# Seasonal Influenza Management Policy

<table>
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<tr>
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<th>Robert Porter, Infection Control Doctor/Consultant Microbiologist</th>
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<td>Author of Policy</td>
<td>Nicola Colborne, Infection Prevention and Control Advanced Nurse Specialist</td>
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<td>Division/ Department responsible for Procedural Document</td>
<td>Specialist Services, Infection Prevention &amp; Control</td>
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<td>Maintain Operational Service delivery</td>
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Other (please specify):

**Note:** This policy has been assessed for any equality, diversity or human rights implications

## Controlled document

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### Full History

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### Associated Trust Policies/procedural documents:

- Infection Prevention and Control Policy
- Outbreak Control Policy
- Adult Community Acquired Pneumonia (CAP) Sev. Assessment and Empirical Antimicrobial Treatment Guidelines
- Guidance for the Management of Suspected Cases of Severe & Imported Respiratory Virus Infections Including Avian Influenza and MERS Cov
- Pandemic Flu Contingency Plan

### Key Words:

- Influenza
- Flu

### In consultation with and date:

Full membership of the Infection Control and Decontamination Assurance Group which includes representation from the executive team, divisional management teams including community services, nursing and medical staff, therapists, facilities, operations support, estates: November 2019

Public Health England’s Devon/Cornwall and Somerset Local Team: 27 November 2019

### Contact for Review:

Infection Prevention and Control Advanced Nurse Specialist
CONTENTS

1. INTRODUCTION........................................................................................................... 5
2. PURPOSE......................................................................................................................... 5
3. DEFINITIONS................................................................................................................... 6
4. DUTIES AND RESPONSIBILITIES................................................................................. 6
5. ARCHIVING ARRANGEMENTS..................................................................................... 6
6. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY......................................................................................................................... 6
7. REFERENCES................................................................................................................... 6
APPENDIX 1: INFECTION CONTROL.................................................................................. 8
APPENDIX 2: MANAGEMENT OF ADMISSIONS ................................................................. 13
APPENDIX 3: TREATMENT AND MANAGEMENT OF CONTACTS.................................. 14
APPENDIX 4: MANAGEMENT OF SUSPECTED FLU PATIENTS ATTENDING THE EMERGENCY DEPARTMENT (ED) ........................................................................................................ 16
APPENDIX 5: MANAGEMENT OF SUSPECTED FLU PATIENTS ATTENDING WYNARD AMBULATORY CLINIC (WYAC) .................................................................................................. 17
APPENDIX 6: IMPLEMENTATION PLAN IN CASE OF EXTRAORDINARY PRESSURE. 18
APPENDIX 7: COMMUNICATION PLAN ........................................................................... 19
APPENDIX 8: EQUALITY IMPACT ASSESSMENT TOOL.................................................. 20
1. **INTRODUCTION**

1.1 Influenza or 'flu' is a respiratory illness caused by flu A or B virus. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints, diarrhoea and vomiting.

1.2 Flu is a highly infectious illness transmitted through the respiratory route by droplets or contact.

1.3 Flu occurs most often in winter and usually peaks between December and March in the northern hemisphere. Illness resembling flu may be caused by several different viruses; therefore national surveillance schemes are in place to detect circulation of flu viruses.

1.4 The flu virus is unstable and new strains and variants are constantly emerging. For this reason the flu vaccine is reformulated each year to match circulating strains, and a booster should be given each year to those qualifying for flu vaccination. Vaccine is recommended for those between the ages of 6 months and 65 years with chronic disease including respiratory conditions, renal disease, liver disease, neurological conditions, diabetes and heart disease. Children between the ages of 2 and 10 and people age 65 or over should also be offered vaccination. Pregnant women are also recognised as being at special risk. Health and social care workers are strongly encouraged to be vaccinated against flu for their own and their vulnerable patients' protection and national targets for vaccination of health and social care workers are set each year by the Department of Health (DH).

