts.</td>
</tr>
<tr>
<td>Issues following Equality Impact Assessment (if any)</td>
<td>No negative impacts.</td>
</tr>
<tr>
<td>Location of hard / electronic copy of the document etc.</td>
<td>The Hard Copy of this Guideline and original electronic document will be kept in the Office of the Infection Prevention and Control team, and the electronic copy accessed in the infection control area of IaN</td>
</tr>
</tbody>
</table>
APPENDIX 2: EQUALITY IMPACT ASSESSMENT TOOL

| Name of document | Guidance for the Management of Suspected Cases of Severe Imported Respiratory Virus Infections Including Avian Influenza and MERS Cov. (Note this does not include pandemic Influenza) |
| Division/Directorate and service area | Specialist Services, Infection Prevention and Control |
| Name, job title and contact details of person completing the assessment | Alaric Colville, Consultant Medical Microbiologist and Infection Control Doctor |
| Date completed: | 29/09/2015 |

The purpose of this tool is to:
- **Identify** the equality issues related to a policy, procedure or strategy
- **Summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **Highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. **What is the main purpose of this document?**
   The purpose of this guideline it to ensure that patients who may have infectious travel associated respiratory infections are promptly identified and managed correctly.

2. **Who does it mainly affect?** *(Please insert an “x” as appropriate:)*
   - Carers ☒
   - Staff ☒
   - Patients ☒
   - Other (please specify)

3. **Who might the policy have a 'differential' effect on, considering the “protected characteristics” below?** *(By differential we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)*
   *Please insert an “x” in the appropriate box (x)*

<table>
<thead>
<tr>
<th>Protected characteristic</th>
<th>Relevant</th>
<th>Not relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Disability</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Sex - including: Transgender, and Pregnancy / Maternity</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Race</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>

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Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to... (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

People who frequently travel, e.g. for business or in the armed forces, but potentially any traveller

Do you think the document meets our human rights obligations? Yes

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:

- **Fairness** – how have you made sure it treat everyone justly?
- **Respect** – how have you made sure it respects everyone as a person?
- **Equality** – how does it give everyone an equal chance to get whatever it is offering?
- **Dignity** – have you made sure it treats everyone with dignity?
- **Autonomy** – Does it enable people to make decisions for themselves?

Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

The guidance is designed to ensue the safety of travellers and their contacts

If you have noted any ‘missed opportunities’, or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

<table>
<thead>
<tr>
<th>“Protected characteristic”:</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue:</td>
<td>NA</td>
</tr>
</tbody>
</table>
How is this going to be monitored/addressed in the future:  
NA

Group that will be responsible for ensuring this carried out:  
NA

NOTES FOR ALL AUTHORS
Do remember that all equality impact assessments need the involvement of somebody beyond the policy/procedure author to provide perspective and guidance.

If you need help with any part of this assessment, please contact either Simon Harrison (for patient related policies/procedures/strategies) or David Matthewman (for Human Resources). We are more than happy to email out an example of a completed form for a policy or a procedure, if that is helpful. Both can be contacted via rde-tr.equality@nhs.net. (If you are using this email please indicate whether you feel the issue is predominantly patient or staff related.)

POLICY/ SOP AUTHORS
Apart from seeking guidance during the development of a policy, this impact assessment will also need final approval by an appropriate equality lead prior to ratification of the policy.

STRATEGY AUTHORS (i.e. strategies which are Board-approved for external publication)
Please be mindful that these impact assessments are intended to be made public, either routinely or on request, and whilst they should be carried out on sensitive commercial and strategic documents presented to the Board, they should also be written in such a way as to enable such publication.