



Influenza /Pandemic Preparedness Plan

Version 2.0
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Contents

Chapter	Description	Page
1.0	<i>Introduction</i>	4
2.0	<i>Scope</i>	5
3.0	<i>General preparedness</i>	6
3.1	<i>Levels of alert within the National Pandemic Preparedness Plan</i>	7
3.2	<i>Levels of Alert within the Mercy University Hospital Influenza Pandemic Preparedness Plan AND staff roles</i>	8
4.0	<i>Admission & Segregation of Patients with Suspected of Confirmed Pandemic Influenza</i>	12
5.0	<i>Treatment Regimes and Bed Allocation</i>	13
6.0	<i>Procedure For The Reception Of Suspected Pandemic Influenza Patients</i>	14
7.0	<i>Staffing Issues</i>	16
8.0	<i>Staff and Patient Contact</i>	17
9.0	<i>Press Contact & Communications</i>	17

ATTACHED DOCUMENTS

- No. 1 Revised Interim Irish Guidelines on the Investigation and Reporting of Suspected Human Cases of Avian Influenza (Influenza A/H5N1)- February 2006
- No. 2 Security Policy
- No. 3 Portering Policy
- No. 4 Infection Control Guidelines
- No. 5 Occupational Health Guidelines
- No. 6 Laboratory Tests

1.0 INTRODUCTION

The internationally accepted definition of a pandemic as it appears in the Dictionary of Epidemiology is straightforward and well-known: *'an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people'*¹.

It should be noted that this definition can apply to infections other than Influenza subject to global spread, e.g. cholera and HIV.

The World Health Organisation developed a more technical set of requirements for a pandemic influenza:

The emergence of influenza A virus significant different genetically from circulating human influenza A viruses (i.e. many of the population are non-immune to the new virus) with the following three characteristics:

- *Able to infect humans,*
- *Able to cause disease in humans,*
- *Able to spread from human to human quite easily.*

Severity has never been part of the WHO definition of a pandemic, although the pandemic virus has to be able to cause disease in at least some people.

Hence once a pandemic starts it is important to assess the severity of the pandemic along a series of parameters using a Risk Based Approach such as the one developed by ECDC².

Unlike Influenza Epidemics, pandemics are very severe outbreaks that rapidly spread to involve all parts of the world.

Most experts agree that pandemic are likely to occur periodically, although the exact timing or severity cannot be predicted. The last declared pandemic was in 2007-8 and although its geographical spread was very wide its mortality and morbidity in Europe was lower than predicted.

During a pandemic, disease often occurs outside of the usual influenza season, including summer months, and multiple waves of disease occur before and after the main outbreak. Infection is not confined to the usual risk groups: **high attack rates occur in all age groups with particularly high morbidity among healthy young adults.**¹⁾

This plan is based on the Department of Health document "a Model Plan for Influenza Pandemic Preparedness" 2002, which in turn is based on the World Health Organisation influenza preparedness plan. The plan provides and outlines MUH's state of preparedness and gives details of actions to be followed for the management of an influenza pandemic.

This plan will be revised as required as health structures change and/or in the event of further recommendations of the National Influenza Public Health Crisis Management Team.

Your cooperation is required and you are requested to read this document carefully and where appropriate instigate and implement the actions identified.

Jim Corbett

Deputy Chief Executive Officer

1

Last J. A dictionary of epidemiology (4th Edition) Oxford University Press 2001

2

Nicoll A *Panning for uncertainty: a European approach to informing responses to the severity of influenza epidemics and pandemics*, Bulletin of the World Health Organization 2011;89:542-544.
doi: 10.2471/BLT.11.089508

Date: February 2015

2.0 SCOPE

The unpredictability of influenza and the serious consequences that can occur when a pandemic strain appears provides ample justification for constant vigilance and good planning.

This plan (February 2015) outlines the response of MUH in the event of an influenza pandemic being declared. This plan supercedes that of January 2005. This plan will also provide appropriate guidance in the event of a serious infectious outbreak except for Ebola Virus Fever and other haemorrhagic fevers for which a separate plan exists.

The World Health Organisation (WHO) suggests that plans should be in place to deal with an influenza pandemic causing illness to 25% of the population. In the worst-case scenario, there will be insufficient time to develop, acquire, distribute and administer the pandemic strain vaccine to the population. This could therefore lead to an attack rate that may reach 100%.

Even if the vaccine against a new strain is available, two doses may be required in order to provide an effective response, which may not be achieved until 6 weeks after the first dose.

The optimal use of beds through reduced delayed discharge of patients, combined with an increased use of day surgery, may not be enough to alleviate the demand for beds in the event of an influenza pandemic.

To enable MUH to respond appropriately and effectively, this plan addresses a range of issues, in a number of chapters, such as

- General preparedness including stages of preparedness
- Role(s) of staff during a pandemic
- Special requirements such as equipment needs
- Activation of the plan when a pandemic is declared
- Operation of MUH during a pandemic

The efficient and effective use of resources that must be employed to address the impact- and to reduce the extent of the disease is essential to the operation of the plan.

