

PANDEMIC (H1N1) 2009 INFLUENZA

Summary infection control guidance for ambulance services during an influenza pandemic



DH INFORMATION READER BOX

Policy HR/Workforce Management Planning/ Clinical	Estates Commissioning IM&T Finance Social Care/Partnership Working
Document purpose	Best practice guidance
Gateway reference	12221
Title	Pandemic influenza: Summary infection control guidance for ambulance services during an influenza pandemic
Author	DH and HPA
Publication date	December 2009
Target audience	Ambulance trust CEs, directors of infection prevention and control, infection control teams
Circulation list	PCT CEs, SHA CEs, medical directors, directors of PH, allied health professionals
Description	This document provides guidance and information on infection control procedures for ambulance services to inform and advise local planning for pandemic influenza
Cross reference	<i>Pandemic influenza: Guidance for infection control in hospitals and primary care settings</i> (November 2007)
Superseded documents	N/A
Action required	N/A
Timing	N/A
Contact details	Pandemic Flu Team Department of Health 451C Skipton House 80 London Road London SE1 6LH www.dh.gov.uk/pandemicflu
For recipient's use	

PANDEMIC (H1N1) 2009 INFLUENZA

Summary infection control guidance for ambulance services during an influenza pandemic

Contents

1	Introduction	1
2	Overview	2
3	Patient management	4
3.1	Acute transport services	4
3.2	Non-acute transport services	5
3.3	Transfer arrangements	5
3.4	Dealing with fatalities	5
4	Infection control precautions	6
4.1	Influenza transmission	6
4.2	Standard infection control precautions	7
4.3	Droplet precautions	8
4.4	Personal protective equipment	9
4.5	Environmental cleaning	13
4.6	Respiratory hygiene	14
4.7	Infection control for regional emergency operations centres and Gold Control	15
4.8	Staff uniforms	17
5	Occupational health	18

1 Introduction

The World Health Organization (WHO) raised its influenza pandemic alert level to Phase 6 during June 2009, reflecting the ongoing community-level outbreaks of H1N1 swine flu in many parts of the world.

The purpose of this document is to set out concise summary guidance for infection control for the ambulance services and it is intended for use during the pandemic. The guidance in this document is equally applicable to lay responders, who should adopt the same infection control and hygiene measures.

This guidance document includes sections on patient management, infection control precautions, use of personal protective equipment (PPE) and environmental infection control, as well as occupational health.

In the current climate, where knowledge about the new pandemic virus is limited, this guidance may need updating if emerging epidemiological and virological information on the virus indicates that it is necessary to change the approach to infection control. Readers are strongly urged to refer to the most up-to-date information on the Health Protection Agency website at www.hpa.org.uk

2 Overview

Key points

Emergence of a pandemic

- Pandemics arise when new viruses or other infectious agents emerge that cause disease in humans and become capable of being easily transmitted from one person to another, spreading throughout the world.
- Predictions based on previous pandemics indicate that clinical attack rates may be high (up to 30%) and almost the entire population will potentially be at risk.
- The pandemic virus is likely to spread throughout the country. If this happens, then ambulance trust staff, like other healthcare staff, will be equally as likely to encounter pandemic influenza in normal daily living, for example in the family home, as they will through their work.

Clinical features of influenza

- Influenza is a respiratory illness with a wide range of symptoms. The symptoms of pandemic influenza are similar to those of regular human seasonal influenza infection and include fever, fatigue, coughing, sore throat and lack of appetite. Some people with pandemic influenza have also reported vomiting and diarrhoea.
- People are most infectious soon after they develop symptoms, and can continue to excrete viruses for about seven days and longer in children and the immunocompromised.

How influenza is spread

- Influenza is spread from person to person through close contact. For seasonal influenza, the evidence suggests that transmission by droplet and through direct and indirect contact are the most important routes. Pandemic influenza is assumed to transmit from person to person in a similar fashion to seasonal influenza.
- Aerosol transmission may occur in certain situations, eg during aerosol-generating procedures such as intubation or bronchoscopy.

- Influenza viruses can survive on environmental surfaces for varying periods (on hard non-porous materials such as stainless steel, for up to 48 hours and on porous materials for up to 12 hours), but are easily killed by soap, alcohol handrub and household detergents and cleaners. Therefore there is risk of influenza being transmitted if contaminated surfaces are touched and then contact is made with the mouth, nose or eyes without first cleaning the hands.

