HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Infection Prevention and Control Department		
Document:	Multidisciplinary Policy and Procedure (MPP)		
Title:	Management of Seasonal Influenza		
Applies To:	All Patient Care Areas		
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1. PURPOSE:

1.1 To provide infection prevention and control guidance to healthcare workers (HCWs) managing patients with suspected or confirmed seasonal influenza at healthcare facilities.

2. DEFINITONS:

2.1 Swine influenza (swine flu or pig flu) is a respiratory disease that occurs in pigs that is caused by the Influenza A virus. Influenza viruses that are normally found in swine are known as swine influenza viruses (SIVs). The known SIV strains include influenza C and the subtypes of influenza A known as HINI, HIN2, H3N1, H3N2 and H2N3. Pigs can also become infected with the H4N6 and H9N2 subtypes. A person who is at high-risk for complications of novel influenza (HI N1) virus infection is defined as the same for seasonal influenza at this time.

2.2 CASE DEFINITION

2.2.1 Influenza-like illness (11.1)* is defined as an individual with an acute respiratory infection with:

2.2.2.1 measured fever of 238 c °
and cough;
With onset within the last 10 days.

2.2.2 A Confirmed case of influenza virus infection is defined as an individual with laboratory confirmed influenza virus infection by one or more of the following tests:

2.2.2.1 real-time RT-PCR

2.2.2.2 viral culture

2.2.2.3 Four-fold rise in influenza virus specific neutralizing antibodies.

2.2.3 Clinical presentation

2.2.3.1 Symptoms of influenza typically include fever, cough, fatigue, sore throat, headache, myalgia, and rigors or chills. Diarrhea and/or vomiting may also occur. Illness can range from asymptomatic infection to severe disease

2.2.3.2 Pneumonia may develop directly from influenza infection (primary influenza pneumonia) or from secondary bacterial infection. Acute respiratory distress syndrome (ARDS) may develop several days after disease onset.

2.2.4 Vaccination

2.2.4.1 The most effective way to prevent or reduce severe outcomes from the illness is vaccination. Influenza vaccine reduces the severity, duration and the need for hospitalization

2.2.4.2 The available vaccine is a trivalent inactivated influenza vaccine (Types A/HINI, A/H3N2 and B). It comes in a pre-filled syringe containing 0.5 ml- administered intramuscularly. The preferred site in adults is into the deltoid muscle

2.2.4.3 The vaccine should not be administered to anyone with a history of severe allergic reaction to egg protein or any component of the vaccine

2.2.4.5 HCW are considered a high-risk group for acquiring influenza infection. Vaccination will protect them, their families and their patients.

3. POLICY:

3.1 STANDARD AND AIRBORNE PRECAUTIONS MUST BE OBSERVED FOR ALL PATIENT CARE

3.2 Mandatory influenza vaccination for all healthcare personnel is imperative. All healthcare personnel are required to provide:

3.2.1 annual documentation of influenza immunization; OR

3.2.2 documentation from a licensed physician indicating medical contraindication against influenza vaccination

4. PROCEDURE:

4.1 Standard Precautions

4.1.1 Hand hygiene

4.1.1.1 HCWs should apply "My 5 moments for hand hygiene".

4.1.1.2 Hand hygiene includes either washing hands with antiseptic soap and water or the use of an alcohol-based waterless hand sanitizer (waterless hands rub).

4.1.1.3 Wash hands with antiseptic soap and water when they are visibly soiled. The use of gloves does not eliminate the need for hand hygiene. Hand hygiene is necessary after taking off gloves and other personal protective equipment (PPE).

4.2 Respiratory precautions

4.2.1 Visual Alerts:

Post visual alerts (in appropriate languages) at the entrance to outpatient facilities(e.g., emergency rooms and clinics) instructing patients and persons who accompany them (e.g., family, friends) to inform healthcare personnel of symptoms of acute respiratory illness (including fever with cough, sore throat, rhinorrhoea, sneezing, shortness of breath, and/or wheezing) when they first register for care and to practice the following Respiratory Hygiene/Cough Etiquette.

4.2.2 Masking and Separation of Persons with Respiratory Symptoms:

4.2.2.1 Offer regular (surgical) masks to persons who are coughing. Regular (surgical) masks may be used to contain respiratory secretions (N-95 masks are not necessary for this purpose).