Useful web sites for updates of national and international information are:

www.doh.ie

www.who.int

www.ndsc.ie

3.0 GENERAL PREPAREDNESS

The World Health Organisation has formulated a series of escalating levels of preparedness and alertness for assessment and appropriate response to an influenza pandemic. These are as follows:

WHO pandemic phases (WHO 2009)

Phases	Description
One	No animal influenza virus circulating among animals has been reported to cause infection in humans.
Two	An animal influenza virus circulating in domesticated or wild animals is known to have caused infection in humans and is therefore considered a specific potential pandemic threat.
Three	An animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks.
Four	Human-to-human transmission of an animal or human-animal influenza reassortant virus able to sustain community-level outbreaks has been verified.
Pandemic	
Five	The same identified virus has caused sustained community level outbreaks in two or more countries in one WHO region.
Six	In addition to the criteria defined in Phase 5, the same virus has caused sustained community level outbreaks in at least one other country in another WHO region.
Post-peak	Levels of pandemic influenza in most countries with adequate surveillance have dropped below peak levels.
Possible new wave	Level of pandemic influenza activity in most countries with adequate surveillance rising again.
Seasonal influenza	
Post-pandemic	Levels of influenza activity have returned to the levels seen for seasonal influenza in most countries with adequate surveillance.

Adapted from "Pandemic influenza preparedness and response: a WHO guidance document (2009)"

Countries within the EU have been required to produce National Alert levels to accommodate actions required once WHO phase 6 has been reached.

3.1 Levels of alert within the Irish National Pandemic Management Plan

The Irish Alert Phases are as follows:

Irish Alert Level 1	Cases only outside Ireland (in a country or countries with or without extensive Irish travel/trade links).
Irish Alert Level 2	New virus isolated in Ireland.
Irish Alert Level 3	Outbreaks in Ireland.
Irish Alert Level 4	Widespread activity in Ireland.

The National Pandemic Plan requires hospitals to have their own phases and Mercy University Hospital has adopted a five phase approach as follows:

3.2 Levels within the Mercy University Hospital Influenza Pandemic Plan and Staff Roles

MUH Phase 1:

This is a preparatory stage where we educate, plan and prepare our response. This stage covers the first four stages of the WHO development definitions up to the declaration of a Pandemic. This is Irish Alert Phase 1

MUH Phase 2:

This is an intense preparatory stage when the WHO has declared the outbreak of a pandemic but with cases only outside Ireland and up to the isolation of a virus in Ireland. This is Irish Phase 2.

MUH Phase 3

This is where a human case has been identified in Ireland. We begin to implement our plans. (Irish Phase 3)

MUH Phase 4

This is where the pandemic is active and vigorous in Ireland – our plans are in full operation (Irish Phase 4)

MUH Phase 5

Pandemic over, we review and debrief

In more specific terms these phases will require the following actions to take place:



MUH Phase 1

The Hospital Plan will be finalised.

The Human Resources Department will compile a list of retired staff who may be available to be called upon in the event that staff numbers are depleted.

Educational material will be distributed internally and Education sessions will take place in the Lecture Theatre, Floor One, Sheares Street Block.

Responsible person: Deputy Chief Executive Officer (with assistance from Director of Nursing, Respiratory Nurse Specialist, Infection Control Dept. and Occupational Health Dept)

MUH Phase 2

The Hospital Pandemic Control Team will be convened Chaired by a Respiratory Physician.

The Control Room will be set up in the Ground Floor Parlour.

Vaccines will be administered to staff.

Educational material received will be distributed and education sessions will be organised as outlined in so that medical, clinical and nursing staff are updated and trained in dealing with the patients who have contracted influenza.

Contact will be made with agencies such as Community Care and Local Authorities by the Regional Public Health Emergency Control Team.

Responsible persons: Deputy Chief Executive Officer and Director of Nursing (with assistance from Lead Physician, Respiratory Nurse Specialist, Infection Control Dept. and Occupational Health Dept)

MUH Phase 3

Admissions to the hospital will be restricted to urgent and **emergency cases** only as defined in the NCEPOD reports – these being people who require life saving treatment within 24 hours.

St Mary's ward will be cleared and the ward will become the principal Pandemic assessment and treatment centre.

Discharge of patients from other wards proceeds as soon as possible.

The segregation of A&E patients proceeds with suspected pandemic cases being triaged by an A&E Team Leader at the door of the department and diverted by the 'outside' route to St Mary's Ward.

The ground floor of the Lee View block will be isolated and only direct care staff working in St Mary's ward or A&E will be allowed on to the floor all others must relocate elsewhere.

Responsibility for these actions rests with Pandemic CMT

MUH Phase 4

This level of the MUH Influenza Pandemic Preparedness Plan addresses full-scale cancellation and discharge of patients, segregation of patients with influenza from other patients through the isolation of wards from each other or in the worst case scenario full isolation of this hospital (i.e. only patients with influenza being resident in the hospital).

