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**Interim Guidance: Infection prevention and control measures for Health Care Workers in
Acute Care Facilities**

Human Cases of Swine Influenza A (H1N1)

This fact sheet has been developed to provide interim guidance to health care workers (HCWs) in the infection prevention and control management of suspect cases with Swine Influenza A H1N1 (swine flu) virus. This infection prevention and control guidance is for HCWs caring for patients with **Influenza-like Illness (ILI)** suspected to be due to the novel Swine Influenza A H1N1 influenza virus. This Interim Guidance has a goal of slowing (mitigating) the transmission of this virus; it is expected that the infection prevention and control recommendations (particularly recommendations related to respiratory protection) may change as further information about the epidemiology (e.g., mode of transmission) and clinical course (e.g., mild or severe disease) of this novel virus is available and the outbreak evolves. In this document we use a point of care risk assessment approach to guide decisions regarding the type of respiratory protection to apply (Appendix A).

This guideline is being provided by the Public Health Agency of Canada in response to the recent outbreak of human swine influenza A (H1N1) in North America. This guideline is based on current available scientific evidence about this emerging disease, and is subject to review and change as new information becomes available. The content of this document is largely based on the general recommendations included in the Public Health Measures Annex of the Canadian Pandemic Influenza Plan for the Health Care Sector.

Below are enhanced screening criteria to determine the need for reporting and for applying the infection prevention and control measures outlined below.

The infection prevention and control guidance provided in this document is for cases fitting the ILI enhanced screening criteria in the box below. It should be noted that this definition will also capture individuals who meet the criteria for severe respiratory illness (SRI). Individuals with SRI have chest radiograph findings of pulmonary infiltrates in addition to the screening criteria noted below.

Influenza Like Illness (ILI) Screening Criteria

- Acute onset of respiratory illness with fever* and cough

*Note: in children under 5, gastrointestinal symptoms may also be present. In patients under 5 or 65 and older, fever may not be prominent.

AND one or more of the following:

sore throat, arthralgia, myalgia, or prostration which could be due to influenza virus.

AND one or more of the following:

Travel/contact exposure:

- Traveller returned from or resident of currently affected area¹ including Mexico and other affected areas, within 7 days of onset of symptoms
- Contact with a traveller/person with ILI from a currently affected area¹ within 7 days of onset of symptoms

Laboratory/Health care setting exposure:

- Laboratory worker who works directly with influenza or other respiratory viruses
- Health care workers exposed to patients linked to a community or health care facility outbreak

¹list of currently affected areas on World Health Organization website: www.who.int/csr/disease/swineflu/en/index.html

Until the etiology is known, **in addition to Routine Practices²**, infection prevention and control measures in health care facilities for **all suspected cases of Human Swine Influenza A (H1N1): ILI cases** meeting the definition above should include:

1. Contact Precautions
2. Respiratory Hygiene (also known as Respiratory Cough Etiquette)
3. Hand Hygiene
4. Accommodation
5. Respiratory protection (Surgical mask or N95 Respirator; and eye or face protection; see #5 below)
6. Reporting

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Routine Practices and Additional Precautions as outlined below are to be practiced with symptom onset and until symptoms have resolved. The recommendations below represent the minimum standard for infection prevention and control management of suspected cases of Swine Influenza A H1N1.

1. **Contact Precautions:**

Wear gloves when entering the room of a suspect ILI case.

Remove gloves just before leaving the room and dispose of in a hands-free waste receptacle.

Gowns are required as per Routine Practices. When worn, remove the gown just before leaving the room and dispose of in a hands-free waste receptacle.

HCWs should use alcohol based hand rubs or soap and water after removing gown and gloves and after leaving the room.

2. **Respiratory Hygiene (Respiratory Cough Etiquette):**

Suspect ILI cases should be taught to perform hand hygiene (See #3 below).

Suspect ILI cases should also be taught how to perform respiratory hygiene practices (coughing into sleeve, using tissues, wearing a mask).

Suspect ILI cases should wear a mask (if tolerated) when HCWs, or other staff or visitors are present.

3. **Hand Hygiene**

HCWs should perform hand hygiene frequently (as per the healthcare organization's policies) using either alcohol based hand rubs (60-90%) or soap and water.

4. **Accommodation:**

Suspect ILI cases should be cared for in single rooms or cohorted with cases with same exposure history. Place infection control signage on the room door indicating the precautions required. A negative pressure (airborne) isolation room is preferred for non-urgent aerosol generating medical procedures (AGMP¹): If an airborne isolation room is unavailable use a single room. When suctioning of intubated cases is required, use closed suctioning when possible. Suspect ILI cases should only leave their rooms for medically necessary procedures; whenever a case leaves the room he/she must wear a mask if tolerated and be instructed on how to perform respiratory hygiene.

