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Pandemic Influenza – Primary Care

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Glossary and Abbreviations

**ALERT phase**  Being alert to the risk of a pandemic and preparing for a pandemic.

**Attack rate**  The number/percentage of people who become infected with the pandemic influenza virus, calculated on the basis that there is no vaccine or treatment available at that time for the general population (estimated by WHO (2006) for planning purposes that this be based on 25% of the population, but this may vary widely). AHMPPI 2008 estimates 40% unmitigated clinical attack rate and 10% mitigated attack rate.

**ARDS**  Acute respiratory distress syndrome

**AHMPPI**  Australian Health Management Plan for Pandemic Influenza

**AI**  Avian influenza

**Antigenic drift**  A random and gradual accumulation of mutations in viral genes that are usually recognized by the immune system.

**Antigenic shift**  A major change in the virus which can occur in one of two ways:

- **Re assortment** - where two different strains of influenza combine to form a new subtype having a mixture of the surface antigens of the two original strains. This is thought to be able to occur if an animal or human is infected with both viruses at the same time.

- **Adaptive mutation** – which is a change in the genes of an animal influenza virus which may allow the virus to infect and be transmitted easily between humans.

Antigenic shift only occurs in Influenza A viruses.

**Antivirals (PI)**  Drugs used which limit the multiplication of the pandemic influenza virus and may reduce the severity and duration of the influenza symptoms.

**ASPREN**  Australian Sentinel Practice Research Network

**Business Continuity Plan**  Action plan developed by an organisation for implementation during a risk event to enable the organisation to continue to deliver key services, or key products. Follows on from the identification of risks which might affect an organisations’ activities during a risk event, and the development of strategies to reduce the impact of those identified risks.

**CDCB**  Communicable Disease Control Branch (part of the Department of Health)

**Community Flu Clinic**  A stand-alone flu assessment clinic established in a suburban area where widespread transmission of pandemic influenza is occurring, aimed at safe medical assessment and management of people with suspected pandemic influenza; and decreasing the number of patient presentations/demand for service at...
hospital EDs and GP practices

**Contact**

A person who has had close contact with a suspected or confirmed case of pandemic influenza, including physical exposure to that individual’s respiratory droplets or secretions, which places them at risk of acquiring the pandemic virus.

**CONTAIN phase**

Once the pandemic virus does arrive in Australia, limiting the early spread.

**Contact tracing**

The process of identifying and contacting people who have been ‘in contact’ with someone who has an infectious illness.

**DELAY phase**

Once the pandemic virus emerges overseas, keeping the virus out of Australia.

**DITR**

Department of Industry, Tourism and Resources

**Environmental hygiene**

Practical prevention and control measures used to improve the basic environmental conditions affecting human health.

**Chief Medical Officer’s Expert Advisory Group (EAG)**

Technical advisory committee which provides medical, scientific and epidemiological advice to the Commonwealth Chief Medical Officer on the pandemic phase and the triggers that should be considered when a decision is made to change the phase.

**Fomite**

An inanimate object or substance capable of carrying infectious organisms (such as germs or parasites) and hence transferring them from one individual to another.

**Front line worker**

Health professional who works in a services that forms part of the health sector response sanctioned by the state and territory health department, and provides direct patient care to a person suspected of, or confirmed of having pandemic influenza, and is considered to be at high risk of exposure to the pandemic virus.

**GPSA**

General Practice South Australia

**HCW**

Health Care Worker

**Home quarantine**

The requirement of an individual to stay at home (voluntarily) until 7 days have elapsed since his/her last exposure to a person suspected of, or confirmed of having pandemic influenza, providing he/she has not become symptomatic during that time.

**Incubation period**

The time interval between initial contact with the virus and the first appearance of symptoms associated with the infection.

**Infectious**

Capable of spreading disease; or a disease that is capable of spreading (also known as communicable).

**Infectivity**

In epidemiology, infectivity refers to the ability of a pathogen to establish an infection.

**Influenza Type A**

A type of influenza virus that occurs in humans and animals.
Pandemic Influenza – Primary Care

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Isolation
The requirement for a person suspected of having pandemic influenza to be isolated/separated from other people until the period of their infectivity is over and all symptoms of pandemic influenza have disappeared, in order to prevent or limit the direct or indirect transmission of the virus.