Cases will be dealt with in Lee View Block Isolation Rooms, then cohorted into main acute wards until all Lee View Block beds are filled.

Responsibility for these actions rests with the Pandemic CMT.

MUH Phase 5

This level of the MUH Influenza Pandemic Preparedness Plan addresses, upon standing down of the plan, the evaluation of the hospital's response to the pandemic. The committee may require detailed reports from various sections or departments within the hospital to enable a full and complete evaluation taking place.

Responsibility for these actions rests with the Pandemic CMT.

3.2 Membership of the Hospital Pandemic Critical Incident Management Team

Pandemic Control Team Membership

Chair: Deputy Chief Executive Officer	– Mr J Corbett
Clinical Director	– Prof D Kerins
Consultants in Respiratory Medicine	-- Dr T O'Connor & Dr D Curran
Consultant Microbiologist	– Dr D O'Brien
Consultant Anaesthetist	– Dr S O'Croinin
Director of Nursing	– Ms M McKiernan
Consultant in Accident & Emergency Medicine	– Dr C Luke & Dr I O'Sullivan
Infection Control Clinical Nurse Specialist	– Ms J Crowley
Bed manager	– Ms C Walsh
Occupational Health Representative	– Ms A Doocey
Other Clinical and Service Managers as required	

All of these members can be deputised by appropriate alternatives if they are not available for any reason.

4.0 ADMISSION AND SEGREGATION OF PATIENTS WITH SUSPECTED OR CONFIRMED INFLUENZA

- 4.1. Throughout this document wherever it is stated that someone is suffering from Influenza this should be taken to include suspected cases in the hospital.
- 4.2. Five isolation rooms have been identified within the Lee View Block of the Hospital for use by patients suspected to be suffering from Pandemic Influenza these rooms have independent ventilation systems.
- 4.3. In addition the Emergency Department has a three bedded negative pressure area which can be utilized until a ward isolation room is available.
- 4.4. Supplies of FP2 and FP3 masks are available for use in all affected ward areas, in most circumstances FP3 masks will not normally be required for influenza protection. The hospital stores also maintains contingency supplies of all PPE stocks. However standard surgical masks have been found to be effective and all staff should use them when necessary.
- 4.5. The hospital has 8 mobile Hepa-Flow air filtration machines The Consultant Microbiologist is responsible for deciding upon the deployment of these machines. In addition there are fixed Hepa Flow installations in the Treatment Area and Isolation Room in A&E and in ICU.
- 4.6. At MUH Level 3 if the number of Influenza admissions and patients being referred or self referring exceeds the hospital's isolation rooms capacity St Mary's ward and/or one or more acute ward 6 bed bay areas will be identified as the hospital's pandemic/epidemic assessment and treatment centre. St Mary's will perform the assessment role throughout a

formal pandemic and if it becomes filled with admitted patients additional Lee View Block wards will be diverted to pandemic admissions incrementally.

- 4.7. The Consultant Microbiologist is responsible for making formal notifications of suspect cases to the Health Services Executive and National Disease Surveillance Centre.

5. TREATMENT REGIME & BED ALLOCATIONS

- 5.1. It is National policy that patients suffering from Pandemic Influenza will be treated at home by their GPs and relatives. However, where patients are referred to the hospital by a GP or other hospital doctor as suspected Pandemic Influenza patients (in accordance with the established WHO guidelines for classifying Pandemic Influenza cases) they will be assessed by the on call medical team in an Isolation Room in the Emergency Department.
- 5.2. Patients who attend the A&E Department will be quickly triaged in the entrance lobby and then encouraged to return home if possible. If they require further assessment then they should be transferred to an inpatient isolation area as soon as possible.
- 5.3. The duty Medical Registrar will assess whether the severity of the patient's symptoms is such as to require admission. Suspicion of Pandemic Influenza infection is not in itself a reason for formal admission.
- 5.4. Where the condition of patients allows (i.e if they are not in a state of collapse or suffering from serious complications) they should be discharged as quickly as possible into the care of their GP.
- 5.5. Patients awaiting or undergoing assessment or who have been admitted for treatment must be fully barrier nursed at all times.
- 5.6. Influenza Patients requiring admission should be admitted to one of the Lee View Block Isolation Rooms in the first instance. If there is any significant delay then either the ED single Isolation Room or the Psychiatric Interview Room or, in the case of multiple influenza patients waiting, the 3 bedded isolation room should be utilized.
- 5.7. If all hospital isolation rooms are full then the Pandemic Control Team (PCT) will authorise the use of St Mary's Ward and/or one or more acute ward 6 bed bay area for use by cohorts of pandemic, epidemic Influenza cases only. Should it be required St Joseph's ward should be used next followed by St Catherine's, St Patrick's and St Finbarr's in that order. This will allocate 122 beds for Pandemic Cases. If further beds are required the PCT will determine which these should be or whether the hospital needs to be closed to ALL non-emergency (defined as those requiring lifesaving treatment within 12 hours) cases.
- 5.8. Patients requiring ventilation or who would in normal circumstances require admission to ICU must be cohorted into one area where they can be nursed by nurses with critical

care experience the medical equipment required will be transferred to the isolation room from ICU if available. The bed complement of the ICU for non-influenza cases might be reduced accordingly.

