



# **Peninsula Dental Social Enterprise (PDSE)**

## **Avian Influenza policy Version 3.0**

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Policy will be updated as required in response to a change in national policy or evidence-based guideline.

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## Avian Influenza (Management of) Guidelines

### 1. Summary

- 1.1 The probability of avian influenza infection should be considered in the context of appropriate clinical findings, relevant travel and contact history along with abnormal baseline investigations.
- 1.2 If avian influenza is suspected, the Infection Control Co-ordinator should be Informed. They will take responsibility for informing other relevant managers or external parties as required.
- 1.3 Transmission of avian influenza almost certainly occurs through multiple routes including large droplets and direct and indirect contact. Airborne or fine droplet transmission may also occur in certain situations such as a dental surgery.
- 1.4 Scrupulous attention to hand washing is particularly important after contact with a suspected case of avian influenza.
- 1.5 The follow up of staff contacts of avian influenza will be performed by the Occupational Health Department.

### 2. Policy objectives

- 2.1 This policy aims to:
  1. Ensure that patients infected with avian influenza receive effective and appropriate care
  2. Minimise the risk of transmission of avian influenza to patients, staff and visitors.

### 3. Introduction

- 3.1 Avian influenza is a disease of birds caused by type A influenza viruses closely related to human influenza viruses. It often causes little or no disease in wild waterfowl but can cause large outbreaks associated with high mortality in poultry. Transmission to humans in close contact with poultry or other birds occurs rarely and only with certain strains. However, large epidemics in birds increases the risk for genetic exchange and opportunities to infect humans. The acquisition of human genes during such outbreaks increases the likelihood of the virus crossing species barriers and human-to-human transmission. The potential for transformation of avian influenza into a form that both causes severe disease in humans and spreads easily from person to person is a great concern for world health and would provide conditions for the start of a pandemic. Avian influenza viruses are frequently highly pathogenic in humans and cause severe respiratory disease with high mortality, particularly in children.

## 4. Patient assessment

4.1 The probability of avian influenza infection should be considered in the context of appropriate clinical findings, relevant travel and contact history along with abnormal baseline investigations. The information that may be useful in assessing a case is given below.

4.2 As soon as the diagnosis of avian influenza is suspected, the patient would be referred to relevant healthcare provider, GP or hospital. :

### 4.3 Clinical presentation

The exact clinical presentation in avian influenza is still unclear. The median incubation period is around 3 days (range 2 - 4 days) and the median time to death after onset of symptoms is around 13 days. The main clinical features that have been reported are listed below:

- Fever
- Cough
- Sore throat
- Rhinorrhoea
- Myalgia
- Conjunctivitis
- Watery diarrhoea
- Severe unexplained respiratory illness.

If there is no fever, it is highly unlikely that avian influenza infection has occurred.

### 4.4 Case definition for suspected avian influenza

Please note that if epidemiological criteria are definitely fulfilled and the patient is severely unwell but with no respiratory symptoms the case should still be considered.

#### 1. Clinical presentation

Fever ( $\geq 38^{\circ}\text{C}$ ) OR history of fever AND respiratory symptoms (cough or shortness of breath) requiring hospitalisation.

OR

Death from unexplained respiratory illness.

AND

#### 2. Epidemiological criteria

History of travel in the 7 days prior to onset of symptoms to an area affected by avian influenza A (H5N1) AND close contact (within 1 metre) with live or dead domestic fowl, wild birds, or swine in any setting, including bird markets.

OR one of the following:

- Close contact (touching / speaking distance) with other case(s) of severe

respiratory illness or unexplained death from above areas

- Part of a Health Care Worker cluster of severe unexplained respiratory illness
- A Laboratory worker with potential exposure to influenza A (H5N1).

Although there is currently no evidence of Severe Acute Respiratory Syndrome (SARS) activity, the possibility of SARS should be considered in patients admitted with a severe unexplained respiratory illness with a history of recent travel to an area classified by WHO as having recent local transmission.

## **5. Isolation and Infection control procedures**

### **5.1. General**

The human influenza virus is transmitted from person-to-person through close contact with a coughing sneezing infected person. Transmission almost certainly occurs through multiple routes including large droplets and direct and indirect contact. Airborne or fine droplet transmission may also occur in certain situations, such as a dental surgery. Experimental studies of influenza virus survival suggest that the virus can survive for limited periods of time in the environment, be transferred from contaminated surfaces onto hands, and is easily inactivated by commercially available alcohol hand disinfectant. Thus, contact spread is likely to be important unless controlled by careful and frequent handwashing and environmental cleaning.

A quick reference guide for infection control for avian influenza is given in Appendix A.

### **5.2. Hand hygiene**

All staff should be familiar with PDSE policy on hand decontamination as described in the Hand Hygiene Policy. Prevention of transmission is based on rigorous hand hygiene before and after contact with patients and their potentially contaminated environments. Rings, wrist watches and wrist jewellery should be removed. Hands should be washed with soap and water at the start and end of clinical duties, when hands are visibly soiled or potentially contaminated and following the removal of gloves. Hands should be decontaminated after contact with a potentially infected patient, removal of protective clothing, and cleaning of equipment.

### **5.3. Record keeping**

A record of all staff and visitors that have contact with the patient should be kept. All healthcare workers and visitors should write their details on a recording sheet so that if follow up or contact tracing is required, details are available. Completed staff forms should be sent daily to the Occupational Health Department.

### **5.4 Waste**

- 5.4.1 All waste should be handled and disposed of as clinical waste as per PDSE Waste policy.

## **6. Management of exposed health care workers**

- 6.1 Any staff, supervisors or students who have had contact with an avian influenza patient or an environment that is likely to be contaminated are recommended to
- Notify the Occupational Health team and their GP immediately.

## **7. Infection Control Measures for Avian Influenza**

- 7.1 Items entering the room or area where patients with avian influenza are present must be cleaned or placed into an appropriate clean container before removal from the environment.
- 7.2 All persons should ensure that they clean their hands and remove the outside layer of PPE before exiting the room or area.
- 7.3 Patients who are suspected of having, or are confirmed as having, Avian Flu should have their dental treatment delayed until they are fully recovered.
- 7.4 Staff who are suspected of having, or are confirmed as having, Avian Flu should not attend work until they are fully recovered, or as advised by the Occupational Health or their GP.