Mitigate
To diminish or lessen (as it relates to a virus increasing greatly or multiplying).

Pandemic
Epidemic on a global scale of an Influenza Type A virus

PCMiP
Primary Care Management in an Influenza Pandemic

PCR
Polymerase chain reaction

PI
Pandemic influenza

POCT
Point of care testing

Point of arrival screening
Checking of individuals/patients for flu symptoms at the entrance to a doctor’s surgery, ED, the workplace, airport, etc to reduce the risk of spreading the pandemic influenza virus.

PPE
Personal protective equipment that is worn by an individual to protect them or others from infection.

Prophylaxis
Medical or public health procedure designed to prevent infection, rather than treat or cure existing disease.

Pre-exposure prophylaxis
A dose or doses of a drug (usually antibiotic or antiviral) given before exposure to an infectious disease to protect the person from being infected.

Post-exposure prophylaxis
A dose or doses of a drug (usually antibiotic or antiviral) given immediately after exposure to a disease (such as influenza) but before onset of illness.

Quarantine
The limitation of freedom of movement for a period of time of well persons who are likely to have been exposed to the virus (‘contact’) to prevent their contact with people who have not been exposed.

RACP
Royal Australian College of Physicians

RACGP
Royal Australasian College of General Practice

RDNS
Royal District Nursing Service SA

RECOVER phase
Once the pandemic is under control, returning to normal, while remaining vigilant.

Recovery
The coordinated process during and after a pandemic of assisting affected communities and businesses in the restoration of emotional, social, economic and physical well-being, achieved through the
provision of information, specialist services and resources.

**SAAS**  
South Australian Ambulance Service

**SDC**  
State Distribution Centre

**Social distancing**  
Measures used to reduce the physical and social interaction of people to slow the spread of the pandemic influenza virus in the community (e.g. modification of workplace practices, closure of schools and child care centres, cinemas and nightclubs, cancellation of sporting events, etc.).

**Shed**  
Ability to cast off (shed) the virus and transmit infection up to one day before onset of symptoms. Peak shedding occurs in the first two days of illness. Children will shed a greater amount of virus and may shed for longer.

**SUSTAIN phase**  
Sustaining the response, while waiting for a pandemic vaccine.

**Triaging**  
The sorting and allocation of treatment to patients (on arrival at a hospital ED, or GP surgery), according to a system of priorities to determine their urgency status for receiving clinical care.

**Vaccine**  
A medication that stimulates the production of antibodies to protect against a specific disease.

**Vectors**  
Mediums for transfer of a disease causing organism to another.

**Viral transport medium**  
Container (plastic sealed tube) in which a viral swab is transported to the SA Pathology Service for diagnostic testing for the pandemic influenza virus.

**Virulence**  
A measure or degree of an organism’s (pathogen) capacity to cause disease (virulence = infectivity + invasiveness + toxigenicity).
Introduction

Scope

It is important to note, there are no links within this document to any referenced sub-plans. To obtain a copy of a sub-plan please utilise the links within the strategic document South Australia Pandemic Influenza Plan available on the SA Health website.

What is Primary Care

Primary care is the first point of call for the majority of individuals seeking health care external to the provision of care in a hospital or specialist setting.

Primary Care incorporates multiple agencies and organisations, all of which link together and will play a vital role in planning for an influenza pandemic, both at the prevention and preparedness, response and recovery phases.

Hospitals will not have the capacity, or need, to care for all influenza cases, and much of the focus of pandemic flu planning in South Australia will be on care that can be provided in the community.

The primary care response will need to be built from the community based organisations and health care workers upwards, and not be a hospital-centric outreach response.

While it is hoped that Government established Community Flu clinics (refer to Community Flu Clinic sub-plan) will be able to take much of the load arising from pandemic influenza off general practitioners (GP) and hospitals, GPs will be an integral part of the pandemic response.

Other primary care providers and organisations will also be involved with the delivery of information, advice and home care (e.g. pharmacists, Royal District Nursing Service (RDNS), telephone information health lines, Department of Families and Communities etc.).

Stakeholders

The stakeholders for primary care comprise those who provide services, as well as those who finance, organise and regulate primary health care.