- 5.9. In the event that St Mary's Ward or two six bed bay is full and the next stage of cohorting is to be implemented the whole hospital will be put into full isolation – see further details below.

6. PROCEDURE FOR THE RECEPTION OF SUSPECTED PANDEMIC INFLUENZA PATIENTS

- 6.1. Patients suspected to be suffering from Pandemic Influenza may be referred to the Mercy University Hospital (MUH) by General Practitioners or from other hospitals and healthcare institutions. They may also self refer. Patients telephoning for advice should be told to contact their GP and NOT to attend the hospital.

6.2. General Procedure for Cases for Whom Advance Notification Has Been Given:

- 6.2.1. When the hospital receives advance notice from a GP that a suspected case is to be brought to the hospital, that notification is most likely to be received by the Bed Management Department or the Senior Nurse on Duty.
- 6.2.2. If a GP is telephoning he/she should be transferred to the on call registrar immediately it becomes apparent that the GP has a suspect PANDEMIC INFLUENZA case **BUT MUST BE TOLD THAT THE PATIENT WILL BE ASSESSED IN the Emergency Department AND SHOULD BE TOLD TO ATTEND THE ASSEMBLY AREA AT THE BOTTOM OF THE ED RAMP WHERE THEY WILL BE MET.** Security will be contacted by the CNM3 in the ED.
- 6.2.3. The Bed Manager should contact the on call registrar as soon as possible to establish whether a patient is being brought to the hospital.
- 6.2.4. The Bed Manager (or out of office hours the senior nurse on duty) will identify and an isolation room for possible use if the patient is to be admitted.
- 6.2.5. The Bed Manager will notify the receiving ward, the Nurse in Charge of the Emergency Department, the on call Medical Registrar (all contact numbers are available via the switchboard).
- 6.2.6. The Nurse i/c A&E will direct the A&E security guard to wait outside the department to notify staff when a referred case arrives.
- 6.2.7. The Senior nurse on duty, will allocate a receiving nurse and will notify portering of the need to send a porter immediately to assist the reception of the patient. The



Nurse and the porter will be given a mask, a gown, cap and gloves in the ward and must wear them to receive the patient. The Ward CNM, or senior nurse on duty, will ensure that the designated isolation room is cleared.

- 6.2.8. On arrival the patient should be given a particulate mask immediately and should then be transferred to the isolation room by the covered trolley.
- 6.2.9. Upon the patient's arrival in the isolation room the on call registrar should be notified to attend immediately to commence patient assessment.
- 6.2.10. If admission is required the patient should be transported to the allocated room/bed. Staff accompanying the patient must wear masks, gowns and gloves and the patient should wear a mask.
- 6.2.11. The receiving ward CNM, or senior nurse on duty, will allocate a receiving nurse. Thereafter the patient will be barrier nursed as an infectious patient until discharged or confirmed as non- INFLUENZA.
- 6.2.12. All reception areas used must be decontaminated before being put back into use.

6.3. Additional Variations for Patients Brought To The Hospital As Emergencies Who Require Resuscitation

- 6.3.1. As soon as it is known that a suspect INFLUENZA case requiring resuscitation is en route by ambulance ED staff should prepare the resuscitation room. The patient should be moved directly to the resuscitation room from the ambulance.
- 6.3.2. The nurse in charge of the Accident & Emergency Department should notify ambulance control that the department is completely closed to all other cases until further notice.
- 6.3.3. When the patient is stabilized he/she should be transferred to the identified isolation room to be cared for by outposted ICU nurses with equipment transferred from ICU.
- 6.3.4. When the patient has left the Emergency Department the resuscitation room should be decontaminated as soon as possible.

7. STAFFING ISSUES

- 7.1. At level three all Departmental Directors should report to the HR Manager the levels of staff they require to deal with a Pandemic and the numbers available.



- 7.2. In principle all staff can be redeployed to other duties as necessary once a Critical Incident is declared. This may be a completely different role to that for which they are employed except that they will not be expected to perform a professional patient treatment role for which they are untrained. However, in principle any staff can be expected to undertake support service roles.
- 7.3. At levels 3 and 4 the hospital will not have many non-emergency specialty cases admitted and all medical staff not engaged with their own specialty emergencies will assist the General Medical Teams in treating Pandemic/Epidemic cases.
- 7.4. At level 3 all staff annual leave will be cancelled. Staff on leave of absence and unpaid leave will be contacted and asked if they are available to return to duty if required.
- 7.5. The PCT will make an assessment at level 3 as to whether staff not engaged in duties related to the pandemic should be recommended to stay at home.