Prevention of influenza transmission

Transmission of the influenza virus can be reduced through:

- strict adherence to infection control practices, especially hand hygiene, respiratory hygiene and the use of PPE according to risk of exposure
- instructing staff members with respiratory symptoms to stay at home and not come in to work
- restricting the transportation of others alongside symptomatic influenza patients
- environmental cleaning, particularly in ambulances and other transport
- education of staff and advising patients about how to minimise transmission.

The pandemic has moved from a containment to a treatment phase. The UK Government has a stockpile of oseltamivir (Tamiflu) sufficient to treat 50% of the population. However now the containment phase is over, unless there are special circumstances (such as a household member having serious underlying health problems), antiviral medication will no longer be offered to contacts of cases.

3 Patient management

Key points

- Patients should be assessed to determine the precautions necessary in order to reduce the risk of transmission of infection.
- Patients with suspected influenza who are scheduled for routine transport should not be conveyed and advice should be sought from control room staff, who will make an appropriate patient referral.
- The risk of infection from those who have died with influenza is low and is minimised by the careful use of standard infection control procedures.

3.1 Acute transport services

Information on the patient's condition will be gathered from a number of sources, including the control room, members of the public or healthcare professionals.

- The patient should be assessed to determine the precautions necessary in order to reduce the risk of transmission of infection (see section 4.4 for PPE).
- Many patients will not require hospitalisation and can be managed in the community; a referral to local primary care services should be made if appropriate. Advice to the patient should include reference to the National Pandemic Flu Service or to the patient's GP.
- If the patient is sufficiently ill enough to require hospital assessment and/or treatment, then the patient should be taken to the nearest appropriate emergency department. A pre-alert is only required for patients who are time critical and who would be taken to the resuscitation room. For routine calls, on arrival at the department the driver should liaise with the nurse in charge of the department prior to removing the patient from the vehicle.
- Acute trusts will be expected to have made specific arrangements for patients referred directly to admissions units with influenza-like symptoms.
- Patients suspected of having influenza should be conveyed without relatives where possible, with the exception of children. Should more than one family member require to be taken to hospital with suspected influenza, consideration should be given to transporting them together.

3.2 Non-acute transport services (patient transport services, ambulance car services, voluntary aid societies, volunteers and private ambulance services)

- Patient transport staff should be given up-to-date infection control guidance by their local ambulance trust.
- Patients with suspected influenza who are scheduled for routine transport should not be conveyed and advice should be sought from control room staff, who will make an appropriate patient referral.

3.3 Transfer arrangements

Ambulance trusts should undertake a risk assessment of all inter-hospital movements in order to reduce the transmission of infection.

3.4 Dealing with fatalities

- Routine referral procedures should be followed when a death occurs at home.
- The risk of infection from those who have died with influenza is low and is minimised by the careful use of standard infection control procedures, such as good hand hygiene and the use of appropriate PPE (gloves and aprons) for any handling. This is to protect from contact with respiratory secretions, which may have contaminated clothing or objects in the patient's environment.
- Body bags are not required unless there is a particular leakage problem. If death occurs during transport to hospital, routine procedures should be followed on arrival at the hospital.

4 Infection control precautions

Key points

- Standard infection control precautions and precautions against droplet transmission must be taken for patients with symptoms of influenza.
- Good hand hygiene and respiratory hygiene among staff and patients are vital for the protection of both parties and their families.
- The use of PPE should be proportionate to the risk of contact with respiratory secretions and other body fluids, and should depend on the type of work or procedure being undertaken.

4.1 Influenza transmission

The principles of measures taken to minimise the transmission of pandemic influenza are based on the premise that pandemic influenza has similar properties to seasonal influenza.

It is well established that influenza is transmitted through close contact with an infected coughing or sneezing person. Transmission almost certainly occurs through multiple routes, including droplets and direct and indirect contact. Aerosol transmission may also occur in certain situations. There is no evidence that establishes a clear hierarchy for modes of transmission, however, the patterns of transmission observed during outbreaks in healthcare settings often point to droplet and contact transmission as the most important and likeliest routes.

