



## **Annex 8.3 Emergency Response Arrangements**

# **Shropshire Community Health Trust**

## **Pandemic Influenza Plan**

**2019/21**

**Version 5.0 2019**

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## Annex 8.3 Pandemic Influenza Plan

i.

Version Number	Date	Author	Description of Change
V0.1	September 2014	Pete Old	First Draft
V0.2	April 2015	Pete Old	Second Draft
V0.3	August 2015	Pete Old	Amendments following publication of Dear Colleague letter 20 May and self-assessment of National Core Standards
V2.0	November 2015	Pete Old	Amendments to distribution and version control post sign off by Quality and Safety Committee
V3.0	July 2018	Pete Old	Review against current national guidance. Updating of references.
V4.0	October 2018	Pete Old	Review against current national guidance. Update of references Approved by Quality and Safety Committee
V4.0	December 2018	Pete Old	Formal publication post staff consultation
V5	October 2019	Liz Watkins	Review against current national guidance.

ii.

### INTERNAL

### EXTERNAL – when pandemic triggered or on request

Name	Name
Trust Board Members	Shropshire & Staffordshire NHS E AT
On call Directors and Managers	Shrewsbury and Telford Hospitals NHS Trust
Trust SharePoint	Robert Jones and Agnes Hunt Orthopaedic Hospital
	Shropshire Council
	Telford and Wrekin Council
	West Mercia Police (Shrewsbury and Telford Divisions)
	West Mercia Local Health Resilience Forum

## 1.0 PREFACE

1. The following plan has been prepared in accordance with the NHS England Operating Framework for Managing the Response to Pandemic Influenza and sits sub-ordinate to the trust Emergency Response Procedures.
2. This plan is intended to give an indication of the Trust response but may require total review when a pandemic is declared and known attack and case fatality rates are known. The trust also accepts its role may change depending on the needs of patients, new national strategy and guidance or services are commissioned a different way in response to the needs of a pandemic.
3. The plan indicates the responsibilities and actions of the staff within the Shropshire Community Health NHS Trust.
4. The plan will be formally updated annually (next update by November 2016) or should the risk to the UK of pandemic increases.
5. Updates will also be made more frequently, as appropriate, following experience from incidents, exercises or in line with changes in National Policy or local guidelines and policy.
6. The Chief Executive of the Shropshire Community Health NHS Trust is accountable for ensuring that the Trust is adequately prepared to respond to NHS major incidents including its response to Pandemic Influenza.

**2.0 Content**

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### 3.0 Introduction

Pandemics have occurred throughout history when a new subtype of influenza develops the ability to spread rapidly through a global human population with little or no immunity to it. Three pandemics occurred in the 20th century (in 1918, 1957 and 1968), with the first pandemic of the 21st century that started in April 2009.

The 20th century pandemics ranged in severity from something resembling a severe outbreak of seasonal influenza to a major event where millions of people became ill and died. They also varied with respect to number of waves of disease, age groups affected and symptoms caused. Planning at the start of the 21st century was based on these events, however the 2009 pandemic did not manifest as anticipated, thus illustrating the uncertainty underpinning the science behind pandemic preparedness.

Pandemic influenza is recognised by the Government as the single most disruptive event facing the UK today. As such this remains at the top of the UK Government National Risk Register and risk registers of the West Mercia Local Resilience Forum and Local Health Resilience Partnership. The 2017/2018 national risk assessment influenza pandemic did not alter the likelihood of a future pandemic. Additionally the general mild nature of the 2009/10 pandemic must not be taken as an indicator of the potential severity of future such events.

#### 4.0 Policy and Guidance

This document recognises the following national and local guidance which was used to inform the trusts plan and response strategy;

- UK Influenza Pandemic Preparedness Strategy, Department of Health, 2011
- Health and Social Care Influenza Pandemic Preparedness and Response, Department of Health, 2012
- Pandemic Influenza Risk Management, A WHO guide to inform & harmonize national & international pandemic preparedness and response. 2016
- Pandemic flu planning information for England and the devolved administrations, including guidance for organisations and businesses. Operating Framework for Managing the Response to Pandemic Influenza, NHS England, October 2013
- Pandemic Influenza: Guidance to the NHS on current and future preparedness for an influenza pandemic, NHS England, 2017
- West Mercia Local Resilience Forum/Strategic Co-ordinating Group Plan – Flu Pandemic Memorandum of Understanding for the mobilization of NHS resources in the event of a significant Public health Incident or outbreak.2016
- Shropshire Community Health NHS Trust: Infection Prevention and Control Arrangements and Responsibilities Policy 2018
- Operating Framework for Managing the Response to Pandemic Influenza 2017
- NHS England North Midlands Concept of Operations for Pandemic Flu. 2018

NHS England is responsible for leading the mobilisation of the NHS in the event of an emergency or incident and for ensuring it has the capability for NHS command, control, communication and coordination and leadership of all providers of NHS funded care.