8. STAFF AND PATIENT CONTACT

- 8.1. Members of staff who have been in unprotected contact with a suspect case will not be treated as a suspect case themselves. They should be re-assured and informed of the symptoms they should be aware of by the Control of Infection Nurse. They should be assessed by the Occupational Health Department daily for up to 10 days and on a regular agreed basis with the patient for up to 21 days. They should be advised to telephone the hospital if any symptoms develop (occupational health department) and their GP.
- 8.2. Patients and other persons in unprotected contact with a suspect case should be re-assured and informed of the symptoms they should be aware of by the Control of Infection Nurse. If such symptoms develop they should be advised to contact their **GP AND NOT TO RETURN TO THE HOSPITAL EXCEPT AS DECIDED BY THEIR GP** in consultation with the hospital and Public Health officials.

9. PRESS CONTACT AND COMMUNICATIONS

- 9.1. Rumour and ill founded comment can easily cause unnecessary public concern and even panic where infectious diseases are concerned. For this reason all public communications and press comment must be directed through the Chief Executive's Office. The making of unauthorized comment to the press by any member of staff will be regarded as gross misconduct which could lead to dismissal.
- 9.2. The DCEO will liaise with the other members of the CMT and the Chief Executive Officer with regard to public announcements or press releases and comment.

- 9.3. The Consultant Microbiologist and the Control of Infection Nurse will be responsible for informing and educating all staff in appropriate preventative actions and the nature of the disease.

JW Corbett
Deputy Chief Executive Officer

This policy should be read in conjunction with the attached documents

- No. 1 Algorithm for the treatment of persons with acute febrile respiratory illness who may have an Avian Influenza, V2.6 HSE-HPSC January 10th 2014
- No. 2 Security Policy
- No. 3 Portering Policy
- No. 4 Infection Control Guidelines
- No. 5 Occupational Health Guidelines
- No. 6 Laboratory Tests



DOCUMENT 1

Algorithm for the management of persons with acute febrile respiratory illness who may have avian influenza

i.e. returning travellers and visitors from countries affected by avian influenza and people with close contact with sick poultry and/or wild birds



1 Screening

As soon as the patient mentions a febrile respiratory illness and travel in the last 2 weeks¹ [to an area of the world affected by H5N1](#)² OR contact with sick, dying or dead poultry and/or wild birds, the following precautions should be taken before continuing with the assessment:

YES

2 Assessment

Clinical

Acute onset of fever (temperature $\geq 38^{\circ}\text{C}$) with signs and symptoms of an acute respiratory infection.

AND

Epidemiological

At least one of the following exposures (a, b, c) within 7 days prior to onset of symptoms:

A. Contact with poultry or wild birds: Reside in or have visited an area of a country where influenza A/H5N1 is currently suspected or confirmed as reported on the [WHO website](#)² AND

Having been in close contact (within one metre) with sick or dead domestic poultry and/or wild birds in the affected area; OR

Having been in a home or farm where sick or dead domestic poultry have been reported in the previous six weeks in the affected area;

B. Human Contact: Having been in close contact (within one metre) with a person reported as a probable or confirmed case of influenza A/H5N1;

C. Laboratory Contact: Having worked in a laboratory where there is potential exposure to influenza A/H5N1;

If patient doesn't meet the above criteria and you are still concerned regarding avian influenza please contact HSE-HPSC 01-8765300.

NO

YES

Unlikely to be Influenza A (H5N1). Treat as indicated.

Refer to Hospital
for Treatment & Investigation

Treatment & Investigations (treat samples as "high risk")

Consider treatment with oseltamivir

- > Combined nose/throat swab in virus transport medium for immediate H5N1 PCR at the NVRL. Seasonal influenza A/B rapid test will be done in parallel at NVRL.
- > FBCs with differential (lymphopenia is a prominent feature of AI)
- > LFTs (liver function frequently deranged with AI)
- > Legionella & pneumococcal urinary antigens
- > Serology mycoplasma, influenza A & B, adenovirus, RSV & 20mls reserve
- > CXR
- > Blood culture
- > Pulse Oximetry
- > Sputum culture \pm gram stain

3

Negative H5N1

Treat as appropriate AND remove from strict respiratory isolation if appropriate

Positive H5N1

Inform local MOH immediately. Local MOH to inform HSE-HPSC immediately of result and discuss prophylaxis.

Infection Control & Reporting³

Strict hand hygiene

Primary care / community

Location: At patient's home if possible

Patient to wear mask (surgical)

Staff to wear mask, gown, gloves and eye protection

Hospital

Location: Side room

Patient to wear mask (surgical)

Staff to wear mask (surgical), gown, gloves and eye protection

Inform Director of Public Health (MOH) immediately

Inform hospital infection control & occupational health

Standard, Contact & Droplet Precautions

Patient: Single room adequately ventilated (≥ 12 air changes per hour)

Staff: Routine care – barrier precautions⁴
Aerosolizing procedures – barrier precautions⁴ & correctly fitted high filtration mask – minimum standard FFP2.