Experimental studies of survival of the influenza virus suggest that it can survive for varying periods in the environment, depending on the surface contaminated. It can then be transferred from contaminated surfaces onto hands.

Aerosol transmission may also occur under certain conditions. Aerosols (very small particles that can remain suspended in the air for long periods and travel over longer distances than droplets, allowing them to be inhaled by others who may be some distance away) can be generated by some procedures involving the respiratory tract. The importance of this type of transmission relative to droplet and contact transmission is uncertain (see section 4.4.2).

4.2 Standard infection control precautions

Standard infection control precautions must be used for all patients. These are a set of broad principles of good practice intended to minimise exposure to and transmission of infection and should be applied to the care of **all** patients, **all** of the time. Standard infection control precautions include hand hygiene, environmental cleaning, and proper procedures concerning blood and body fluid spillages, sharps, waste, linen and PPE.

4.2.1 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 precautions. 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 dirty they should be washed with soap and water (or a detergent wipe that is suitable for use on skin) and then thoroughly dried.
- Alcohol handrub can be used for decontaminating visibly clean hands. The process should take 15–30 seconds and must be carried out even if gloves have been worn.
- Avoid touching the face with hands that have not been cleaned, or with gloved hands.

Ambulance trust staff will be issued with a personal alcohol handrub dispenser, to be viewed as part of trust uniform. Staff should liaise with occupational health if they are concerned that they may have pre-existing conditions that would prevent use of the handrub.

Hands should be cleaned before:

- any direct patient contact
- eating, drinking or handling food
- taking a break/going home.

Using soap and water, alcohol handrub or a skin-friendly detergent wipe, unless otherwise stated, hands should be cleaned after:

- cleaning equipment or environment
- removing PPE, including gloves
- handling waste.

And after other activities or contacts that potentially result in hands becoming contaminated, including after blowing the nose or covering a cough or sneeze.

4.2.2 Gloves and plastic aprons

Gloves should be worn in accordance with standard infection control principles and must be worn as single-use items. They should be put on immediately before an episode of patient contact and removed as soon as the activity is completed. If glove supplies become limited or pressurised, glove use should be prioritised for contact with blood and body fluids, invasive procedures and contact with sterile sites.

Plastic aprons are worn to protect clothing from contamination.

4.3 Droplet precautions

Droplet precautions are required to prevent transmission of infection via respiratory droplets. Droplet transmission occurs as a result of droplets being expelled from the respiratory tract of an infected individual directly onto a mucosal surface (or conjunctivae) of another individual, eg during coughing and sneezing. When expelled, because of their relatively large size, droplets generally travel only short distances (typically less than one metre) before settling on surfaces.

4.3.1 Droplet precautions for patients during transport

- When transporting a patient with symptoms of influenza, the patient should be encouraged to wear a surgical mask to minimise droplet dispersal. The mask should be worn throughout the period of transport.
- If the patient cannot tolerate a mask, good respiratory hygiene should be encouraged and a tissue or similar can be offered to hold against their mouth and nose to 'catch' secretions from coughing, sneezing or blowing the nose.
- Patients suspected of having influenza should not be transported with other patients who do not have influenza.

4.3.2 Droplet precautions for staff

- A fluid repellent surgical mask will provide a physical barrier and minimise contamination of the nose and mouth by respiratory droplets and must be worn when working in close contact (within about one metre) with a patient suspected of having influenza.
- Putting a mask on only when within one metre of the patient is not workable, therefore, for practical reasons, ambulance staff should wear a surgical mask at all times when transporting patients with symptoms of influenza. The mask should be kept on for the duration of the transportation/activity or until the surgical mask requires replacement, eg it is wet or damaged.

Surgical masks should:

- cover both the nose and the mouth
- not be allowed to dangle around the neck after or between each use
- not be touched once put on
- be changed when they become moist
- be worn once only and then discarded in an appropriate receptacle as clinical waste – hand hygiene must be performed after disposal is complete.

4.4 Personal protective equipment

If a risk assessment and patient assessment indicate the possibility of influenza, then appropriate PPE should be worn before being in close proximity to, or having contact with, the patient. The risk assessment will include information provided prior to arrival at a scene.