The Local Health Resilience Partnerships (LHRP) will oversee health pandemic preparedness and act as a conduit for health to engage with the Local Resilience Forum (LRF) preparedness arrangements. Clinical Commissioning Groups (CCGs),

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Public Health England (PHE) and the Directors of Public Health (DsPH) in local authorities also have roles to play in pandemic influenza resilience in planning, response and recovery.

**This Plan should also be read in conjunction with the following documents:**

- West Mercia LRF Joint Emergency Response Arrangements (JERA) 2016
- the LRF Communications Plan, and the plans held by Warwickshire & West Mercia Police in relation to the activation and functions of the Strategic Co-ordinating Group and Gold Facility. (Pages Resilience Direct)
- The Incident Response Arrangements as per the NHS England Area Teams (Shropshire & Staffordshire and Arden, Herefordshire & Worcestershire).
- Specific Incident response plans of all local providers of NHS Funded Care.
- The Incident Response Arrangements as per all Local Authorities
- All organisation Media and Social Communication Plans
- Excess Death Plan and Emergency Mortuary Plans
- Rest / Humanitarian Centre Plans

## 5.0 NHS Strategic Objectives

### NHS Strategic Approach to Managing Pandemic Influenza

**The overall objectives of the UK's approach to preparing for an influenza pandemic are to:**

- minimise the potential health impact of a future influenza pandemic
- minimise the potential impact of a pandemic on society and the economy
- instil and maintain trust and confidence

Towards this, the Strategy identifies a series of stages, referred to as 'DATER'

- Detection,
- Assessment,
- Treatment,
- Escalation and
- Recovery

These stages are non-linear and have identified indicators for moving between them. A full explanation of these terms can be found in the Operating Framework for Managing the Response to Pandemic Influenza 2017.

## 6.0 Shropshire Community Health NHS Trust Strategic Objectives

- provide the public with information
- contain the emergency – limiting its escalation or spread
- maintain critical and normal services at an appropriate level in response to pressures during the pandemic
- protect the health and safety of personnel
- promote self-help and recovery
- maintain timely and appropriate reporting of the situation to inform decisions
- restore normality as soon as possible
- evaluate the response and identifying lessons to be learned

## 7.0 NHS Planning Assumptions

Influenza pandemic planning in the UK has been based on an assessment of the 'reasonable worst case' derived from experience and a mathematical analysis of seasonal influenza and previous pandemics. This suggests that up to 50% of the population could experience symptoms of pandemic influenza during one or more pandemic waves lasting 15 weeks, although the nature and severity of the symptoms would vary from person to person. Analysis of previous influenza pandemics suggests that we should plan for up to 2.5% of those with symptoms dying as a result of influenza, assuming no effective treatment was available.

In adopting this strategy the community trust will need to be aware that it means;

- The treatment of individual cases and population treatment through routine NHS services,
- enhancement of the health response to deal with increasing numbers of cases
- escalation of surge management arrangements in health and other sectors
- prioritisation and triage of service delivery with the aim to maintain essential services

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NHS England states that ‘given the uncertainty about the scale, severity and pattern of development of any future pandemic, three key principles should underpin all pandemic preparedness and response activity’:

- **Precautionary**: the response to any new virus should take into account the risk that it could be severe in nature
- **Proportionality**: the response to a pandemic should be no more and no less than that necessary in relation to the known risks
- **Flexibility**: there should be a consistent, UK-wide approach to the response to a new pandemic but with local flexibility and agility in the timing of transition from one phase of response to another to take account of local patterns of spread of infection and the different healthcare systems in the four countries

## 8.0 Command & Control

### 8.1 Overall

NHS England is responsible for leading the mobilisation of the NHS in the event of an emergency or incident and for ensuring it has the capability for NHS command, control, communication and coordination and leadership of all providers of NHS funded care.

The Shropshire and Staffordshire NHS England area team will establish a command and control system with the support of the Clinical Commissioning Groups. NHS England will be the NHS lead or representative at the West Mercia Strategic Coordinating Group.

### 8.2 Shropshire Community Trust

The community trust will utilise its Emergency Response Procedures document to coordinate the trusts response and resources, using where relevant or required the trusts Surge and Capacity Plan and Corporate Business Continuity Plan into the overall approach to coordinating the trusts activity, freeing additional capacity and identify critical service provision.

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On declaration of a Pandemic or when advised, the trust will appoint a director lead to manage the trusts pandemic response. This director will lead the trusts response for the duration of the pandemic in order to give consistency of approach and in recognition that the issues may be complex and response strategies may need to be implemented over a number of weeks.