In addition to general practitioners and locum services, primary care services during an influenza pandemic may also be provided by:

> community pharmacies (for advice, initial assessment, directing people to home care, general practice, or community flu clinics);
> private allied health workforce e.g. physiotherapists, chiropractors, podiatrists;
> RDNS and other nursing agencies;
> Domiciliary Care SA;
> community health centres;
> community health nurses in country health services;
> long term residential care including nursing homes (e.g. aged care, hostels, correctional services)
> Nunkuwarrin Yunti and other community based Aboriginal health services;
> community support through the Department of Families and Communities;
> AIDS Council of South Australia (ACSA) and Adelaide Diocesan AIDS Centre (ADAC); and
> Migrant Health Service.
Other organisations with specific briefs for the provision of services to people with identified welfare or social needs may also provide services during a pandemic:

> local government councils;
> organisations such as Anglicare SA, Uniting Care Wesley, the Salvation Army, St Vincent de Paul etc.;
> organisations providing services to Cultural And Linguistically Diverse (CALD) communities such as the:
  - Migrant Resource Centre of South Australia (MRC); and
  - Multicultural Communities Council of SA Inc (MCCSA).

Whilst the information provided within this Primary Care sub-plan is primarily for General Practice, much of the content in this plan would be useful for all the primary care service providers listed.

**Effect of Pandemic Influenza on Primary Care providers**

Modelling by the Department for Health and Ageing (DHA) Communicable Disease Control Branch (CDCB) in 2006 indicated that a 25% pandemic influenza attack rate is possible in South Australia. This would cause illness in an estimated 370,000 people over a period of eight (8) weeks, although it is believed by some that this may be an underestimation. The modelling does not allow for the impact of antivirals or vaccines.

A 25% attack rate would result in approximately:

> 46,000 new cases a week;
> 2,600 more deaths per month (more than twice the usual number);
> 9,500 excess hospitalisations per week.

It is estimated that there are approximately 1400 FTE general practitioners in South Australia, whilst the total number is around 2300. Assuming that 40% of the affected people attend their GP clinic only once, and 10% see their GP twice during their illness, this would evaluate to about:

> 23,000 extra GP consultations per week (12 extra patients per week/doctor).

These calculations assume that all general practitioners are available, that the illness is evenly distributed in time and place throughout South Australia and GP services are distributed in proportion to the population.

Assuming that 75% of GPs were working during any week, and all of these were working full-time, each would see an extra 17 patients per week (based on approximately 1400 FTE GPs).

The impact of the pandemic influenza attack rate on the ability of primary care providers to continue to provide services will therefore be severely taxed, with the possibility that some providers may not be able to continue to provide care due to illness, work overload, family and other pressures.

**General Practice Planning & Preparedness**

General practitioners play a central role within the primary care sector seeing approximately 85% of the Australian adult population every year.

Some general practices may not be able to cope with the predicted increase in patient consultations during a pandemic. Many practice staff may be ill themselves (up to 1 in 4) and practices may need to implement their pandemic practice plan in order to cope. They may elect to reduce their working hours, pool resources or amalgamate with other practices within their division, or close entirely.
General practice will therefore need to be well prepared for an influx of potential pandemic influenza patients prior to being advised of the imminence of a pandemic. They should consider suspending some face-to-face consultations (e.g. repeat prescriptions, pap smears) and offer some clinical services by telephone to ensure the health and welfare of staff and patients during a pandemic.

Partnerships with other health services and community providers are important for general practice planning. Regional and particularly rural hospitals have a vested interest in ensuring that there is a locally planned response to pandemic influenza to prevent potential cases flooding hospitals as the common reaction.

A pragmatic model for primary health care planning by key groups within the local community would be for at least three lead organisations within a region to drive the process of pandemic preparedness and planning. The local Divisions of General Practice, the local hospital/community health service and the local district council could take this lead role in ensuring regional primary care planning for pandemic influenza. This would ensure that there is a coordinated approach to planning and response during a pandemic and that all stakeholders are aware of their roles and responsibilities during a disaster.

Essential to preparation for an influenza pandemic in the first instance is business continuity planning.

**Business Continuity**

**Preparing for a Pandemic**

The Commonwealth Government Department of Industry and Science prepared a Business Continuity Guide for Australian Businesses (2006) which has a lot of useful generic material applicable to general practice and other primary health care services. This document can be obtained from the Commonwealth in hard copy or website by clicking [here](#).