1.5 For most people flu infection is just a nasty experience, but for some it can lead to more serious illnesses. The most common complications of flu are bronchitis and secondary bacterial pneumonia. These illnesses may require treatment in hospital and can be life threatening especially in the elderly, people with chronic illness or immunosuppression.

1.6 **Failure to comply with this policy could result in disciplinary action.** However, it is recognised that the management of flu and the appropriate actions to take are entirely dependent on the background levels of disease in the community and therefore the volume of patients admitted to hospital. As the flu season escalates, close liaison between the clinicians and the infection prevention and control team (IPCT) may result in pragmatic adjustments in practice.

2. **PURPOSE**

2.1 The purpose of this document is to provide information to ensure the Trust is able to respond to the consequences of rising numbers of patients with seasonal flu and to ensure patients with flu are managed safely and effectively.

2.2 This policy supports the Trust's Infection Prevention and Control Policy.

2.3 This policy will be implemented when the Public Health England (PHE) national surveillance scheme indicates that flu virus A or B is circulating and there is a substantial likelihood that people presenting with a flu-like-illness (ILI) are infected with flu virus.

2.4 The policy would also be implemented if an outbreak of flu is detected locally or within the Trust, in the absence of evidence from national surveillance as in 2.3.
2.5 The policy may also be implemented in the early stages of a flu pandemic before the need for the Trust’s Pandemic Flu Plan to be implemented.

3. DEFINITIONS
3.1 Definitions are contained within the body of the policy.

4. DUTIES AND RESPONSIBILITIES
4.1 Directors of Infection Prevention and Control (DIPCs) and Infection Prevention and Control Team (IPCT):
   - To monitor and contribute to surveillance schemes
   - To notify the Trust’s Senior Management Team when there is evidence from PHE’s national surveillance scheme, or elsewhere, to indicate that flu virus A or B is circulating and there is a substantial likelihood that people presenting to the Trust with a flu-like-illness are infected with flu virus
   - To participate in Trust Influenza Control Team Meetings and carry out actions contained within this plan

4.2 Microbiology Laboratory
   - To provide appropriate capability for the diagnosis of viral respiratory illness, either at ward level, on site or by referring specimens to another laboratory.
   - The level of diagnostic capability to be varied so as to be consistent with the requirements of the Trust to diagnose and to manage flu-like-illness in non-epidemic and epidemic conditions.

4.3 Trust Influenza Control Team
   - To meet when notified by the Trust’s Senior Management Team (see 4.1)
   - To co-ordinate the response to the consequences of rising numbers of patients with seasonal flu and to ensure patients with flu are managed safely and effectively.

4.4 Clinical and Non-clinical Divisions
   - Contribute to the response to seasonal flu by participating in Trust flu Control meetings and communicating actions to relevant staff

5. ARCHIVING ARRANGEMENTS
The original of this policy, will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust’s “archived policies” shared drive, and will be held indefinitely.

6. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY
6.1 This policy will be monitored during and after the management phase of the response to seasonal flu and any development actions identified incorporated into a revised policy.

7. REFERENCES


**NOTE** References to flu infection control guidance generated in preparation for a pandemic are included as general sources for information which can be applied to epidemic flu as deemed appropriate by local teams.
APPENDIX 1: INFECTION CONTROL

1 Clinical features
1.1 Flu is a viral respiratory illness. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints, diarrhoea or vomiting. Flu is highly infectious and transmitted by droplets and fine droplet nuclei (airborne) and also by direct and indirect contact. The infectious period starts 12 - 24 hours before onset of symptoms. Immunocompetent adults and children older than 12 years should be considered potentially infectious until 7 days have lapsed from onset of symptoms. Children under 12, especially younger children may be infectious for longer, as are immunocompromised patients.

2 Isolation
2.1 Patients with suspected flu will be admitted to a single room. Patients with confirmed flu will remain isolated in a single room or cohort bay for the duration of their infectious period, or until discharged. Isolation will be directed by site management in cooperation with the IPCT.