The Trust acknowledges that its incident control room will need to be established and be effective for a number of weeks rather than the usual model of response to a major incident where an incident control might only be established for a few hours. This need will be taken into account early in the response to a pandemic to ensure the trust can coordinate its response over extended times and days and fulfil the need for regular upward reporting and coordination across other stakeholders to the response...

### **9.0 Potential Impact on the Workforce**

It is estimated that up to 50% of the workforce may require time off at some stage over the entire period of the pandemic, with individuals likely to be absent for a period of seven to ten working days. Absenteeism should follow the pandemic profile, with an expectation that it will build to a peak lasting for two to three weeks, when between 15% and 20% of staff from the workforce may be absent, and then decline.

However as the rate of infection in residential facilities may be higher over a short period, higher levels of absence must be planned for. Additional staff absences are likely to result from other illnesses, taking time off to provide care for dependants (e.g. children), family bereavement, other psychosocial impacts, fear of infection or practical difficulties in getting to work.

The Government may advise schools and early years/childcare settings to close in order to reduce the spread of infection amongst children. This advice will be provided only if closure is anticipated to produce significant health benefits. Closures will be

area specific (whilst the virus is circulating in the locality) and are likely to be for two to three weeks, although they may be extended if the pandemic remains in the area.

A further 5–6% of staff could be absent as a result of school closures, though this is based on an analysis of informal childcare being available for parents.

### **10.0 Staff Welfare Planning**

People will be the most valuable resource and the most vulnerable during a pandemic. In order to effectively manage this essential resource, a Staff Welfare Team will be formed to work alongside the Influenza Trust's Emergency Management Team. The Staff Welfare Team's main purpose will be to assist staff during the pandemic, from recording absences to enabling staff to return to work.

As part of the planning process, the Human Resources Department will develop plans to:

- ensure that contact details and characteristics of the available workforce are captured so that they can be easily contacted in the event of a pandemic, and identifying possible risks in service delivery and find solutions where possible.
- identify if a specific workforce or team has a high proportion of people with young children and other personal caring responsibilities that may impact upon their ability to attend work during 'normal' hours, develop plans to support them with childcare or alternative work options
- develop a training and education programme that builds capacity into the existing workforce through teaching new skills and updating existing ones (both clinical and non-clinical). This will allow some staff to take on additional duties, so that those with higher clinical skills or experience can focus on those patients who may be at particular risk or on treating those suffering from the complications of influenza pool staff as a 'critical mass', which would enable staff without a set stream of work to be directed towards the most necessary task within their capability
- ensure that consideration has been given to employing and allocating agency or locum staff to support the coordination of locum resource across the locality and,

where this is possible, ensuring that appropriate arrangements are in place (i.e. that stipulate terms and conditions) prior to a pandemic

- facilitate arrangements for joint working and 'buddying up' of community teams or specialist services build on or develop links with voluntary organisations, community partnerships and local businesses to maximise opportunities to support the community at large as well as the health service response
- review normal and acceptable minimum staffing levels of core functions and services and address any potential changes to working practices that may be needed to facilitate this
- develop internal systems for monitoring and reporting real-time absence rates.
- inform staff in an appropriate way of the risks associated with pandemic influenza and what action they can take to protect themselves and others, and instructing them not to attend work when they are symptomatic but to attend work when they are well
- review locations of staff at home and at work and implement a travel assistance policy in the event that normal transport services are unavailable
- working with local organisations, map out those health and social care professionals who provide services to the same patient and where care could be consolidated
- develop arrangements for staff to access counselling and support services
- review local human resources policies and procedures to maximise flexibility for staff to be able to work and accommodate caring obligations, annual leave and special leave (carer's leave, bereavement leave, etc.)
- provide education and training, including voluntary and recently retired staff.

### **11.0 Commissioning Arrangements**

The Trust is obliged, through the National Contract, to support the management of a major incident, such as a pandemic. However, specific actions being requested by commissioners will be approved jointly to ensure the trust has the capacity with which to deliver the request being made, so it can identify any risks in general or threats to its critical services specifically and, any additional costs that might be incurred.

A senior commissioner will therefore be consulted as a member of the Trust Incident Management Team to clarify any arrangements should the need arise. The Trust has agreed flexibility arrangements with staff organisations which allow for reasonable redeployment in the event of managing a major incident response. This includes the potential requirement to work in other areas of the health sector as required.

### **12.0 Mutual Aid**

Whilst it is generally acknowledged that during a pandemic, there will be little capacity for mutual aid between neighbouring organizations, Mutual Aid requests will be coordinated by the NHS area team.

### **13.0 Shropshire Community Health Trust – Operational Arrangements**

#### **13.1 Service and Resource Management**

A pandemic will impact on the trusts normal service provision and the organisations Surge and Capacity Plan alongside the service level business continuity plans will be used to allow flexible response whilst maintaining essential services.