In addition the South Australian government Department of State Development have also developed Disaster management tools around Business Continuity to assist small businesses with their planning which can be viewed by clicking [here](#).

Some disruption to normal community life will be inevitable during a pandemic. However, with good planning and preparation this can be minimised. All businesses and essential services should be developing business continuity plans and raising the awareness of their staff about pandemic influenza.

The South Australian Pandemic Influenza Plan includes engagement with primary care providers, to ensure that these providers seriously consider and plan for the impact of a pandemic on their service.

There are several practical and important reasons for this:

- Employers are required under *Work Health and Safety Act 2012* (SA), *Work Health and Safety Regulations 2012* (SA), Codes of Practice, and supporting policies and practices to provide a safe working environment for their employees;
- There is the ethical and medico-legal requirement to provide best practice care to users of the service; and
- Planning is an essential Risk Management exercise.

Despite best efforts, people will become ill and could die. However, with good planning and implementation, illness and deaths can be minimised. In addition, good management will lead to less people being afraid to come to work. Hence, primary care providers MUST develop a plan of action for their practice or organisation.
Developing a Practice Plan

The Practice Pandemic Influenza Plan should outline how the practice will prepare for and then function during a pandemic. All general practices should have a practice pandemic plan.

Coordination

> Nnominate a Pandemic Coordinator to plan for the event of an influenza pandemic. Ensuring that the plan can also be utilised during a high impact seasonal flu season.

> The Pandemic Coordinator could be the person responsible for infection control in the practice, a nurse or another staff member. They would:
  - coordinate pandemic activities that relate to the practice;
  - work with practice staff to develop a practice pandemic plan that identifies staff resources (e.g. reserve/back-up staff), key tasks and clarifies roles and responsibilities;
  - review necessary infrastructure (e.g. personal protective equipment (PPE) supplies, practice environment, communications, Internet/Broadband access etc.);
  - maintain close contact with the local Division of General Practice, the DHACDCB and the local council Public Health Unit;
  - organise education and training sessions for staff and practice ‘dry runs’ for a pandemic situation.
  - Appoint a ‘back up coordinator’ in case of illness.

Refer to: APPENDIX 1 for a more detailed outline of the role of the Pandemic Coordinator.

Consider organisational changes during a pandemic

Practices need to prioritise key tasks and consider:

> proactively seeking information updates from the DHA and the CDCB;
> a process for seeing a patient with a fever or a patient with suspected influenza like illness (ILI)
> writing prescriptions for a longer period of time and a process for patients obtaining repeat prescriptions that avoids unnecessary contact with the surgery;
> a process for booking appointments and telephone consultations (see Triage);
> reviewing and rationalising visits for preventive purposes or routine monitoring;
> home visiting policy and associated risks to staff (refer to Visiting patients at home);
> safe triage areas (possibly outside the practice);
> providing masks for patients with coughs at the door of the reception / waiting room;
> clinic security (for antivirals, PPE, PI vaccines).

Practices need to ensure that there are PI policies and protocols in place for all components of preventing and managing an influenza pandemic, including:

> triage (see Triage);
> changes to workloads and rosters of practice staff;
> laboratory testing and notification (refer to Diagnostic testing sub-plan);
> handling and disposal of infectious materials and used PPE;
> cleaning and waste disposal.
Practice environment

Prior to a pandemic
Instituting changes to the practice environment will have immediate benefits for the prevention and control of other respiratory illnesses. These include:

> provision of patient education material/signage/posters on walls;
> reviewing the waiting room layout for separation of potentially infectious patients,
> removal of commonly handled items from waiting rooms such as books, magazines and toys to reduce the chance of these acting as a vector for spreading infection;
> minimising the spread of infection through provision of non-touch waste receptacles for used tissues, etc.;
> regular cleaning of surfaces that are frequently handled such as hand rails, door bells and door handles (at least daily) with detergent and water followed by a disinfectant (such as 1000ppm sodium hypochlorite or an alcohol wipe).