2.2 If a patient requires ventilatory support, a negative pressure room on ITU should be used. If respiratory HDU is required a discussion between a consultant respiratory physician, IPCT/microbiology and site management must happen.

2.3 If it becomes necessary single rooms or cohort areas will be designated for patients with confirmed and suspected flu by Trust management with the IPCT.

3 Hand hygiene
3.1 Hand hygiene is the single most important practice needed to reduce transmission of the virus. Flu viruses are susceptible to alcohol hand gel. Hand hygiene must be performed using soap and water if visible soiling is present on hands.

3.2 Hand hygiene must be performed before and after removing surgical face masks (to avoid contamination of the eyes and mucous membranes from contaminated hands). This means that all other protective equipment such as gloves and aprons/gowns must be removed first, then hand hygiene is performed and then respiratory/eye protection can be removed. Hands must then be cleaned after disposing of respiratory/facial protection and prior to leaving the room (refer to pages 9 and 10).

4 Protective clothing (PPE)
4.1 For contact with patients with suspected or confirmed flu the following PPE should be worn:

- surgical facemask (unless FFP3 indicated)
- plastic apron
- non sterile gloves
- eye protection

Aerosol generating procedures (AGP) may result in aerosol production and increase the risk of infection to healthcare staff and include:
- Intubation and non-invasive ventilation.
- Suction – closed suction systems should be used for intubated patients.
- Cardiopulmonary resuscitation (CPR)
- Bronchoscopy
- Chest physiotherapy

If undertaking AGPs enhanced PPE should be worn, consisting of:
4.2 PPE will be available in key areas as necessary. Contact Top Up if PPE is required and not in stock, do not take from theatres. Out of hours, contact Porters and request PPE from emergency store.

4.3 It is a legal requirement that FFP3 respirators are fitted correctly and cover both nose and mouth. No disposable FFP3 respirator will be effective for staff with beards. People likely to have to wear an FFP3 respirator must be fit tested in advance to ensure the respirator is suitable for the wearer.

4.4 In the event of shortages of FFP3 face masks, NHS Supply Chain may not be able to supply the same brand that staff have been fit tested for in advance. If a substitute FFP3 respirator is supplied at short notice it may not be possible to undertake fit testing for the substitute brand of respirator. The emphasis must therefore be on performing a fit check prior to performing AGPs.

- Put on the FFP3 respirator and ensure that any shaping devices over the nose are pressed close to the bridge of the nose
- Cover the front of the respirator with both hands being careful not to disturb the position of the respirator.
- Inhale/exhale sharply - if any leakage is detected adjust position of respirator and/or tension of the strap/s
- Retest the seal and repeat procedure until the respirator is sealed properly

5 Waste
5.1 All waste must be disposed of as clinical waste using the designated waste streams.

6 Laundry
6.1 All laundry must be disposed of in water-soluble bag, followed by a red outer bag. Laundry will be collected on the normal way.
Guidance for staff on putting on PPE for flu

PPE should be put on BEFORE entering the room/area

- **Clean your hands**
- **APRON:**
  - Pull over head and fasten at back of waist
- **FACE MASK:**
  - Secure ties at middle of head and neck
  - Fit flexible band to nose bridge
  - Fit mask snugly to face and adjust to fit
- **GLOVES:**
  - extend to cover wrists

**Remember:** keep hands away from face, limit surfaces touched, change gloves regularly/clean hands within room as needed.