5. **Respiratory Protection** (Surgical mask and eye or face protection; or N95 Respirator and eye or face protection)

HCWs should wear respiratory protection when within 2 meters of a suspect ILI case. The choice between a surgical mask and N95 respirator should be based on the following:

Wear a surgical mask:

- If the patient is compliant (willing and able) with respiratory hygiene practices
- or
- If the patient has a weak or no cough. Individuals who may have a weak cough are the frail elderly and pediatric patients.

Wear an N95 respirator:

- When the patient is coughing **and** the patient is unable or unwilling to comply with respiratory hygiene;
- If conducting an aerosol-generating medical procedure (AGMP¹) on a suspect ILI case all individuals in the room should wear an N95 respirator.

Whenever a surgical mask or respirator is required, the HCW should also wear eye or face protection. Eye or face protection should be removed after leaving the case's room and disposed of in either a hands-free waste receptacle (if disposable) or in a separate receptacle to go for reprocessing (if reusable).

The surgical mask or N95 respirator should be removed by the straps, being careful not to touch the mask or respirator itself, after leaving the case's room and disposed of in a hands-free waste receptacle.

HCWs should perform hand hygiene after removing the respiratory protection and after leaving the case's room

There is no indication for use of personal air-purifying respirators (PAPRs) in the care of a suspect ILI case.

6. **Reporting**

Notify Infection Prevention and Control personnel in your acute care facility that a case with symptoms compatible with influenza who has traveled (or been in contact with someone who has traveled) to an area

¹ Aerosol-generating Medical Procedures (AGMPs): any procedure carried out on a patient that can induce the production of aerosols of various sizes, including droplet nuclei. Examples include: non-invasive positive pressure ventilation (BIPAP, CPAP); endotracheal intubation; respiratory/airway suctioning; high-frequency oscillatory ventilation; nasopharyngeal aspiration/swab; tracheostomy care; chest physiotherapy; aerosolized or nebulized medication administration; diagnostic sputum induction; bronchoscopy procedure; autopsy of lung tissue.

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of concern is being assessed. Infection Control personnel in your facility will notify Public Health of suspected cases of Swine Influenza A H1N1.

Resources and Additional Information:

- ILI protocols and case-investigation form available at the following websites:
http://www.phac-aspc.gc.ca/eri-ire/pdf/02-ILI-Surveillance-Protocol_e.pdf
http://www.phac-aspc.gc.ca/eri-ire/pdf/03-ILI-Report-Form_e.pdf
- Nosocomial and Occupational Infections Section, Centre for Communicable Diseases and Infection Control, PHAC <http://www.phac-aspc.gc.ca/nois-sinp/index-eng.php>

Appendix A

Point of Care Risk Assessment Tool for Human Cases of Swine Influenza A (H1N1)

Prior to any patient interaction, all health care workers (HCWs) have a responsibility to always assess the infectious risk posed to themselves and to other patients, visitors, and HCWs. This risk assessment is based on professional judgement about the clinical situation and up-to-date information on how the specific healthcare organization has designed and implemented engineering and administrative controls, along with the availability and use of Personal Protective Equipment (PPE).

Point of Care Risk Assessment (PCRA) is an activity performed by the HCW before every patient interaction, to:

1. Evaluate the likelihood of exposure to the Human Cases of Swine Influenza A H1N1 virus,
 - from a specific interaction (e.g. performing/ assisting with aerosol-generating medical procedures, other clinical procedures/ interaction, non-clinical interaction (i.e. admitting, teaching patient/ family), transporting patients, direct face-to-face interaction with patients, etc.),
 - with a specific patient (e.g. infants/ young children, patients not capable of self care/ hand hygiene, have poor-compliance with respiratory hygiene, copious respiratory secretions, frequent cough/ sneeze, early stage of influenza illness, etc.),
 - in a specific environment (e.g. single rooms, shared rooms/ washrooms, hallway, influenza assessment areas, emergency departments, public areas, therapeutic departments, diagnostic imaging departments, housekeeping, etc.),
 - under available conditions (e.g. air exchanges in a large waiting area or in an airborne isolation room, patient waiting areas);

AND

2. Choose the appropriate actions/ PPE needed to minimize the risk of patient, HCW/ other staff, visitor, contractor, etc. exposure to the Human Cases of Swine Influenza A H1N1 virus/suspect ILI case

PCRA is not a new concept, but one that is already performed regularly by professional HCWs many times a day for their safety and the safety of patients and others in the healthcare environment. For example, when a HCW evaluates a patient and situation to determine the possibility of blood or body fluid exposure or chooses appropriate PPE to care for a patient with an infectious disease, these actions are both activities of a PCRA.