Staff not required to deliver its critical services may be used to support other aspects of the trusts response to a pandemic.

#### **13.2 Scope of Pandemic Specific Delivery**

Shropshire's Community Trust could support a pandemic response in a number of specific areas as follows:-

- Increasing community-based care to vulnerable people and patients with increased acuity;
- Providing clinically trained staff to support other parts of the health economy or independent care sector as necessary;

- Supporting the delivery of medicines (Anti-Viral) to housebound patients;
- Managing helplines and the logistical requirements of delivering PPE, vaccines, medicines etc.;
- Assisting in the staffing and management of anti-viral collection points if requested;
- Providing suitably trained clinical staff to support immunisation programmes;

### **13.3 Staff Safety & Immunisation**

One of the trusts paramount concerns is to ensure that its staff will be safe whilst working during normal trust business this will remain a priority in a response to a pandemic.

Suitable training in relevant aspects of the pandemic response along with appropriate Personal Protective Equipment will be available to any staff required to treat patients with an influenza like illness or delivering care under revised clinical priorities set whilst managing an infectious outbreak or pandemic influenza.

As part of the annual flu immunisation process staff are be strongly encouraged to participate in immunisation programmes for both their own protection and that of their patients and all reasonable efforts will be made to make access to vaccinations as easy as possible. This includes providing vaccination clinics in the workplace.

### **14.0 Infection Control**

The following section is adapted from the Department of Health publication Pandemic flu – A summary of guidance for infection control in healthcare settings which is part of the Infection Control Training Material published in October 2007.

A national strategic reserve of personal protective equipment (PPE) and anti-viral drugs is maintained for use in the event of a pandemic; however the trust is expected to maintain stock for seven days use. In the event of the release of the national stockpile of pandemic equipment the trust will receive this at its community

Equipment Store, Hortonwood, Telford from which it can be distributed throughout the trust.

### 14.1 Key points

- Standard infection control principles and droplet precautions must be used for patients with or suspected of having pandemic influenza.
- Good staff and patient hand hygiene is vital for the protection of both parties
- Good respiratory hygiene is essential.
- The use of PPE should be proportional to the risk of contact with respiratory secretions and other body fluids, and should depend on the type of work procedure being undertaken.

### 14.2 Pandemic Influenza Infection Control Precautions

Standard infection control principles and droplet precautions must be used for patients with or suspected of having pandemic influenza. Standard infection control principles are a set of broad statements of good practice to minimise exposure to and transmission of a wide variety of micro-organisms. Standard principles should be applied by all healthcare practitioners to the care of all patients all of the time.

### 14.3 Hand hygiene

- Hand hygiene is the single most important practice needed to reduce the transmission of infection in healthcare settings and is an essential element of standard infection control principles.
- Hand hygiene includes hand washing with soap and water and thorough drying, and the use of alcohol-based products that do not require the use of water. If hands are visibly soiled or contaminated (for example, contaminated with respiratory secretions), they should be washed with soap and water and dried.
- When using an alcohol hand-rub, hands should be free of visible dirt and organic material.
- Hands should be decontaminated, even if gloves have been worn, before and after all contact with an infected patient or their bed area (including inanimate

objects), removal of protective clothing and cleaning of equipment.

- All staff, patients and visitors should clean their hands when entering and leaving areas where care is delivered

#### **14.4 Applying droplet precautions for pandemic influenza**

In addition to standard infection control principles, droplet precautions should be used for a patient known or suspected to be infected with influenza, which is transmitted by droplets that can be generated by the patient during coughing, sneezing or talking and during some procedures.

#### **14.5 Patient placement**

Ideally, patients with influenza should be placed in single rooms; however, during a pandemic this may not be possible. Therefore, patients should be cohorted (grouped together with other patients who have influenza and no other infection), in a segregated area. Patients should be kept at least one metre apart, special ventilation is not required. Single-sex guidelines should not be breached.

#### **14.6 Surgical masks**

Surgical masks must be worn when working in close contact (within one metre) with a patient with symptoms. In an area where influenza patients have been cohorted together, for practical reasons, this is likely to mean wearing a surgical mask at all times.

#### **14.7 Patient transport**

The movement and transport of patients from their rooms or the cohorted area should be limited to essential purposes only. If transport or movement is necessary, minimise patient dispersal of droplets by masking the patient, if possible. The surgical mask should be worn during transport until the patient returns to the

segregated area. If a surgical mask cannot be tolerated then good respiratory hygiene must be encouraged.