1. Includes the possibility of a long incubation and late presentation

2. For countries affected by AI see http://www.who.int/influenza/human_animal_interface/HAI_Risk_Assessment/en/index.html

3. For infection control advice see http://apps.who.int/iris/bitstream/10665/69707/1/WHO_CDS_EPR_2007_6_eng.pdf

4. Barrier precautions = adequate hand hygiene, use of gowns, clean gloves, medical mask and eye protection if splashes are anticipated

Please check HPSC website www.hpsc.ie for further updates.

DOCUMENT 2

SECURITY POLICY – PANDEMIC INFLUENZA

If required to isolate the Emergency Department Security department plan to cordon off and isolate the emergency department **as follows:**

The decision to cordon off the emergency department will be made by the senior nurse on duty in the emergency department or a member of the EMB present and in command.

The instruction to security staff to put this plan into effect will be given by the senior nurse on duty in the emergency department or a member of the EMB present and in command..

The security personnel will then put in place the following procedures:

- A. Collect the tape and bollards stored at the security office, mansion house, floor 1.
- B. Cordon off the entire emergency department at the five (5) locations identified below.

Location 1.	At the external entrance doors to A/E. close the gates (do not lock them), tie tape on the gates and place the sign on the gates.
Location 2.	Place bollards, tape and sign on the main corridor, Catherine McAuley block, ground floor, at the pastoral care office.
Location 3.	Close the fire door, place tape and sign on extern of door.
Location 4.	Place bollards, tape and sign on the corridor to cork cancer research centre, at room 1, Thomas Moore block. (CCRC staff to use exit @ boiler house)
Location 5.	Place tape and sign on the first floor landing, stair 3, Thomas Moore block.

NOTE:

IT IS POSSIBLE TO IMPLEMENT THIS PLAN WITHOUT ENTERING THE EMERGENCY DEPARTMENT. TAKE ALL PRECAUTIONARY MEASURES AS OUTLINED BY THE M. U. H., INFECTION CONTROL DEPARTMENT.

SECURITY STAFF ON DUTY INSIDE THE A&E DEPARTMENT WILL BE PROVIDED WITH APPROPRIATE PERSONAL PROTECTIVE EQUIPMENT BY THE HOSPITAL



Tony O' Regan, Security Manager, Mercy University Hospital.

Document 3

PORTERING DEPARTMENT

Duties of the Porter

Transfer of Patient from Emergency Department to Assessment Area

The porter will receive instruction from the Department Head regarding his responsibility-

- Any suspect/probable/definite INFLUENZA patient will be assessed in the Emergency Department or another notified assessment location which will probably be St Mary's Ward. Patients may be admitted after assessment if their condition is sufficiently serious. Patients will be transferred by trolley. This requires the assistance of a porter. All staff involved in the transfer must wear standard infectious PPE, FP2/3Mask, gloves, long sleeved clinical gown, masks or visors
- The trolley is transported via the outside route to the ground floor entrance of the Lee View Block
- The porter **MUST** wear full protective gear (as outlined in the Infection Control Guidelines). **NB. Hand washing & proper use of the FP2 Mask.**
- Before returning to the A/E Department the trolley **MUST** be stripped, washed and disinfected (in the outer area of the room) with Milton 1:10. Rinse off afterwards with clean water. Use alcohol 70% for the chrome parts of the trolley,

Transportation of Laboratory Specimens

- As outlined in the Infection Control Guidelines a transport box is available from the Microbiology Laboratory containing the necessary equipment for collection of blood/ other specimens. It is the duty of the appointed porter to collect and return this box to the laboratory. Gloves must be worn.

Other Duties

- There may be other duties for porters i.e. ensuring sufficient oxygen/ other miscellaneous requests by the Department Head. In this instance risk assessment determines the extent of protective wear but in the infected area it is advisable to wear a mask and gloves at all times. If in doubt contact the department head. Any queries/ doubts contact Infection Control

MERCY UNIVERSITY HOSPITAL INFECTION CONTROL GUIDELINES

1. Reduce the number of staff attending to a suspect/ probable/ definite PANDEMIC/EPIDEMIC INFLUENZA case to the minimum required aim for the person/persons allocated to the patient to attend to all that patient's needs (this includes both medical/nursing-staff) i.e. meal trays, any required equipment/ products etc. should be left outside the door. Ensure that the telephone system is in place to enable immediate contact with the person inside. This applies to both the A/E Department and the Negative Pressure Room.

2. **Protective Wear-** The following **MUST** be worn by staff attending to the patient

- Full length, full sleeved gowns (oncology gowns)
- FP2/3Mask
- Gloves
- Goggles/visors
- Disposable hats
- Disposable overshoes

NB. The patient **MUST** wear an FP2/3 Mask. If the patient is unable to tolerate such a mask replace it with an ordinary surgical mask.

NOTE: All of the above requirements are available from the A/E Departments for where /by whom needed.

3. Isolation Signs

- *"Red" Isolation Sign on the door. Remember to keep the door closed at all times.*

4. Specimens

- The Microbiology Laboratory **MUST** be contacted before collection of blood/ other specimens.
- The Microbiology Laboratory will issue the relevant equipment in a "special box" (stored in the lab) and collected specimens are to be placed in this box and will be distributed to the relevant laboratories by the Microbiology Laboratory.
- **NB. No** bloods/ other specimens to be taken in the A/E Department- bloods/ specimens to be taken **ONLY** in the negative pressure rooms.