Adapted from Department of Health ‘Prepare and Protect’ 2007
Guidance for staff on putting on and removing PPE for ‘flu

The correct order for removing PPE is: GLOVES, APRON, MASK

PPE should be removed & disposed of into clinical waste bag before leaving the room/area

- GLOVES: Grasp the outside of one glove with the opposite gloved hand; peel off
- Hold the removed glove in the gloved hand
- Slide the fingers of the ungloved hand under the remaining glove at the wrist
- Peel the second glove off over the first glove
- Dispose of gloves

- APRON: break ties
- Pull apron away from the neck and shoulders, break at collar to avoid lifting over head, touching inside only
- Fold or roll into a bundle
- Dispose of apron
- **Clean your hands**

- MASK: unfasten the ties- first the bottom, then the top
- Pull away from the face without touching front of the mask
- Dispose of mask
- **Clean your hands**

Adapted from Department of Health 'Prepare and Protect' 2007
7 **Visits to other departments for investigations**
7.1 Patients can undergo investigations in other departments, provided the relevant department has been informed in advance.

7.2 While outside the isolation room or cohort bay the patient should wear a surgical face mask. The area and equipment that the patient has been in contact with should be appropriately decontaminated after the patient has left.

8 **Cleaning**
8.1 Daily cleaning of isolation rooms should be undertaken. In addition, in areas where flu patients are being nursed, frequent cleaning with a hyper-chlorite solution of ward areas, door handles, staff toilets, sluice etc. is essential and this is the responsibility of domestic services. Damp dusting should be performed wherever possible to avoid aerosolisation of virus. This should be monitored by ward housekeepers and ward managers.

8.2 Terminal cleaning is the responsibility of domestic services. There is no need to wash walls. Curtains must be changed.

8.3 If a positive case has been identified in a bay, the bed space of the infected case should receive a terminal clean and a curtain change. All other horizontal surfaces within the bay should be disinfected with a hyper-chlorite solution. Providing this cleaning occurs when the positive case has been moved, no further terminal cleaning is required prior to the bay opening. NB – this will be reviewed if multiple cases of flu are identified in a bay or if there is evidence of spread of the virus in the bay (hospital acquired flu).

9 **Discharge arrangements**
9.1 Flu positive patients should be discharged as soon as they are medically fit. Patients are infectious for 7 days after onset of symptoms and should be advised to stay at home until they are no longer infectious.

10. **Community Settings or Patient Homes**
10.1 In community care settings, i.e. patient’s own home or a care home, personal PPE must be worn by staff as detailed in section 4, until the patient is no longer considered infectious (7 days from onset of symptoms, patient is well and afebrile).

11 **Care of the Deceased**
11.1 If a flu positive patient dies during the infectious period, the same level of PPE as worn prior to death should be worn for last offices. The body should be placed in an impermeable bag prior to transfer to the mortuary. Family should be able to view the body if they wish, however it is important that advice against facial contact e.g. kissing should be enforced, and hand hygiene is important after touching the body with or without gloves.

11.2 If a full or limited post mortem examination should be performed, this must be discussed first with the IPCT and a Consultant Microbiologist. This is to allow appropriate precautions to be undertaken and to make arrangements for specialist diagnostic services.
APPENDIX 2: MANAGEMENT OF ADMISSIONS

1   Admissions to hospital  
   1.1 Cases of suspected or confirmed flu should only be managed in hospital if this is essential.

2   Patients identified as possible flu cases before admission  
   2.1 Those requiring admission should be admitted directly into a single room. It is essential to confirm in advance that the receiving ward is ready and prepared to receive the patient.

   2.2 There must be close liaison with ambulance personnel by the admissions coordinator, informing them where they should bring the patient. The patient should be given a surgical mask to wear during transfer to an isolation room without delay.

3   Patients identified as possible flu cases after admission  
   3.1 These patients should be transferred to a single room on a suitable ward as soon as possible. The patient should be given a surgical face mask to wear during transfer.

   3.2 The IPCT should be contacted to advise on identifying patient contacts, and environmental cleaning required.

4   Paediatric Patients  
   4.1 Children should only be admitted if hospital treatment is essential and should go to a single room on Bramble ward.