#### **14.8 Management of a coughing and sneezing patient**

Patients, staff and visitors should be encouraged to minimise potential influenza transmission through good hygiene measures:

- Cover nose and mouth with disposable, single-use tissues when sneezing, coughing, wiping and blowing noses.
- Dispose of used tissues in nearest waste bin.
- Wash hands after coughing, sneezing, using tissues or contact with respiratory secretions and contaminated objects

#### **14.9 Aerosol-generating procedures**

Several medical procedures have been reported to generate aerosols and some have been suggested to be associated with increased risk of pathogen transmission. However, the risk associated with many of the aerosol-generating procedures is not yet well defined, and may change with further studies in the area.

In a recent revised WHO document, Infection prevention and control of epidemic - and pandemic-prone acute respiratory diseases in healthcare, the following are considered to be aerosol generating;

##### ***Procedures associated with a documented increase in risk of pathogen transmission:***

- intubation and related procedures, for example manual ventilation and suctioning
- cardiopulmonary resuscitation
- bronchoscopy surgery
- post-mortem

The performance of aerosol-generating procedures should be minimised as far as possible without compromising patient care and carried out in a single room with the door closed. To avoid unnecessary exposures, only those healthcare workers needed to perform the procedure should be present.

#### 14.10 Personal protective equipment

PPE should be worn to protect staff from contamination with body fluids to reduce the risk of transmission of pandemic influenza between patients and staff and from one patient to another. Appropriate PPE for care of patients with pandemic influenza is summarised in Table 2. Standard infection control principles apply at all times. All surgical masks should be fluid repellent. PPE should comply with the relevant BS EN standards (European technical standards as adopted in the UK) where these apply.

#### 14.11 Personal protective equipment for care of patients with pandemic influenza

Personal Protective Equipment	Entry to cohorted area but no patient contact	Close Patient contact (within one metre)	Aerosol Generating Procedures
Hand Hygiene	✓	✓	✓
Gloves	X <sup>b</sup>	✓ <sup>c</sup>	✓
Plastic apron	X <sup>b</sup>	✓	X
Gown	X	X <sup>d,e</sup>	✓ <sup>c</sup>
Surgical mask	✓ <sup>f</sup>	✓	X
FFP3 Respirator	X	X	✓
Eye Protection	X	Risk assessment	✓

#### NOTES:

- (a) Wherever possible, aerosol-generating procedures should be performed in Side rooms or other closed single-patient areas with minimal staff present.

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- (b) Gloves and an apron should be worn during environmental cleaning procedures.
- (c) Gloves should be worn in accordance with standard infection control principles. If glove supplies become limited or pressurised, this recommendation may need to be relaxed. Glove use should be prioritised for contact with blood and body fluids, invasive procedures and contact with sterile sites.
- (d) Consider in place of apron if extensive soiling of clothing or contact of skin with blood and other body fluids is anticipated (for example during intubation or caring for babies).
- (e) If non-fluid-repellent gowns are used, a plastic apron should be worn underneath.
- (f) Surgical masks are recommended for use at all times in cohorted areas for practical purposes. If surgical mask supplies become limited or pressurised, then use in cohorted areas should be limited to close contact with a symptomatic patient (within one metre). Surgical masks must be replaced when wet and should be worn for the time period specified in the manufactures instructions.

**Care must be taken to ensure that PPE is worn and removed correctly, in order to avoid inadvertent contamination – see also instructions on putting on and removing PPE. Please see Annex 2**

**PPE would not normally be required to be worn by patients, visitors unless they were carrying out personal care or having close contact (within 1 metre) of the patient.**

### 14.12 Eye protection

Eye protection should be considered when there is a risk of contamination of the eyes by splashes and droplets, for example by blood, body fluids, secretions or excretions. There should be an individual risk assessment at the time of providing care. Eye protection should always be worn during aerosol-generating procedures. Disposable, single-use eye protection is recommended.

### 14.13 Surgical masks

- A surgical mask should be worn by healthcare workers for close patient contact (within one metre) to provide a physical barrier and minimise contamination of the nose and mouth by droplets.
- When pandemic influenza patients are cohorted in one area and multiple patients must be visited over a short time or in rapid sequence, it may be more practical to wear a single surgical mask upon entry to the area and keep it on for the duration of the activity or until the surgical mask requires replacement.
- All contaminated PPE must be removed before leaving a patient care area. Surgical masks or FFP3 respirators should be removed last.

### 14.14 Higher Level Respiratory Protection

The Trust Infection Prevention and Control team are trained to train staff to fit test and wear respiratory protection and will roll out training programs in response to the threat of pandemic influenza, trust areas with a higher risk of encountering air borne infectious patients already have access to training and relevant protection.

It is unlikely that most community trust staff will normally provide care in circumstances where respirators are required however, a disposable face mask providing the highest possible protection factor available (i.e. an EN149:2001 FFP3 disposable respirator) should be worn by healthcare workers when performing procedures that have the potential to generate aerosols.