5. "Cadaver" Packs

- A pack containing inner/outer "Cadaver" bag, protective wear, wash bowl, cloths etc (all requisites required for "laying out") is available in the A/E Department.

6. Maintenance

- Ensure that maintenance personnel are informed of the status of the patient
- Ensure that the necessary full protective wear (as outlined above) is made available to them
- Maintenance should respond immediately when contacted to remove the refuse from the room.
- Refuse **MUST** go directly from the room to the compound and stored Separately in the compound.

7. Cleaning/Disinfection Guidelines

Cleaning/ Disinfection of affected Room/ A/E Area

Preparation of the Room/Area

- Remove as much equipment as possible from the room/ area where the patient is being treated.
- Remember to place the Hepa Filter Unit in the A/E Room and switch on.
- Place polythene sheeting over anything which cannot be removed i.e. equipment, open shelving etc. If possible secure this sheeting with clips.
- “RED” Isolation sign on the door and remember to keep closed at all times.
- Ensure that the negative pressure is set (in negative pressure room) or the appropriate hepa Filter Unit/ Extractor functioning properly (in the A/ E Dept. both in the rear room and in the treatment area itself).
- Ensure adequate supply of necessary equipment i.e. yellow bags/yellow “sharps” bin/ yellow rigid bins.
- Bio-hazard labels (yellow sticker with B.H. written in red) to be placed on outside of case notes, inside of kardex, on all request forms (as per “Infectious” sticker policy).
- Adequate supply of protective wear i.e. long sleeved, heavy duty gowns, disposable gloves/overshoes/hats and N95 masks and surgical masks (for the patient if unable to tolerate the N95) to be placed outside the area.

Cleaning/ Disinfection of Equipment

- Clean with detergent and hot water. After cleaning disinfect with Milton 1/10 and alcohol 70% for chrome
- Full personal protective wear as outlined above should be worn by the person cleaning and on removal placed in double yellow bag and immediately secured/ removed from the area.
- Promptly dispose and secure any waste. Remove and dispose of all polythene covering. Any remaining notices/posters on the walls should also be discarded at this time. It is necessary in this situation to double bag all waste.
- Close the door and leave the room/ area for 1hour
- Any equipment within the room (which needs to be removed) should be properly cleaned/ disinfected before removing.



- Thorough cleaning/disinfection of the entire area/ room is necessary. This includes all surfaces, ledges, windows, doors, walls, floors etc.
- Any cloths, detergent bottles etc. used must be disposed of and non- disposable equipment must be properly cleaned/ disinfected

Re- Occupation of Room

This depends on the degree of risk-

A/E- Low Risk-

- Good surface cleaning/Disinfection as outlined above
- Cleaning/Disinfection of Hepa Filter Units and leave the units switched on(high power)
- If urgently needed the room may be used after 1hr.
- If not ideally leave over night

A/E -High Risk

- In the case of “high” risk sterilization/fumigation should be considered and the room should be left closed for 24hrs.

Negative Pressure Room- Low Risk

- Good Surface cleaning /disinfection as outlined above.
- Leave at negative pressure.
- If urgently needed the room may be used after ½- 1hr.
- If not ideally leave over night

Negative Pressure Room – High Risk

- In the case of “high” risk sterilization/ fumigation should be considered and the room should be closed for 24hrs.

Any queries/problems/doubts contact Infection Control.

OCCUPATIONAL HEALTH GUIDELINES FOR PANDEMIC INFLUENZA

Guidelines to be followed by Occupational Health Nurse in the event of a staff member having had unprotected contact with a positive influenza case.

- Initial assessment of staff member - questionnaire to be completed by O.H.N. by speaking with the staff member on phone – see questionnaire attached. If initial assessment is clear then :-
- The staff member is to be given a PANDEMIC/EPIDEMIC INFLUENZA symptom sheet – see attached symptom sheet - and instructed that they must report any symptoms to Occupational Health as soon as they occur.
- Daily temperature checks and monitoring of staff member for symptoms, to be carried out for 10 days post arrival back in Ireland. Any symptoms occurring after this period staff to contact Occupational Health.
- Temperature check and monitoring for symptoms to be carried out prior to the staff member reporting for duty each working day.
- The above monitoring will take place in the Emergency Department by arrangement with the CNM3.
- When the staff member is found to be afebrile and is symptom free they may proceed to work.

In the event of a staff member having a pyrexia and/or reporting symptoms.

- The OHN should provide the staff member with an FP2/3 mask to be donned stat.
- The OHN must don an FP2/3 mask.
- The OHN will inform the Nurse Manager in the A&E department of the situation.
- OHN will contact the on call registrar to have the staff member medically assessed.