4.4.1 PPE to be used for the care of patients with symptoms of influenza

- To protect from contact with respiratory secretions, an apron, gloves and a fluid repellent surgical mask (single use) should be worn for close patient contact.
- The patient should wear a surgical mask to minimise droplet dispersal if they can tolerate it. If the patient cannot tolerate a mask, good respiratory hygiene should be encouraged, and a tissue or similar can be offered to hold over their mouth and nose. Hand hygiene should then be offered to reduce environmental contamination.
- Risk assessment should be undertaken regarding the requirement for eye protection. If the assessment indicates that eye splashing is likely, then eye protection should be worn.

4.4.2 Aerosol-generating procedures

- Aerosol-generating procedures (AGPs) are procedures which generate tiny particles (aerosols) small enough to remain in the air for extended periods, travel long distances and be inhaled.
- The AGPs relevant to ambulance workers that are associated with an increased risk of respiratory infection transmission ie considered potentially infectious, are intubation (and related procedures, for example insertion of laryngeal masks, manual ventilation and open suctioning) and cardiopulmonary resuscitation.
- Unless absolutely essential, these potentially infectious AGPs should be avoided during transport of influenza patients.

4.4.3 PPE for AGPs

- When a procedure with the potential to generate infectious aerosols (see section 4.4.2) is undertaken, an **apron**,* **gloves**, an **FFP3 respirator** (single use) and **eye protection** should be worn.
- A correctly fitting respirator is critical to provide proper protection. Anyone likely to need to use a respirator should be **fit tested** and trained in the use of the respirator in compliance with Health and Safety Executive and Control of Substances Hazardous to Health regulations.
- A **fit check** should also be performed by staff before each use, according to manufacturer (or trust) instructions. A common way to fit check is to wear the respirator and pant hard a few times. The respirator should move in and out with the breaths if it is fitted correctly and there should be no air leaks from the sides.
- 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 are available and, where practical, should be considered if a good fit cannot be achieved with disposable respirators.
- Respirators should be replaced after each use and changed if breathing becomes difficult, if the respirator becomes damaged, distorted or obviously contaminated by respiratory secretions or other body fluids, or if a proper face fit cannot be maintained.
- Aerosols can travel further than droplets. If it is essential to carry out an AGP on a patient in a vehicle, the driver need not wear a respirator but instead should open the window to improve ventilation. Where possible a vehicle ventilation option that does not re-circulate air should be used. Gloves and an apron are impractical for the driver and unnecessary because at this distance there is minimal risk of respiratory droplets contaminating clothing.
- Care must be taken to ensure that all PPE is put on, worn and removed correctly in order to avoid inadvertent contamination (see section 4.4.5). All used PPE must be disposed of as clinical waste and reusable items such as eye protection must be cleaned according to manufacturer instructions.

* In hospital and other healthcare settings, when undertaking an AGP, a gown is part of the recommended PPE. However, since gowns are not supplied for ambulance work, an apron is recommended.

4.4.4 Use of 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 (including respiratory secretions) or excretions.
- An individual risk assessment should be carried out at the time of providing care.
- Eye protection should always be worn during AGPs.

Disposable, single-use eye protection is recommended.

4.4.5 Wearing and removing PPE

The level of PPE used will vary based on the procedures being carried out and not all items of PPE are always required. When all items of PPE are required, the following order for putting them on and removing them should be followed. The order given here for putting on is practical (but the order for putting on is less critical than the order of removal):

Putting on PPE

1. Apron

- Apron – put on as illustrated and fasten at back of waist.
- Fasten at back of neck and waist.



2. Surgical mask (or FFP3 respirator for an AGP)

- Secure ties or elastic bands at middle of head and neck.
- Fit flexible band to nose bridge.
- Fit snug to face and below chin.
- Fit check if using a respirator.



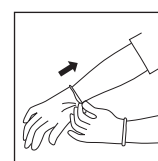
3. Eye protection (for an AGP and as appropriate after risk assessment)

- Place over face and eyes and adjust to fit.



4. Disposable gloves

- Extend to cover wrist.

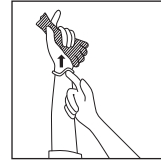
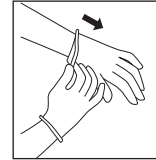


Removing PPE

PPE should be removed in an order that minimises the potential for cross-contamination:

1. Disposable 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 ungloved hand under the remaining glove at the wrist.
- Peel the second glove off over the first glove and discard appropriately.



