

RESPIRATORY VIRUSES POLICY

Including Severe Acute Respiratory Syndrome (SARS)

Version 6. December 2018

Reviewed December 2018

Document Control Sheet

Name of document:	Respiratory Viruses Policy including SARS
Version:	6
Status:	Approved
Owner:	Infection Prevention and Control Team
File location / Filename:	
Date of this version:	December 2018
Produced by:	Infection Prevention and Control Team
Synopsis and outcomes of consultation undertaken:	Joint Infection Control Committee. Reference to key guidance documents IPACC
Synopsis and outcomes of Equality and Diversity Impact Assessment:	No specific issues. National EIA give more details on measures to reduce Healthcare Acquired Infections
Approved by (Committee):	Joint Infection Control Committee (JICC) Professional Executive Committee IPACC
Date ratified:	14/12/2018
Copyholders:	
Next review due:	December 2020
Enquiries to:	ecch.infectionprevention@nhs.net .

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
January 2011	Updated reference inserted	IPCT	2
December 2012		IPCT	3
December 2014		IPCT	4
November 2016	Amalgamated Respiratory and SARS policy	IPCT	5
December 2018		IPCT	6

Approvals

This document requires the following approvals either individual(s), group(s) or board.

Name	Title	Date of Issue	Version Number
JICC		January 2011	2
IPACC		18/2/2013	3
IPACC		02/12/2014	4
IPACC		29/11/2016	5
IPACC		14/12/2018	6

Contents

1	Introduction	4
2	Purpose and scope	4
3	Policy statement	4
4	Roles and responsibilities	4
5	Policy monitoring	4
6	Review	4
7	What to do if you have a patient with suspected viral respiratory infection	4
8	Management of patients with viral respiratory infection	5
9	Ending isolation	5
10	Members of staff	5
11	Visitors	6
12	Severe Acute Respiratory Syndrome (SARS)	6
13	Assessment	6
14	Recommended Infection Control Measures	6/7
15	Guidance for Assessing and Managing a SARS Case	8/9
16	Surveilling and Reporting of Cases	9
17	References	9
18	Author	10
	Appendix 1	11/12/13
	Posters	14/15
	Equality and diversity impact statement	16

1. Introduction

Respiratory infections are common, principally causing colds in both adults and children. Most are fairly mild, self-limiting and confined to the upper respiratory tract (URTI). However, these can progress and cause more severe infections which are associated with increased hospitalisations and mortality. There is a seasonal problem of epidemic respiratory virus infections in the UK for example, influenza occurs mostly during winter months and can affect all age groups, particularly the elderly and those with compromised immune, cardiac, or pulmonary systems due to complications such as pneumonia.

Newly emerging diseases such as Severe Acute Respiratory Syndrome (SARS) and Avian Influenza have the potential to cause severe human illness. Transmission occurs from person to person by close contact, predominantly by large droplet/airborne respiratory secretions and/or contamination of hands.

To aid healthcare planning, surveillance of infections in the community is used to alert health-care providers to diagnostic considerations, management and prevention options. Under criterion 10 of The Health Act (2008) organisations must ensure *'so far as is reasonably practicable, that care workers are free of and protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection.'*

2. Purpose and scope

The purpose of this document is to provide concise instructions for all staff to minimise the potential risks of infection and to ensure prompt recognition of those patients who are at risk of infection. This document applies to all staff either employed or contracted within East Coast Community Healthcare CIC (ECCH).

3. Policy statement

This policy will be implemented to ensure adherence to best and safe practice.

4. Roles and responsibilities

It is the responsibility of all staff to ensure that they adhere to best and safe practice

5. Policy monitoring

It is the responsibility of all department heads/professional leads to ensure that staff they manage adhere to this policy.

6. Review

This policy will be reviewed every two years by the Infection Prevention and Control Team or sooner if new legislation is passed.

7. What to do if you have a patient with suspected viral respiratory infection

- Any patient admitted with an URTI or suspected URTI should be nursed in a side room, **not** on a ward with immunocompromised patients.
- During Respiratory Syncytial Virus (RSV) annual epidemic, it may be necessary to cohort symptomatic patients. This decision should be based on clinical symptoms.
- Patients and visitors should be reminded about the importance of strict hand hygiene.
- A normal chest x-ray does not rule out respiratory virus infection.

- The infection prevention and control team should be contacted immediately where clinical signs, travel history and exposure suggest infection with new or re-emerging respiratory diseases such as SARS or Avian Influenza:

On presentation- prior to medical assessment- the patient should be placed immediately in a side room/single room. The patient must wear a surgical mask. Healthcare workers must also wear a mask (a tight fitting respirator FFP3 mask or if not available immediately then a surgical mask) long sleeved gown and disposable gloves.