During a pandemic
The following additional physical changes to premises are suggested:

> establish a well ventilated triage area for coughing patients (e.g. front of practice in a separate room, outside practice in a shaded area or in the practice car-park);
> establish quarantine areas for managing patients who are potentially infectious (e.g. > 1 metre rule);
> implement layout changes in waiting and consultation room to limit the spread of infection (e.g. reception area, doctor’s desk and chairs >1 metre apart);
> provide hand-washing signs and soap dispensers over sinks, alcohol hand rub in waiting room;
> provide tissues and non-touch waste bins for patients;
> providing a “hygiene station” at the entrance to the practice with supplies of tissues, surgical masks and alcohol hand rub;
> removal of toy box and magazines.

Infection control procedures

> Identify an infection control coordinator for the practice with responsibility for developing infection control policies and procedures and implementation of these (hand hygiene, cough etiquette, use of PPE, waste handling). This could be the same person as the practice pandemic coordinator.
> Ensure all practice staff receive training in standard and additional infection control precautions.
> Establish a system for rotation and maintenance of stocks of PPE and other items (refer to Appendix 3 – Checklist for PI).
> Develop protocols to handle suspected cases of pandemic influenza appropriately.
> Display posters/information in the practice that informs patients of the key elements of infection control (hand & respiratory hygiene).

Refer to: the Department for Health and Ageing Influenza Management Guidelines at SA Health Influenza Guideline or to the RACGP website at www.racgp.org.au/
Treatment with Antivirals

The use of antiviral medication during a pandemic influenza will depend on the phase of the pandemic in Australia and on availability according to the Commonwealth’s National Medical Stockpile (NMS) which States/Territories will receive when an influenza pandemic occurs. Antiviral treatment will be closely monitored at the State/Territory and Commonwealth level.

Refer to: the Antiviral Distribution sub-plan

General practices will need to consider the appointment of a staff member to:

- receive antivirals delivered to the practice by the SA State Distribution Centre (SDC);
- supervise storage of the antivirals in a secure locked area with restricted access;
- monitor and record the distribution of antivirals; and
- notify the Commonwealth of any adverse events in relation to the use of antivirals

Immunisation

- Vaccines used for seasonal influenza use will not protect against a pandemic strain which by definition is new and unpredictable.
- Seasonal influenza vaccination has been shown to reduce the risk of hospitalisations and death from influenza and pneumonia in at risk groups. Vaccinated health care workers reduce the risk of transmission to the vulnerable patients they care for.
- Additionally, seasonal vaccination programs build infrastructure which can be used to implement a mass vaccination program in the event of a pandemic. Therefore, practices should consider the following strategies:
  - implement practice policies recommending influenza vaccination of all practice staff;
  - promote seasonal flu vaccine to all patients;
  - promote Pneumovax to eligible patients;
  - ensure vaccination of practice staff when a pandemic vaccine becomes available;
  - promote seasonal flu vaccine and Pneumovax among practice staff.

Refer to: the Vaccination sub-plan

Workforce Issues

Surge demand

During a pandemic the workload from a practice’s existing patients is certain to increase dramatically with patients presenting with influenza like symptoms.

To manage demand and ensure business continuity, it will be important for general practices to consider how they will cope as soon as a pandemic becomes inevitable.

Workloads generated by existing practice populations are only manageable because most people are not sick at the same time.

- Estimate current clinic workload and activities and number of extra sessions that could be offered.
- As there will be little capacity to take on new patients:
  - identify who is prepared to continue working/will not be working during a pandemic;
  - identify if there is any additional capacity in the practice workforce to expand hours/take on other clinical tasks;
▪ consider how to share the load with all clinical staff in the practice.

▶  Estimate how many clinical consultations could be freed up by delegating, delaying, and by improved triage
  ▪ consider making other arrangements for regular attendees and patients with chronic stable conditions to be seen by practice nurses.

▶  Practices should:
  ▪ identify patients with chronic conditions and rationalise management;
  ▪ draw up clear management plans for patient care (suitable for use by locum services, non-medical staff and RDNS); and
  ▪ ensure patients are kept up-to-date with influenza and pneumococcal vaccination where appropriate.

▶  Many patients with serious medical conditions who, under normal circumstances, would require hospital admission will need to be managed at home by GPs. Due to risks of infection, even assessment of such patients at GPs’ rooms may not be feasible.

▶  Telephone consultative support for GPs by local hospital specialists may save many lives during an influenza pandemic. Divisions of General Practice should be encouraged to establish such links as soon as possible and inform practices within their Division of who can provide advice.