2. Apron

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



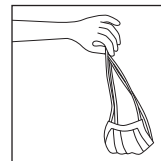
3. Eye protection

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



4. Surgical mask (or FFP3 respirator)

- 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.

4.5 Environmental cleaning

4.5.1 Cleaning vehicles used for patient transport

The following advice applies to all vehicles used for conveying patients, including **A&E** (accident and emergency), aircraft (both fixed and rotary wing), **PTS** (patient transport services), **RRV** (rapid response vehicle), **HCS** (hospital car service), **CFR** (community first responder) and others as deployed.

- Vehicles should be **checked and clean** at the commencement of a shift.
- **Routine cleaning** should be undertaken after each patient journey. A solution of detergent and warm water or detergent wipes should be used and particular attention should be paid to areas within about one metre of the patient (surfaces within this distance from the patient are more likely to have been contaminated by respiratory droplets). Stretcher cots, mattresses, manual handling equipment and horizontal surfaces in the ambulance, as well as fixtures and fittings (including the cab area) that are frequently handled should be cleaned and allowed to air dry (or paper towels can be used to accelerate drying). Appropriate PPE must be worn for cleaning, ie gloves and a plastic apron. Although sufficient supplies of PPE should be carried in vehicles, carriage of excess supplies of other equipment should be avoided in order to keep items at risk of contamination to a minimum and to reduce cleaning workload. Influenza viruses are inactivated by detergent so it is not necessary to enhance routine cleaning with chlorine-based disinfectants. **Note: chlorine-based disinfectants** cannot be used in aircraft and cars (they are corrosive to some metals and also cannot be used on soft fabrics including carpets, seats etc).
- **Surfaces contaminated by blood or other body fluid excretions or spillages**, eg vomit, should be cleaned according to routine ambulance trust procedures for such contaminated surfaces, ie as soon as possible using water and detergent (or detergent wipes) followed by the use of chlorine-based disinfectant/spillage kits. Appropriate PPE must be worn. Contaminated disposable items should be discarded as clinical waste and equipment such as monitors and suction devices should, where possible, be removed and manufacturer's cleaning guidelines followed.
- **Fresh linen** must be used for every patient in accordance with the Department of Health *Ambulance guidelines* (2008) (available at www.clean-safe-care.nhs.uk). If the linen appears to be visibly contaminated then it should be treated as infected and handled according to local trust policy.
- **Floors** are a low risk for the transmission of influenza. They should be cleaned using warm water and detergent at least once during each shift, and more frequently if visibly contaminated. If contaminated with blood or body fluids, ambulance trust procedures for contaminated surfaces should be followed.

- **Air conditioning:** There is no evidence to suggest that air conditioning systems increase the risk of infection to patients or staff. Routine maintenance should occur with regular changes of filters according to manufacturer recommendations. Ventilation systems that re-circulate air should not be used during AGPs.
- **Cars:** Transportation by car should only be undertaken following a thorough risk assessment. Ideally, cars should not be used for patients with respiratory symptoms because they cannot be cleaned effectively due to the presence of soft fabrics. If transport by car is unavoidable, plastic seat covers should be used to protect seats and disposed of between patients. Hard surface areas in cars within one metre of the patient (such as dashboards) should be cleaned according to routine cleaning (see above). If patients are transported in the front of cars then they should wear a surgical mask to minimise droplet spread to the driver.

4.5.2 Other environmental cleaning

Good environmental cleaning is important throughout ambulance trusts. In addition to transport, this includes ambulance control rooms, stations, offices and workshops.

- In non-patient transport areas, hard surfaces should be cleaned at least twice a day using detergent wipes or equivalent. Table tops, handles and other frequently touched surfaces should receive particular attention.
- Gloves and a plastic apron should be worn when undertaking environmental cleaning.

4.6 Respiratory hygiene

Respiratory infections spread easily. Like many infections, influenza is almost certainly transmitted via multiple routes. One of the most likely and most important routes is via respiratory droplets (eg coughing). Because of their relatively large size, droplets generally travel only short distances (typically less than one metre) before settling on surfaces. Contact transmission from contaminated surfaces where droplets have landed is also highly likely.