8. Management of patients with viral respiratory infection

- The door to the side/single room **must** be kept closed
- Staff contact should be kept to a reasonable minimum without compromising patient care
- Hand hygiene is essential after contact with the patient or his/her environment, and on leaving the patient's room in order to prevent contact transmission
- Respiratory hygiene/cough etiquette- patients should receive active instruction and supplies to ensure they cover their mouth and nose when coughing/sneezing and use tissues to contain respiratory secretions
- Provision must be made for patients to dispose of used tissues into an appropriate waste receptacle prior to discarding into an orange clinical waste bag
- Provision must be made for patients to perform hand hygiene after contact with respiratory secretions and contaminated items.
- The movement of patients must be restricted
- Healthcare workers in direct contact with the patient or their bed linen must wear disposable gloves and aprons
- Linen must be treated as infected and placed in a red dissolvable bag inside a white laundry bag, as per laundry policy.
- Standard precautions must be maintained at all times
- Standard surgical masks **must** be worn for close contact with infected patients with an active cough

9. Ending isolation

Isolation of the patient may be discontinued after 7 days of the onset of clinical illness providing symptoms are no longer present, if symptoms persist for longer than 7 days isolation should be continued until these resolve. NB Immunocompromised patients may excrete viruses for a longer period. The infection prevention and control team may be contacted for advice.

10. Members of staff

- **Seasonal influenza vaccine is strongly recommended and uptake expected for all front line clinical staff on an annual basis. It is the responsibility of all front line clinical staff to access this service in order to minimise the risk to patients, staff and their families. Staff who do not take up the offer must explain the rationale for this with their line manager**
- Staff suffering from persistent, unexplained respiratory symptoms, especially following foreign travel, must report to their General Practitioner and should not attend work
- Staff suspected and/or diagnosed with a communicable respiratory disease must inform the occupational health service and their line manager immediately

- In the event of new and re-emerging respiratory diseases, such as SARS and Avian Influenza, relevant advice will be given by infection prevention & control team and the occupational health service

11. Visitors

- All visitors with symptoms of respiratory disease should be discouraged from visiting

12. Severe Acute Respiratory Syndrome (SARS)

Severe Acute Respiratory Syndrome (SARS) and Avian Influenza have the potential to cause severe human illness. Infection can be acquired by direct and indirect contact. Transmission occurs from person to person by close contact, predominantly by large droplet/airborne respiratory secretions and/or contamination of hands.

13. Assessment

A **suspected case** will have:

- High fever of >38°C, which is sometimes associated with rigors, headache and malaise
- One or more of the symptoms of lower respiratory tract illness (cough, difficulty in breathing, shortness of breath)
- A recent history of travel to an infected area classified by the World Health Organisation (WHO) as a potential zone for re-emergence i.e. China and Hong Kong by a patient or close contact
- X ray evidence consistent with pneumonia or Respiratory Distress Syndrome

A **probable case** would include:

- Any individual with the above signs and symptoms and with preliminary laboratory evidence of SARS CoV infection

A **confirmed case** would include

- Any individual with the above signs and symptoms with preliminary laboratory evidence based on two positive different samples

14. RECOMMENDED INFECTION CONTROL MEASURES

14.1 Healthcare Workers

- Standard precautions should be taken by all ECCH staff who come into close contact (see below) with a possible case of SARS. This would usually include gloves and a respirator conforming to at least European standard EN149:2001 FFP3 (Detailed guidance on the use of face-masks and respirators is available in Appendix 1).
- If a respirator is not immediately available, a surgical face-mask should be worn.
- All Healthcare workers in close contact with a possible SARS case should be considered a contact of that case and should follow the guidelines below
- Instructions on the correct way of using the respirator are supplied with the respirator and should be read carefully. Fit is critically important and a fit check or user seal check should be done each time a respirator is worn. The respirator should fit tightly to the face so that no air enters from the sides. Masks or respirators should be disposed of immediately after use as clinical waste, according to local waste policy. They should only be removed when the wearer is in a safe area e.g outside the patient's room

- Standard precautions should be followed (including careful attention to hand hygiene with the use of hand sanitisers where available).
- Disposable gloves should be used when in direct contact with body fluids of the patient
- Standard precautions should be used when handling any clinical waste, which must be placed in leak-proof biohazard bags or containers and disposed of safely, following the local clinical waste policy