If an FFP3 disposable respirator is not immediately available, the next highest category of respirator available should be worn (for example FFP2). Fitting the respirator correctly is critically important for it to provide proper protection. Every user should be fit tested and trained in the use of the respirator. In addition to the initial fit test carried out by a trained fitter, a fit check should be carried out each time a respirator is worn. 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.

Other types of respiratory protective equipment (for example powered hoods / helmets) are available and should be considered if a good fit cannot be achieved with disposable respirators. A powered respirator might be the only type suitable for some, for example someone who, perhaps for cultural reasons, prefers not to remove their beard.

FFP3 respirators should be replaced after each use and changed if breathing becomes difficult, the respirator becomes damaged or distorted or obviously contaminated by respiratory secretions or other body fluids, or if a proper face fit cannot be maintained. Respirators should be disposed of as clinical (also known as infectious) waste.

### **14.15 Personal Protective Equipment – General Guidance to Staff**

The level of PPE used will vary based on the procedures being carried out and not all items of PPE will always be required. If full PPE is required, for example for an aerosol-generating procedure, all staff in the room should wear the following PPE.

The order given here is practical but the order for putting on is less critical than the order of removal:

1. Gown (or apron if not aerosol-generating procedure)
2. FFP3 respirator (or surgical mask if not aerosol-generating procedure)
3. Goggles or face shield (for an aerosol-generating procedure and as appropriate after risk assessment)
4. Disposable gloves

PPE should be removed in an order that minimises the potential for cross contamination. Before leaving the area, gloves, gown and eye goggles should be removed (in that order, where worn) and disposed of as clinical (also known as infectious) waste. After leaving the area, the respirator (or surgical mask) can be removed and disposed of as clinical waste.

### **14.16 Guidance on the order of removal of PPE is as follows:**

**Please refer to Annex 2**

### 1. Gloves

- Grasp the outside of the glove with the opposite gloved hand; peel off.
- Hold the removed glove in gloved hand.
- Slide the fingers of the un-gloved hand under the remaining glove at the wrist.
- Peel the second glove off over the first glove and discard appropriately.

### 2. Gown or apron

- Unfasten or break ties.
- Pull gown/apron away from the neck and shoulders, touching the inside of the gown only.
- Turn the gown/apron inside out, fold or roll into a bundle and discard.

### 3. Goggles or face shield

- To remove, handle by headband or earpieces and discard appropriately.

### 4. Respirator or surgical mask

- Untie or break bottom ties, followed by top ties or elastic and remove by handling ties only and discard appropriately.
- To minimise cross-contamination, the order outlined above should be applied even if not all items of PPE have been used.

***Clean hands thoroughly immediately after removing all PPE.***

### **14.17 Segregation and cohorting**

Cohorting of patients in segregated areas of the hospital should be carried out from the outset of the pandemic to help contain influenza infection within one part of the hospital and reduce the risk to other patients. A designated self-contained area/wing of the hospital should be used for the treatment and care of patients with pandemic influenza whenever possible adhering to same-sex guidelines

This area should:

- include a reception area separate from the rest of the hospital and, if feasible, have a separate entrance/exit from the rest of the hospital not be used as a thoroughfare by other patients, visitors or staff, including patient transfers, staff going for meal breaks, and staff and visitors entering and exiting the building
- Be separated from other non-segregated areas by closed doors.
- To control entry, signs should be displayed warning of the segregated pandemic influenza area.

### **14.18 Visitors**

During a pandemic, visitors to all areas should be kept to a minimum. Visitors with influenza symptoms should not enter the clinical area and should be encouraged to return home.

It is particularly important that every effort is made to ensure that people with influenza symptoms do not enter wards or units where there are immunocompromised patients, such as haematology and transplant units.

All visitors entering a cohorted area must be instructed on hand hygiene practice and the wearing of protective clothing as appropriate.

### **14.19 Environmental Infection Control**

#### **14.19.1 Clinical and non-clinical waste**

No special handling procedures beyond those required to conform to standard

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infection control principles are recommended for clinical (also known as infectious) and non-clinical waste that may be contaminated with influenza virus.

Waste generated within the clinical setting should be managed safely and effectively, with attention paid to disposal of items that have been contaminated with secretions/sputum (for example paper tissues and surgical masks) in addition to other routine and domestic waste management.

(See also Department of Health has published guidance on the safe disposal of healthcare waste: *HTM 07-01: Safe Management of Healthcare Waste.*)

### **14.19.2 Linen and laundry**

Linen should be categorised as 'used' or 'infected' as per NHS Executive guidance on *Hospital laundry arrangements for used and infected linen*.<sup>9</sup>

Both 'used' and 'infected' linen must be handled, transported and processed in a manner that prevents skin and mucous membrane exposures to staff, contamination of their clothing and the environment, and infection of other patients.