Patients

During assessment in the home and during transportation, as part of droplet precautions influenza patients should be encouraged to wear a surgical mask in order to minimise droplet dispersal. If the patient cannot tolerate a mask, good respiratory hygiene should be encouraged, for example tissues or similar can be offered to hold against their mouth and nose. Hand hygiene should then be offered.

Staff

Staff should not work if showing influenza symptoms but awareness of good respiratory hygiene is important for everyone. Respiratory hygiene, especially when combined with hand hygiene and environmental cleaning, will reduce the risk of transmission:

- Influenza viruses spread easily – tissues should be used to catch any coughs and sneezes and disposed of promptly and carefully, preferably in a lined bin.
- Hands should then be cleaned as soon as possible.

4.7 Infection control for regional emergency operations centres (EOCs) and Gold Control

- Access will be limited to those staff working directly in the area (access doors will remain locked and staff must knock and wait or use intercoms).
- Alcohol handrub will be situated at access points – staff should use these before entering and upon leaving.

All staff are to comply with the following hygiene advice:

- Use a tissue (not a handkerchief) when coughing or sneezing or blowing the nose.
- Dispose of used tissues carefully and promptly, preferably in a lined bin.
- Clean hands frequently by washing with soap and water or using alcohol handrub or a skin-friendly detergent wipe.
- Alcohol handrub can be used for decontaminating visibly clean hands. Staff will be issued with a personal alcohol handrub dispenser to be viewed as part of trust uniform. Using alcohol handrub for cleaning hands should take 15–30 seconds and must be carried out even if gloves have been worn.
- Clean hard surfaces (such as desks and door handles) frequently using a detergent wipe.

Hands should be cleaned **before**:

- entering EOC
- taking a break or going home
- eating, drinking or handling food.

Using either soap and water, alcohol handrub or a skin-friendly detergent wipe, unless otherwise stated hands should be cleaned **after**:

- using the toilet (using soap and water or a skin-friendly detergent wipe)
- blowing the nose or covering a cough or sneeze
- cleaning equipment or environment
- handling waste.

It is imperative that staff displaying symptoms of influenza do not attend work in order to prevent the spread of infection to colleagues (see section 5). Staff developing influenza symptoms while at work will be instructed to return home until well and symptom-free.

Environmental cleaning

Cleaning programmes will be enhanced in EOCs and Gold Control.

Members of staff should take responsibility for cleaning their own workstations regularly. Each workstation will be provided with detergent wipes, which are safe to use on hands and hard surfaces as well as computer screens etc.

The following equipment used and shared by staff should be cleaned **before** commencing work at the station and at the **end** of the shift:

- workstation horizontal surfaces.
- keyboard, mouse and monitors.
- telephone, keypad and handset.
- headsets, including ear piece and microphone.

In addition to this, staff should ensure that areas are kept generally clean and tidy in order to facilitate cleaning. Staff should only eat food in designated areas within regional EOCs and Gold Control, and not at individual workstations.

Cutlery and crockery should be washed after use as usual, in a dishwasher or using hand-hot water and washing-up liquid.

4.8 Staff uniforms

- A clean uniform should be worn each day and changed if visibly contaminated.
- Ambulance workers should not travel to and from work in uniform.
- Ideally, facilities should be provided where staff can change into uniforms upon arrival at work.
- Used uniforms should be transported home in a plastic bag and laundered separately from other linen in a domestic washing machine, washed at the hottest temperature suitable for the fabric, then ironed or tumble-dried.

5 Occupational health

- Ambulance trust staff with symptoms of influenza should not come to work and should report such illness to their line manager promptly.
- Staff with influenza should be encouraged to complete a course of antivirals (if prescribed) and return to work when they are well and symptom-free.
- Staff at high risk of complications from influenza, eg pregnant women, should not provide direct patient care to people with suspected influenza.
- Bank and agency staff should follow the same deployment advice as permanent staff.
- Occupational health should lead on the implementation of systems to monitor for illness and absence.
- As part of their employer's duty of care, occupational health departments or providers have a role to play in ensuring that fit testing programmes are in place for those who might need to wear respirators.
- Occupational health departments or providers should facilitate staff access to antiviral treatment where necessary in line with ambulance trusts arrangements in this area and implement a vaccination programme for the workforce when required.