14.2 Patients

- Patients with possible SARS should use a surgical mask while symptomatic whether in hospital, at home or in transit
- The mask must fit snugly over the face, with the coloured side out and the metal strip at the top. The strings should be positioned to keep the mask firmly in place over the nose, mouth and chin and the metallic strip shaped to the bridge of the nose. The mask must not be touched again until it is removed
- When the patient is unable to wear a mask, carers/ ECCH staff must wear a mask when in close contact
- The patient must be advised to cough/sneeze into a paper tissue and dispose of this safely into a toilet/or a plastic bag tied off at the top, prior to placing in a bin
- Patients hands should be frequently washed particularly after contact with body fluids (e.g. respiratory secretions, urine or faeces)
- Close contacts hands should be thoroughly washed before and after contact with a patient and after activities that are likely to cause contamination

14.3 General

- Laundry should be washed on the highest temperature recommended for the fabric
- Crockery and cutlery should not be shared but can be used by others after routine cleaning either in a dishwasher or with hot water and washing-up liquid
- Blood and body fluid spillages should be mopped up using gloves and paper towels first, then the area cleaned and disinfected using household bleach diluted to 1 in 10 with cold water
- Environmental surfaces should be cleaned with general-purpose detergent and cold water and dried using disposable paper towels
- If surfaces are contaminated disinfect using household bleach diluted to 1 in 100

15. Guidance for assessing and managing a potential SARS case

- Patients should initially be assessed at home if at all possible, rather than in a GP setting. It is important that clinicians obtain a detailed travel history from patients with symptoms and signs consistent with clinical SARS as well as ascertaining whether other family members and/or close contacts (particularly within a hospital setting) have had a similar illness within 10 days prior to the patient's onset of illness.
- Standard precautions should be taken when examining or taking samples from a potential SARS case (please see below for details).
- GPs should make an initial assessment and provisionally classify the patient according to the case definition:

http://webarchive.nationalarchives.gov.uk/20120713223318/http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1195733843888

If a patient fits the current case definition of possible SARS refer to an acute hospital:

- Patients should be dealt with through normal channels, and the receiving hospital should be alerted to the patient's possible SARS diagnosis in advance of their arrival
- A surgical mask should be used where possible for symptomatic patients whether at home, in hospital or in transit
- Patients with possible SARS should be reported by telephone to the Public Health England, Communicable Disease Surveillance Centre (CDSC) duty doctor and the local CCDC Telephone: **03003038537**

If a patient's illness is mild/resolving/or they may not require hospitalisation:

- If they do not fit the case definition, patients should be managed at home. They should stay indoors and keep contact with other people to a minimum until their symptoms have resolved and they are afebrile for 48 hours.

15.1 Management of close contacts of a SARS case or a Possible Case

- Close contacts are considered to be family, friends or staff workers who lived with or who have had direct contact with the patient, respiratory secretions, body fluids and/or excretions (e.g. faeces) of a possible or probable case of SARS, whilst the patient was symptomatic
- Management depends on whether the patient is a possible, probable or confirmed SARS case. See section 13 for definitions.
- Contacts of a possible case should be given information on SARS, available at: http://webarchive.nationalarchives.gov.uk/20120713223318/http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1195733843888
- No specific follow-up of contacts is needed
- Contacts are free to continue with usual activities unless they become unwell.
- A close contact who develops symptoms of SARS within ten days of contact with a possible case should phone their GP and seek medical advice. They should inform medical staff of their contact with a possible or probable case. Close contacts remain at risk until ten days after their last contact with a symptomatic case,

15.2 Management of Close Contacts of a Probable Case:

- Generate a list of contacts and record the date on which they last had contact with the case
- Liaise with the local CCDC/Health Protection team on follow-up responsibilities
- On day one, the GP or local Public Health England should telephone the contact to assess their health and provide them with information on SARS: **03003038537**
- On day ten following last contact with the case, GP or local Public health England team should telephone the contact to assess their health
- If the contact develops symptoms consistent with SARS they should be assessed at home. See Guidance for assessing and managing potential SARS Case 14

15.3 Management of Close Contacts of a Confirmed Case:

- Voluntary home isolation is recommended for a close contact of a confirmed case of SARS

Such close contacts should:

- Stay indoors and keep contact with other people to a minimum for a period of ten days from the time of last contact with the case
- Inform their GP of their contact
- Monitor their health for SARS symptoms over this ten day period, and phone their GP if they develop any symptoms
- In addition, the GP or local Public Health England team should telephone the contact daily to assess their health during the ten-day home isolation period

16. Surveillance and Reporting of Cases

- Patients fitting the case definition of possible SARS should be reported by telephone to the Public Health England, Communicable Disease Surveillance Centre (CDSC) duty doctor **03003038537**