### **14.19.3 Staff uniforms**

During a pandemic, healthcare workers should not travel to and from work or between remote hospital residences and places of duty in uniform.

Hospitals and other healthcare facilities should provide changing rooms/areas where staff can change into uniforms upon arrival at work.

- Ideally, the Trust laundry services should be used to launder uniforms.
- If there are no laundry facilities available then uniforms should be transported home in a tied plastic bag and laundered separately from other linen in a domestic washing machine, washed at the optimum temperature recommended by the detergent manufacturers that is appropriate to the maximum temperature the fabric can tolerate, then ironed or tumble-dried.

The Trust will consider the use of theatre-type uniforms for staff who do not

usually wear a uniform, but who are likely to come into close contact with patients, for example medical staff.

#### **14.19.4 Crockery and utensils**

No special precautions, beyond those required to conform with standard infection control principles, are recommended for dishes and eating utensils used by a patient with pandemic influenza. Dishes and eating utensils should be washed in a dishwasher with a hot rinse.

#### **14.20 Environmental cleaning and disinfection**

Freshly prepared detergent and warm water should be used for cleaning the hospital or other healthcare environment. As a minimum, patient cohorted areas should be cleaned daily. Clinical rooms should be cleaned at least daily and between clinical sessions for patients with influenza and clinical sessions for patients not infected with influenza if the same clinical room is used.

Frequently touched surfaces such as medical equipment and door handles should be cleaned at least twice daily and when known to be contaminated with secretions, excretions or body fluids.

Domestic staff should be allocated to specific areas and not moved between influenza and non-influenza areas.

Domestic staff must be trained in correct methods of wearing PPE and precautions to take when cleaning cohorted areas.

#### **14.20.1 Furnishings**

All non-essential furniture, especially soft furnishings, should be removed from reception and waiting areas in hospitals, GP consulting and treatment rooms, accident and emergency departments and day rooms/lounges.

## Annex 8.3 Pandemic Influenza Plan

The remaining furniture should be easy to clean and should not conceal or retain dirt and moisture. Toys, books, newspapers and magazines should be removed from the waiting area.

### **15.0 Training and Exercising**

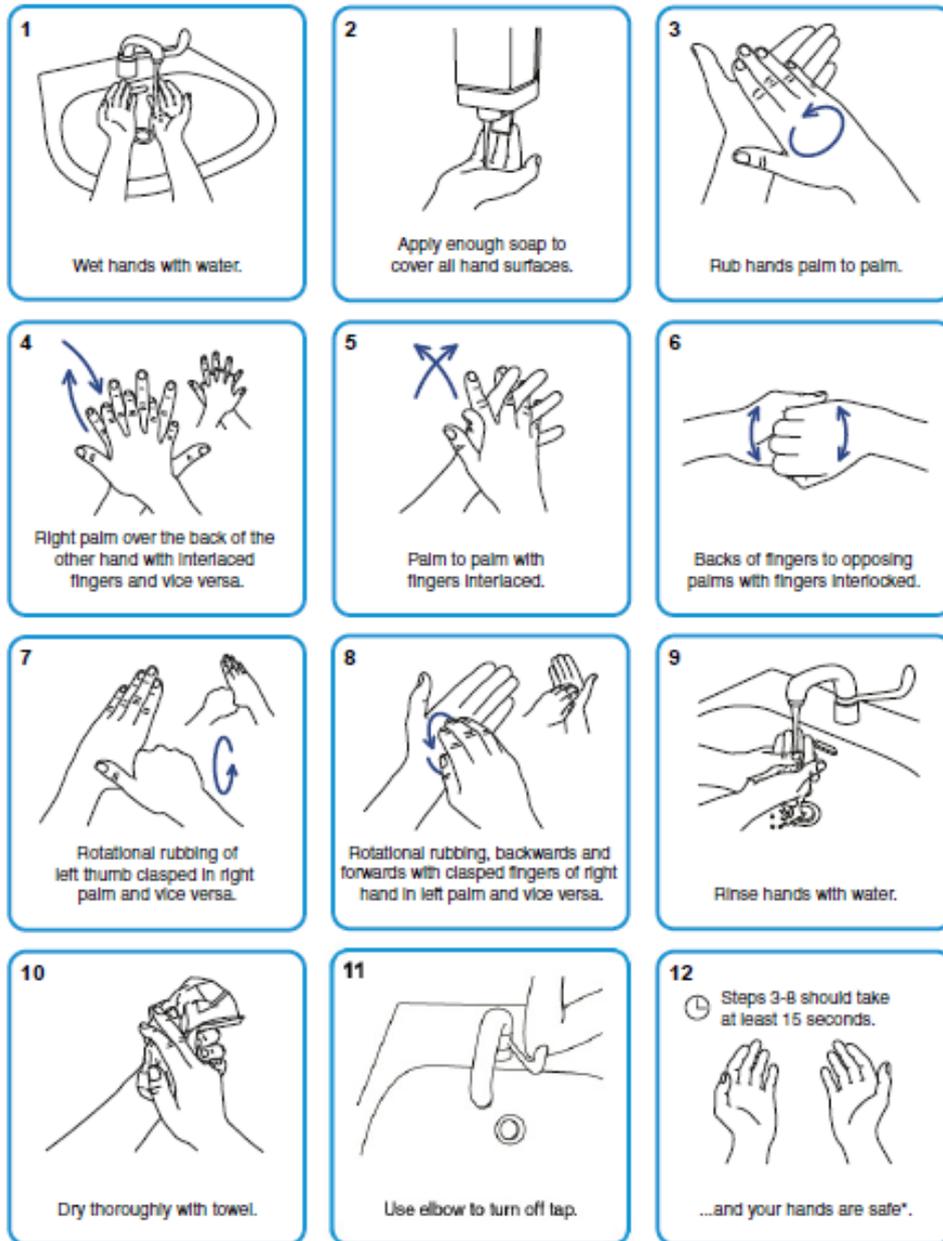
The trust practices its response to surge and capacity management throughout the year, tests and reviews its arrangements for business continuity and exercises its Emergency Response Arrangements annually. In respect to infection prevention and control the trust is proactive in ensuring its staff and patients are protected by effective use of personal protective equipment and good infection control procedures.