   4.2 Babies must not be re-admitted to the Neonatal Unit from the community.

   4.3 Parents or carers who accompany children with probable or confirmed flu may themselves be infected or incubating flu. If appropriate they may stay with their children but should be isolated and not allowed to use shared parent accommodation or other areas of the hospital. Advice should be sought from the IPCT.
APPENDIX 3: TREATMENT AND MANAGEMENT OF CONTACTS

1 Patients with suspected or confirmed flu
1.1 Admitted patients assessed as likely to have flu or with laboratory confirmed flu should be given antiviral treatment in accordance with current PHE recommendations. Refer to the Trust guidance on use of antiviral agents for the treatment and prophylaxis of influenza

1.2 If flu negative the specific antiviral treatment should be stopped and appropriate management determined according to clinical judgment.

2 Vaccination
2.1 All healthcare workers (HCWs) are offered the seasonal flu vaccine, and should have this, unless contraindicated, for the protection of patients, other staff and themselves.

3 Staff contacts
3.1 Only essential HCWs should have access to the single room/cohort where a suspected or confirmed flu patient is located.

3.2 If symptoms of flu develop, staff must stay at home, and contact their GP for advice on treatment. They must also inform their manager that they may have flu symptoms.

3.3 Flu prophylaxis is not offered to staff contacts who did not wear appropriate PPE when caring for flu patients. However any staff contacts who are concerned because they consider themselves to be in a high risk group should contact their GP. Advice from occupational health or microbiology can be obtained, normally during working hours.

3.4 Significantly immunocompromised staff and those with certain chronic respiratory, cardiac, renal and other illnesses should NOT enter areas where flu patients are being cared for. The need to avoid flu contact should be confirmed with occupational health and line managers must be informed of the risk. In addition pregnant staff should not care for flu patients.

4 Visitors
4.1 All visitors must be advised of the risks of infection and preferably not visit. If they insist on visiting they must take the same precautions as staff if not already classed as a close contact, in which case it may be felt that PPE is not warranted.

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.

5 Contact Tracing
5.1 The following should be considered contacts: People who live in the same household an infectious case or Patients nursed in the same bay as an infectious case. People who have had face to face encounters with an infectious case, or been within a meter an infectious case for a significant time (more than four hours in a continuous period) are also classed as contacts.

5.2 Identification of inpatient contacts
- When a patient is identified as being flu positive during their admission and has not been isolated, all patients who have been in the bay with the infectious patient for more than four hours are considered contacts.
- The IPCT will compile a list of patient contacts. Identified patient contacts should be prescribed prophylaxis.
• Contacts may need to be isolated in a single room or in a cohort bay if they remain in hospital to avoid secondary spread. The IPCT will advise.

5.2.2 Identification of contacts in clinics, day case and outpatients
• If a suspected or confirmed case attends a clinic, day case or outpatient setting and is not isolated, then other patients in the same area will be potentially infected. Areas of special risk include oncology and haematology outpatients and day case, both paediatric and adult, also renal outpatients and haemodialysis patients.
• The IPCT should be informed by clinic staff of potential incidents. The clinic staff will draw up a list of potential contacts using clinic lists etc. Senior clinicians will review potential contacts to identify those who need prophylaxis. It is the responsibility of the clinician to make arrangements for the patients who require prophylaxis to be contacted. In addition contacts, whether or not on prophylaxis, who may return within the incubation period e.g. for day case or dialysis appointments should be identified so that they can be isolated appropriately for these visits.
APPENDIX 4: MANAGEMENT OF SUSPECTED FLU PATIENTS ATTENDING THE EMERGENCY DEPARTMENT (ED)

Patient arrives at ED reception with flu like symptoms. Type “suspected flu” in the presenting complaint field.

Patient triaged and isolated if appropriate and capacity allows.

Assess if patient can be treated in the community and discharge if possible.

If patient requires admission to hospital - viral nose swab for flu processed on the POCT machine. If positive for flu antivirals prescribed.

Refer to appropriate specialty requesting a side room. Note the clinical reason for request as ‘suspected or confirmed flu’.

AMU co-ordinator informed via e-referral of side room requirement.

Patient admitted to appropriate isolation or cohort facility.