17. References

Notifiable diseases: <https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report>

National Institute for Health and Clinical Excellence (2008) *Respiratory tract infections-antibiotic prescribing*. NICE Clinical Guideline 69. London

Department of Health (2006) *Immunisation against infectious disease*. (The Green Book) London

Department of Health (2008) The Health and Social Care Act. DoH London_ 292435

Department of Health (2010) The Health and Social care Act 2008, Code of Practice on the prevention and control of infections and related guidance. London. Gateway reference 14808

Goldman D A (2001) Epidemiology and Prevention of Viral Respiratory Infection in Healthcare Institutions. *Emerging Infectious Diseases*, 7(2), 249-253

National Institute for Health and Clinical Excellence (2014) Infection prevention and control (Quality Standard 61)

National Institute for Health and Clinical Excellence (2016) NICE Clinical Guideline 69. e-learning respiratory tract infections

Public Health England SARS Advice

http://webarchive.nationalarchives.gov.uk/20120713223318/http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1195733843888

18. Author

Infection Prevention and Control Team

Appendix 1

INFORMATION ON THE USE OF MASKS AND RESPIRATORS

Frequently Asked Questions

- Wearing a mask or respirator is just one way to prevent the spread of SARS.
- Standard precautions should be adhered to including good personal hygiene, strict hand hygiene, disposable gloves, aprons, gowns, visors, and goggles when appropriate.
- Wearing a mask is not a guarantee of protection against SARS.
- Masks and respirators are not recommended for the general public. They are recommended for healthcare workers, and possible SARS patients only.
- Healthcare workers should wear a respirator complying with the European standard EN149:2001 FFP3 or higher filtration.
- Possible or probable SARS patients should wear a surgical face mask or higher filtration.

What is the difference between a mask and a respirator?

The main purpose of a mask is to help prevent particles (droplets) being expelled into the environment by the wearer. Masks are also resistant to fluids, and help protect the wearer from splashes of blood or other potentially infectious substances. They are not necessarily designed for filtration efficiency, or to seal tightly to the face.

Respirators are intended to help reduce the wearer's exposure to airborne particles. Some, including the ones recommended here resemble surgical face masks. They are made to defined national standards, such as the United States NIOSH-approved N95 respirator, or the similar European standard EN149:2001 FFP2 respirator. The standards define the performance required of the respirator, including filtration efficiency. When worn correctly, they seal firmly to the face, thus reducing the risk of leakage.

When should masks or respirators be used?

Masks and respirators are components of a number of infection prevention & control measures intended to protect healthcare workers, and prevent the spread of SARS. These include general hygiene measures set out in infection prevention & control Decontamination and cleaning policies.

Healthcare workers should use respirators, correctly fitted, for contact with possible or probable cases of SARS. A mask should be used only if a respirator is not available. It is

better to wear a mask than no protection. Patients should use a mask while symptomatic whether in hospital, at home or in transit.

Who should wear a mask or respirator?

All healthcare workers who come into contact with a possible or probable case of SARS should wear a respirator conforming to at least EN149:2001 FFP3. If a respirator is not immediately available, a surgical face mask should be worn.

Patients with possible or probable SARS should wear a surgical face mask, if able to do so, when in close contact with uninfected persons. If the patient is at home and unable to wear a mask, others in the household should do so.

WHO recommends that well individuals traveling from or to SARS affected areas do not need to wear a mask. Wearing a mask or respirator is not a guarantee of protection against SARS.

What is the correct way to use a mask?

The mask should fit snugly over the face, with the coloured side out and the metal strip at the top. Position the strings to keep the mask firmly in place over the nose, mouth and chin. Mold the metallic strip to the bridge of the nose.

Do not touch the mask again until it is removed. Healthcare workers should discard the mask as clinical waste according to local policy. Patients should place the mask in a plastic bag, then into domestic waste, and then wash hands. Go to a safe area and replace the mask at once, if it is damaged or soiled.

Follow local infection control or SARS policies, because the mask is just one of several infection control precautions. Hand hygiene is particularly important after removing the mask

PLEASE READ THESE INSTRUCTIONS.

It is important to follow the instructions carefully, and to do a fit check each time a new respirator is worn. The checks given in the user instructions vary according to the design of the respirator. Fit is critically important. The respirator must seal tightly to the face or air will enter from the sides. A good fit can only be achieved if the area where the respirator seals against the skin is clean-shaven. Beards, long moustaches, and stubble may cause leaks around the respirator.

Go to a safe area and change the respirator immediately if breathing becomes difficult, the respirator becomes damaged or distorted or contaminated by body fluids, or if a proper face fit cannot be maintained.