The trust recognises the need to specifically train staff for a pandemic response where operational practice requires a different response, this will be delivered as soon as the risk of pandemic heightens internationally or more specific detail is available to guide what is expected of the trust.

**Recommended hand wash technique**

How to hand wash – step-by-step images

Steps 3-8 should take at least 15 seconds.



\*Any skin complaints should be referred to local occupational health or GP.

Adapted from the World Health Organization



Germs. Wash your hands of them.



Part of the National Infection Prevention and Control Manual (NIPCM), available at: <http://www.nipcm.hps.scot.nhs.uk/>.  
Produced by: Health Protection Scotland, July 2018.

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### How to hand rub – step-by-step images

Duration of the process: 20-30 seconds.



Adapted from the World Health Organization



Germ. Wash your hands of them.



Part of the National Infection Prevention and Control Manual (NIPCM), available at: <http://www.nipcm.hps.scot.nhs.uk/>.  
Produced by: Health Protection Scotland, April 2016.

Use safe work practices to protect yourself and limit the spread of infection

- Keep hands away from face and PPE being worn.
- Change gloves when torn or heavily contaminated.
- Limit surfaces touched in the patient environment.
- Regularly perform hand hygiene.
- Always clean hands after removing gloves.

NB Masks and goggles are not routinely recommended for contact precautions. Consider the use of these under standard infection control precautions or if there are other routes of transmission.

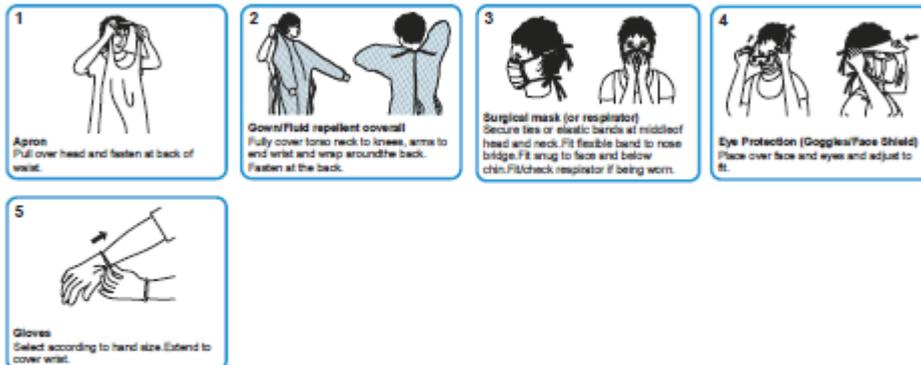
The type of PPE used will vary based on the type of exposure anticipated, and not all items of PPE will be required.

The order for putting on PPE is Apron or Gown, Surgical Mask, Eye Protection (where required) and Gloves.

The order for removing PPE is Gloves, Apron or Gown, Eye Protection, Surgical Mask.

1. Putting on Personal Protective Equipment (PPE).

- Perform hand hygiene before putting on PPE



2. Removing Personal Protective Equipment (PPE)



- Perform hand hygiene immediately on removal.
- All PPE should be removed before leaving the area and disposed of as healthcare waste.

Part of the National Infection Prevention and Control Manual (NIPCM), available at: <http://www.nipcm.hpa.scot.nhs.uk/>. Produced by: Health Protection Scotland, April 2016.