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The PCRA tool consists of tables 1 to 4. A step-by-step description on how to use them follows:

- Step 1:** In Table 1, choose one of the physical setting and level of patient interaction options (in the highlighted column) using the description and example columns in the table.

Step 2: In Table 2, choose one of the patient clinical status and source control capability options (in the highlighted column) using the description and patient presentation column in the table.

Step 3: Using the matrix on Table 3, match the physical setting and level of patient interaction option from Table 1 (Step 1) with the patient clinical status and source control capability option identified from Table 2 (Step 2), to determine the appropriate level of precautions.

Step 4: From Table 4, determine what specific measures and personal protective equipment are indicated for the level of precautions identified in Table 3 (Step 3).

Table 1: Identification of the Physical Setting and Level of Patient Interaction

Physical Setting and Level of Patient Interaction	Description	Example
No Patient Interaction, Non-Clinical	Area with no patient access (restricted areas)	Non-clinical setting (medical record department, administrative office, central pharmacy, information technology office, central storage area, mail room, central maintenance areas, business office, etc.).
No Direct Patient Interaction and No Indirect Contact	No face-to-face interaction and no indirect contact with patients.	Hallways, cafeteria, public areas, clinical areas with no patient access (charting room, office, storage room, staff lounge, medication room, etc.), totally enclosed reception/triage areas.
Indirect Contact	No direct patient interactions; indirect contact only Contact with patient environment or contaminated inanimate objects	Discharge patient room cleaning, equipment cleaning.
Direct Patient Interaction	Direct, face to face interaction with patient (within 2m of the patient)	Providing patient care, home care visit, assisting with Activity of Daily Living (ADL), diagnostic imaging, phlebotomy services, physiotherapy, occupational therapy, recreational therapy, intra-hospital transport/portering, non-enclosed triage/registration area, cleaning patient bedspace while occupied, routine ambulance or inter-facility transport.
Direct Patient Interaction with Potential for Aerosol Generation	Performing and/or assisting with Aerosol Generating Medical Procedures (AGMP)	Open endotracheal suctioning, bronchoscopy, endotracheal intubation, tracheostomy procedures, nebulized therapy, cardiopulmonary resuscitation, nasopharyngeal aspirate/swab.

Table 2: Identification of the Patient Clinical Status and Source Control Capability

Patient Clinical Status and Source Control Capability	Description	Patient Presentation
Recovered from Influenza	Patient recovered from influenza	Influenza infected patient, beyond the known period of communicability
Influenza and Compliant or Weak Cough and Not Compliant	1) Patient with symptoms compatible with influenza with cough	Cough of any intensity and Adherence with respiratory hygiene Adherence to hand hygiene
	2) Patient with symptoms compatible with influenza with weak or no cough	Weak or no cough and Not adherent with respiratory hygiene Not adherent to hand hygiene
Influenza and Forceful Cough and Not Compliant	Patient with symptoms compatible with influenza	Forceful cough and Not adherent with respiratory hygiene Not adherent to hand hygiene
Influenza and AGMP	Patient with symptoms compatible with influenza	And an Aerosol Generation Medical Procedure (AGMP) is being performed

Note: If more than one risk level identified (e.g. multiple concurrent patient interactions), select the higher risk level.

Table 3: Level of Precautions Matrix

Patient Clinical Status and Source Control Capability	Physical Setting and Level of Patient Interaction				
	No Patient Interaction Non clinical	No Direct or Indirect Patient Interaction	Indirect Contact	Direct Patient Interaction	Direct Patient Interaction with AGMP
Recovered from Influenza	I	I	II	II	II
Influenza and Compliant or Weak Cough and Not Compliant	I	I	II	III	IV
Influenza and Forceful Cough and Not Compliant	I	I	II	IV	IV
Influenza and AGMP	I	I	II	IV	IV

Note: It is anticipated that the majority of patients with Human Swine Influenza A virus will be cared for using level II and III and a minority would be cared for using level IV precautions.

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Table 4 Personal Protective Equipment Required for the Level of Precautions for Human Cases of Swine Influenza A (H1N1)

	Hand hygiene	Respiratory hygiene	N95 Respirator	Mask	Eye Protection	Gown	Gloves
Level I	Yes	Yes	No Patient Contact – Not Required				
Level II	Yes	Yes	No, Except as per Additional Precautions*	As Per Routine Practices			
Level III	Yes	Yes	No, Except as per Additional Precautions*	Yes	Yes	As Per Routine Practices	
Level IV	Yes	Yes	Yes	No	Yes	As Per Routine Practices	

*Additional Precautions recommends an N95 respirator for known or suspected active tuberculosis or measles