Guidance for Management of Exposures to Severe Acute Respiratory Syndrome or PANDEMIC INFLUENZA for Healthcare Settings

1. Health care workers who have unprotected exposure to PANDEMIC INFLUENZA should be vigilant for fever or respiratory symptoms during the 21 days following exposure.
2. Those who develop fever or respiratory symptoms should limit interactions outside the home and should not go to work, school, out-of-home childcare, church or other public areas.



3. Symptomatic healthcare workers should use infection control precautions to minimize the potential for transmission and should seek healthcare evaluation. In advance of the evaluation healthcare providers should be informed that the healthcare worker may have been exposed to PANDEMIC INFLUENZA.
4. If symptoms do not progress to meet the suspect PANDEMIC INFLUENZA case definition within 72 hours after first symptom onset, the health-care worker may be allowed after consultation with infection control, occupational health and/or local health authorities, to return to work
5. For healthcare workers who meet or progress to meet the case definition for suspected PANDEMIC INFLUENZA (e.g. develop fever and respiratory symptoms), infection control precautions should be continued until 21 days after the resolution of fever, provided respiratory symptoms are absent or improving. Suspected PANDEMIC INFLUENZA should be reported to local health authorities immediately.
6. Exclusion from duty is not recommended for an exposed health-care worker if they do not have either fever or respiratory symptoms. However, the worker should report any unprotected exposure to PANDEMIC INFLUENZA patients to the appropriate facility point of contact (e.g. Infection Control or Occupational Health) immediately.
7. Active surveillance for fever and respiratory symptoms, e.g. daily screening, should be conducted on health-care workers with unprotected exposure, and the worker should be vigilant for onset of illness. Workers with unprotected exposure developing such symptoms should not report for duty, but should stay at home and report symptoms to the appropriate facility point of contact immediately.
8. Passive surveillance, should be conducted among all healthcare workers in a facility with a PANDEMIC INFLUENZA patient, and all health-care facility workers should be educated concerning the symptoms of PANDEMIC INFLUENZA.



PANDEMIC INFLUENZA QUESTIONNAIRE

This questionnaire is to be completed by the Occupational Health Nurse, in the case of an employee returning from a country where there are PANDEMIC INFLUENZA cases or suspected cases. This document is to be completed via a telephone conversation with the staff member, prior to that staff member returning to work. The employee is to be informed that this information may be given to the infection control team.

Name of employee:

Date:

Date of Birth:

1. Have you had a close contact i.e. have you lived with, or had you direct contact with respiratory secretions or body fluids of a suspect / probable PANDEMIC INFLUENZA case? **Yes / No**
2. Where have you travelled to?
3. What cities / areas did you visit in that country?
4. What airports did you stop at on your journey?
5. Did you remain in the aeroplane or disembark?
6. If you did disembark, how long did you spend in the airport terminal?
7. Have you shortness of breath? **Yes / No**
8. Have you a cough? **Yes / No**
9. Have you a fever? **Yes / No**
10. Have you a headache? **Yes / No**
11. Have you loss of appetite? **Yes / No**
12. Have you diarrhoea? **Yes / No**
13. Have you general malaise? **Yes / No**
14. Have you an overall feeling of discomfort? **Yes / No**

If the employee answers 'yes' to any of the questions, or has travelled to or passed through a high risk area, a member of the infection control team is to be contacted and informed of this information before the employee is allowed to return to work.



Symptom Sheet for PANDEMIC INFLUENZA Virus

Do not come to work if you develop any of the symptoms listed below.

If you have any of the following symptoms please ring the Occupational Health Department (021-4271971 ext 5307), outside of hours please ring your General Practitioner.

- Fever (temperature >38.0 degrees C)
- Cough
- Difficulty with breathing
- Headache
- Body aches
- Shortness of breath
- Diarrhoea
- Malaise
- Loss of Appetite

LABORATORY TESTS

It is important that laboratory and other departments are made aware that samples are coming from a suspect/potential PANDEMIC INFLUENZA.

All lab samples should be sent directly to Microbiology in the container provided, from there they will be distributed to other labs as appropriate. They should not be placed in the pneumatic tube.

All materials required for the lab investigation of PANDEMIC INFLUENZA patients are available in a "PANDEMIC INFLUENZA BOX", available from the Microbiology Lab.

Microbiology

Patients with suspect or probable PANDEMIC INFLUENZA should be investigated for causes of community-acquired respiratory infection including:

- Sputum for Culture and sensitivity
- Nose/throat or nasopharyngeal or mouth washings – viral swab. Must use specific viral transport swabs...available in PANDEMIC INFLUENZA BOX.
- Sputum for PANDEMIC INFLUENZA PCR – Sputum during day 6 – 10 of illness is best. Normal sputum container.
- Faeces specimen for PANDEMIC INFLUENZA.
- Serum for Atypical pneumonia serology.

Please remember to take a convalescent sample 10-14 days later!

Haematology

- Full blood count.
- ESR.
- C reactive protein

Biochemistry

- Urea and electrolytes.
- Liver function tests.
- Creatine Phosphokinase.

All specimens should be labelled RAS/03 in addition to usual details.