4.2.2.2 When space and chair availability permit, encourage coughing persons to sit at least I meter away from others in common waiting areas.

4.2.2.3 Healthcare facilities should ensure the availability of materials for adhering to Respiratory Hygiene/Cough Etiquette in waiting areas for patients and visitors.

4.2.2.4 Provide tissues and no-touch receptacles for used tissue disposal.

4.2.2.5 Provide conveniently located dispensers of alcohol-based hand sanitize.

4.2.2.6 Where sinks are available, ensure that supplies for hand washing (i.e., antiseptic soap and disposable towels) are consistently available.

4.2.3 Triage for rapid identification of patients with influenza like illness (Il-I)

4.2.3.1 Clinical triage should be used for early identification of all patients with ILI in the Emergency Rooms, dialysis units and the Clinics.

4.2.3.2 Identified ILI patients should be asked to wear a surgical mask. They should be evaluated in an area separate from other patients.

4.2.3.3 Infection control and prevention precautions should be promptly implemented

4.2.3.4 If ILI patients cannot be evaluated immediately, they should wait in a waiting area dedicated for the acute respiratory infection patients with spatial separation of at least 1 m between each patient and others.

4.2.3.5 Clinical and epidemiological aspects of the cases should be evaluated as soon as possible and the investigation can be complemented by laboratory evaluation

4.3 Infection prevention and control precautions for aerosol generating procedures

4.3.1 An aerosol-generating procedure is defined as any medical procedure that can induce the production of aerosols of various sizes, including small (< 5 micron) particles.

4.3.2 Aerosol-generating procedures that may be associated with an increased risk of infection transmission includes both elective procedures such as bronchoscopy, sputum induction, elective intubation and extubation, as well as emergency procedures such as cardiopulmonary resuscitation, emergency intubation, open suctioning of airways, manual ventilation via umbo bagging through a mask before intubation, and initiation of non-invasive ventilation (e.g. Bilevel Positive Airway Pressure - BiPAP).

4.3.3 BiPAP is not recommended in influenza infected patients because of the high risk of generating infectious aerosols and lack of evidence for efficacy over elective endotracheal intubation and mechanical ventilation for patients with pneumonia.

4.3.4 Additional precautions should be observed when performing aerosol generating procedures, which may be associated with an increased risk of infection transmission

4.3.4.1 Wear PPE with Standard and Airborne Precaution.

4.3.4.2 Perform procedures in a negative pressure room

4.3.4.3 Limit the number of persons present in the room to the absolute minimum required for the patient's care and support

4.3.4.4 Perform hand hygiene before and after contact with the patient and his or her surroundings and after PPE removal.

4.4 Admission criteria

4.4.1 The majority of patients suspected to have influenza infection will not require admission to hospital. However, admission may be considered for those who have clinical or radiological evidence of pneumonia and persons at increased risk of disease complications (e.g. persons aged >65 years or <5 years of age, pregnant women and people with certain chronic medical conditions

4.5 Duration of isolation precautions for influenza infection

4.5.1 Patients may shed influenza virus for up to 24hours (1day) before onset of symptoms and usually until 7 days after the onset of symptoms. Viral shedding in adult speaks in the first 1 to 2 days after symptom onset, and then reduces to very low levels by 5 days after onset of symptoms. Not all cases of influenza infection exhibit fever, but when it is present, it is correlated with viral shedding.

4.5.2 Children and younger adults may shed influenza virus for 10 or more days, and immunosuppressed persons may shed virus for weeks.

4.5.3 Patients are considered no longer infectious if:

4.5.3.1 24 hours have elapsed since the resolution of fever, provided either;

4.5.3.2 Have received 72 hours of anti-influenza medication

4.5.3.3 5 days have elapsed since onset of respiratory symptoms.

5. MATERIALS AND EQUIPMENT:

5.1 Personal Protective Equipment

6. RESPONSIBILITIES:

6.1 ALL MCH EMPLOYEE

7. APPENDICES:

7.1 N/A

8. REFERENCES:

8.1 Command and Control. Infection Prevention and Control Guidelines for Seasonal Influenza in Healthcare Setting Nov 2015

9. APPROVALS:

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