Vacated cubicle in ED is cleaned with Chlorclean before use by next patient.

If patient requires Resus level care then a ‘bed space’ clean arranged promptly afterwards.

If patient brought in to ED by ambulance.

Patient triaged and isolated if appropriate and capacity allows.

If patient requires admission to hospital - viral nose swab for flu processed on the POCT machine. If negative, investigate alternative causes for symptoms.

Droplet and contact infection control precautions for all staff (surgical face mask, apron, gloves).

If not admitted to AMU - ward staff must inform ward doctor that patient has been admitted directly from ED to isolation/cohort facility.

The ward doctor ensures the patient receives a timely review by a senior doctor (SpR or above).

Seasonal Influenza Management Policy 2019/20
Ratified by: Infection Control & Decontamination Assurance Group: 19 November 2019
Review date: November 2024 Page 16 of 22
APPENDIX 5: MANAGEMENT OF SUSPECTED FLU PATIENTS ATTENDING WYNARD AMBULATORY CLINIC (WYAC)

Admissions Coordinator (AC) takes telephone referral from GP.
AC uses WYAC attendance criteria to triage patient. If patient suitable for WYAC, they MUST be informed by GP to come directly to WYAC and stop at A bay, knock on the door, where they will be expected.

Patient must wear a surgical face mask whilst sat in A bay

Patient seen in A bay WYAC. Viral nose swab should be taken from patient and processed on POCT machine.

Patient is Flu positive by PCR on POCT

Patient is RSV positive by PCR on POCT, but Flu negative

Patient is Flu and RSV negative by PCR on POCT

Remove patient from A bay and place in isolation room elsewhere, or discharge

Patient reviewed by Medics and decision made to admit or discharge home

Decision to admit
Contact Site Management Team to inform them and suitable isolation room/cohoot bed will be found. Inform IPCT of positive result and patient being admitted. Place IC alert on the E-Whiteboard

Ensure prophylaxis prescribed before sending patient to receiving area

Patient transferred to relevant ward. Ensure patient wears surgical face mask while being transported. If on O2 via mask, then surgical face mask not required.

Discharge home
Patient should be discharged as soon as possible from decision. They must remain in A bay whilst awaiting their transport. They MUST be informed to leave the hospital immediately, not to stop in any cafes, the restaurant or any shops. They must not use any facilities outside of the ward. Oseltamivir should be prescribed in line with current guidance. Give patient information leaflet.

General advice for A bay
- Staff in bay must wear appropriate PPE for droplet and contact precautions.
- Hand hygiene required as per 5 moments of hand hygiene
- Alcohol hand gel is effective against flu virus
- The toilet/bathroom between A bay and B bay should be allocated for patients in A bay only.
- If accompanying person stays with patient, they must be advised of the risk and offered PPE.
- Bay should receive a horizontal surface clean with Chlor-clean in the middle of the day and the whole bay will receive a terminal clean at the end of the day
APPENDIX 6: IMPLEMENTATION PLAN IN CASE OF EXTRAORDINARY PRESSURE

1.1 If there is evidence of pandemic flu circulating, or if there is evidence of extraordinary flu pressure within the Trust, or if there is a virulent strain of flu with high mortality circulating, the Trust Influenza Control Team should be convened.

1.2 Influenza Control Team Membership

- Chief Nurse or Deputy (Chair)
- DIPC
- IPCT representative
- Microbiology
- Medicine
- Respiratory Consultant(s)
- Emergency Department (ED)
- Intensive Care Unit (ICU)
- Paediatrics
- Cancer Services
- Pharmacy
- Other Divisional Reps as required
- Site Management
- Others as required, e.g.:
  - Human Resources (HR)/Occupational Health (staffing, vaccination)
  - Logistics