The respirator is one component of a number of infection control precautions.

These include hand hygiene, gloves, goggles, visors, gowns or gown and apron. Protective equipment should be removed in the following order: gown/apron, gloves, respirator, and goggles, followed by hand hygiene. The respirator should only be removed in a safe area, away from the patient.

What is the correct way to use a respirator?

User instructions are usually supplied with the respirator. If respirators are individually packed, the instructions are on the packaging. If the respirators are supplied in shelf packs, i.e. several unwrapped respirators in one box, the instructions are either on the side of the box or on a loose insert. If the contents of the shelf box are split, a photocopy of the instructions should accompany each respirator. It is also important that the respirator is protected from damage during transit.

Does a beard or stubble affect the performance of a respirator?

Yes. See 'What is the correct way to use a respirator?'

What protection should be worn for intubation and other aerosol producing procedures?

If possible, aerosol-producing procedures should be avoided. These procedures include nebulised medication, diagnostic sputum induction, bronchoscopy, airway suctioning and intubation. If unavoidable, the procedure should take place in a negative pressure single room with as few staff present as possible. All staff present should wear a correctly fitted respirator with a filtration efficiency of at least EN149:2001 FFP3, goggles, visor, gloves, single use gown or gown and apron according to local policy.

How often should masks or respirators be changed?

Masks or respirators used in close contact with a possible or probable SARS case should be disposed of immediately after use. They should only be removed when the wearer is in a safe area, outside the patient's room.

The length of time a patient on home isolation should wear a mask before changing it depends on the quality of the mask, and how much the patient is coughing. As a guide, the mask should be changed after eight hours, or sooner if it becomes saturated or breathing is difficult.

How should masks and respirators be disposed of?

Healthcare workers should dispose of masks and respirators as clinical waste, according to local infection control policy. Patients on home isolation should place the used mask in a plastic bag, and then into domestic waste. It is important to wash hands after handling the mask. This includes touching the mask while it is still being worn.

Which masks or respirators should be worn in the community/primary care?

All healthcare workers who come into contact with a possible or probable case of SARS should wear a respirator conforming to at least EN149:2001 FFP3. If a respirator is not immediately available, a surgical facemask should be worn. See 'Who should wear a mask or respirator?'

Where can community/primary care staff get masks and respirators?

Staff should be able to order masks and respirators using their normal supply route, including direct ordering from pharmaceutical suppliers. The majority of trusts order them from NHS Logistics Authority.

Coughs and sneezes spread diseases



always carry tissues



cover your coughs and sneezes



throw used tissues in a bin



always clean your hands

Stop germs spreading



COULD THIS BE YOU?

If you have a cold or 'flu (with a 'runny' nose, sore throat, raised temperature and a cough) you should refrain from visiting until the symptoms have cleared up completely

If in doubt please consult the nurse in charge **before** visiting

For further infection prevention and control advice contact
Infection Prevention and Control Team
01502 445255. ecch.infectionprevention@nhs.net

EQUALITY AND DIVERSITY IMPACT ASSESSMENT

Impact Assessments must be conducted for:

- All ECCH policies, procedures, protocols and guidelines (clinical and non-clinical)
- Service developments
- Estates and facilities developments

Name of Policy / Procedure / Service	Respiratory Viruses Policy
Manager Leading the Assessment	Teresa Lewis
Date of Assessment	December 2014

STAGE ONE – INITIAL ASSESSMENT

<p>Q1. Is this a new or existing policy / procedure / service?</p> <p><input type="checkbox"/> New</p> <p>√ Existing</p>
<p>Q2. Who is the policy / procedure / service aimed at?</p> <p><input type="checkbox"/> Patients</p> <p>√ Staff</p> <p><input type="checkbox"/> Visitors</p>
<p>Q3. Could the policy / procedure / service affect different groups (age, disability, gender, race, ethnic origin, religion or belief, sexual orientation) adversely?</p> <p><input type="checkbox"/> Yes</p> <p>√ No</p> <p>If the answer to this question is NO please sign the form as the assessment is complete, if YES, proceed to Stage Two.</p>

Analysis and Decision-Making

Using all of the information recorded above, please show below those groups for whom an adverse impact has been identified.

Adverse Impact Identified?

Age	No
Disability	No
Gender	No
Race/Ethnic Origin	No
Religion/Belief	No
Sexual Orientation	No

- Can this adverse impact be justified?
- Can the policy/procedure be changed to remove the adverse impact?

If your assessment is likely to have an adverse impact, is there an alternative way of achieving the organisation's aim, objective or outcome

What changes, if any, need to be made in order to minimise unjustifiable adverse impact?