1.3 Actions

- Co-ordinate preparatory actions and refer to Capacity Management Plan
- Determine criteria to cancel electives to maintain capacity of Respiratory Physicians
- Agree consistent approach for responding to enquiries from patients/carers directly to consultants
- Review arrangements with other departments in the Trust to co-ordinate care delivery to manage extreme demand on services
- Review medical staffing to provide cover for areas and review need for medical cover over 24 hour period to support discharge of patients
- Review Regional Paediatric Intensive Care Unit (PICU) arrangements and contingency plans
- Review Regional ICU and Extra Corporeal Membrane Oxygenation (ECMO) arrangements and contingency plans. If ECMO is likely to be needed the ICU staff will liaise with the appropriate centre and arrange transfer if agreed.
- Check stocks of anti-virals
- Review vaccine availability and consider further vaccination sessions or liaise with Divisions regarding peer vaccination
**APPENDIX 7: COMMUNICATION PLAN**

**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 policy</th>
<th>Executive Directors, Associate Medical Directors, Clinical Leads, Divisional Directors, Assistant Directors of Nursing, Senior Nurses, Matrons, Divisional Business Managers, Cluster Managers, Service Managers</th>
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<tbody>
<tr>
<td>The key changes if a revised policy</td>
<td>Reformatted and removed unnecessary information. Staged response removed and some appendices as no longer relevant. New flowchart for Wynard ambulatory added.</td>
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<tr>
<td>The key objectives</td>
<td>To provide information and guidance to ensure the Trust is able to respond to the consequences of rising numbers of patients with seasonal flu and to ensure patients with flu are managed safely and effectively.</td>
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<tr>
<td>How new staff will be made aware of the policy and manager action</td>
<td>Cascade when flu virus A or B is circulating and there is a substantial likelihood that people presenting with a flu-like-illness are infected with flu virus.</td>
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| Specific Issues to be raised with staff                | **Clinical Staff:**  
  - Use of PPE in cohort areas and non-cohort areas (including fit-testing)  
  - Symptoms  
  - Need to test  
  - Treatment  
  - Criteria isolation/cohorting  
  - Need to move patients promptly out of single rooms when not infected and test is negative |
| Training available to staff                            | N/A |
| Any other requirements                                 | N/A |
| Issues following Equality Impact Assessment (if any)   | N/A |
| Location of hard / electronic copy of the document etc. | The original of this policy, will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely. |
APPENDIX 8: EQUALITY IMPACT ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>Name of document</th>
<th>Seasonal Influenza Management Policy</th>
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<tbody>
<tr>
<td>Division/Directorate and service area</td>
<td>Specialist Services – Infection Control</td>
</tr>
<tr>
<td>Name, job title and contact details of person completing the assessment</td>
<td>Mel Burden - Consultant Nurse/Joint Director for Infection Prevention and Control</td>
</tr>
<tr>
<td>Date completed:</td>
<td>10/01/2020</td>
</tr>
</tbody>
</table>

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 document is to provide information to ensure the Trust is able to respond to the consequences of rising numbers of patients with seasonal flu and to ensure patients with ‘flu are managed safely and effectively.

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>
<tr>
<td>Religion / belief</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Sexual orientation – including:</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Marriage / Civil Partnership</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>

Seasonal Influenza Management Policy 2019/20
Ratified by: Infection Control & Decontamination Assurance Group: 19 November 2019
Review date: November 2024 Page 20 of 22
4. 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.)?

The purpose of this document is to provide information to ensure the Trust is able to respond to the consequences of rising numbers of patients with seasonal ‘flu and to ensure patients with ‘flu are managed safely and effectively.

5. Do you think the document meets our human rights obligations? ☒

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?

6. 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?

Old age, pregnancy and chronic conditions are risk factors for acquiring flu and suffering with serious complications of flu. This policy will have a positive impact on patients with these risk factors in our care by protecting them from acquiring influenza and thus complications of flu such as pneumonia. This is well documented in all published flu guidance.

7. 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>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Issue:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>How is this going to be monitored/addressed in the future:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Group that will be responsible for ensuring this carried out:</strong></td>
<td></td>
</tr>
</tbody>
</table>