Pooling resources

▶  Specific issues to consider before and during a pandemic are whether the practice:
  ▪ will be able to stay open with the expected significant increase in patient workload (e.g. staffing, facilities);
  ▪ can continue to provide care in a manner that is safe for patients and staff;
  ▪ should consider the need to pool resources with other general practices in close vicinity of each other, or between Divisions of General Practice
  ▪ how else could doctors and other staff be able to contribute if the practice closed.

▶  It will be therefore be necessary to monitor and review the situation in the practice on a regular basis during a pandemic to determine whether it should pool resources, amalgamate with another practice, or close.

Locum Agencies

Locums are likely to have a key role in the care of pandemic influenza patients within their homes.

▶  A locum GP may be the health care provider who has first contact with a person suspected of having pandemic influenza, given that people returning home from overseas may call after-hours for a consult.

▶  Locum agencies will need to be included in the planning for a pandemic.

▶  Locum agencies’ medical staff will need to be fit-tested for P2 N95 masks.

Absenteeism/leave arrangements/payment of staff

Issues to address are:

▶  discussing and acknowledging staff beliefs/preferences about continuing to work (risk to themselves and their families) and taking these into account for PI planning;
> staff absentee policy (e.g. staying home if respiratory symptoms in self/family) including length of
time for absence;
> skeleton staff on rosters, others on leave (paid/unpaid);
> rosters with contingency planning;
> delegation/substitution of work;
> policies, protocols and standards developed are systematically reviewed and maintained using
continuous quality improvement principles.
> Monitoring of OHS & W issues in the practice

Information in relation to work safety and relevant legislation is available from SafeWork SA at

General Practices should:
> keep records of health care workers who have received seasonal flu vaccination;
> monitor all staff for the emergence of influenza-like illness, including self-monitoring of GPs and
other clinical staff;
> maintain screening protocols for the identification of potential cases;
> keep records of health care workers who have attended patients with suspected or confirmed
pandemic influenza; and
> ensure that staff symptomatic with suspected or confirmed pandemic influenza should be sent
home or remain at home.

Practice staff education
Including GP’s, practice nurses, administration and other staff
> It is important that practice staff are up-skilled as they may be required to take on/perform other
duties outside of their job description.
> Reception staff should be taught how to record a basic patient history of influenza like illness
(including telephone details of symptoms)

Refer to: 4.1.5 Box 1 on Screening Questions – POINT OF ARRIVAL

4.1.6 Box 2 on Screening Questions - TELEPHONE

> All practice staff should receive education in basic infection control principles.

Protection of self/family/home life
> Provision of antivirals will only be available for frontline workers (not for their families).
> It may become necessary to care for seriously ill family members at home with little or no outside
help.
> The principles of infection control at home will be no different from those at work, although
implementation may be more difficult. Pharmaceuticals and equipment may become scarce or
unobtainable due to high demand, disruption to manufacturing, and border closures.
> A family emergency kit is advisable plus a fortnight’s supply of non-perishable food.
> When the pandemic infection is widespread in the community, GPs and their staff may consider
living away from their families while on a duty cycle and for the duration of the incubation period
after that.

• Options to consider are sleeping at the practice rooms. At least some re-organization within
people’s homes will be necessary, for example, workers on duty sleeping separately and using separate bathrooms.

- A major challenge for many essential workers will be maintaining resilience in the face of large increases in workload, and the adverse psychological effects of uncertainty, the risk of transmitting infection to family and friends, and potential periods of separation from their families.
- Health workers are likely to face special challenges brought about by the need to ration scarce resources (including attention to their patients) and of having to make difficult ethical decisions.
- Security at home and at work may need to be an important consideration, as many patients are likely to become distressed and demand urgent attention.

Testing the practice PI plan
Practices will need to consider testing their pandemic plan by a practice-based ‘dry-run/flu practice day’:
- scenarios – e.g. coughing patient just arrived home from Indonesia. What to do?
- scenario analysis (what went right/wrong/necessary changes);
- ensure all practice staff have at least one dry-run;
- develop appropriate checklists to monitor dry-runs.

This process should be repeated annually and form part of the practice policy and procedures manual. Any new practice staff should have their role, in the event of a pandemic, explained.

Indemnity
Information was sought from three (3) medical indemnity organisations (MDASA, Avant and United Medical Protection Group) on a range of medical indemnity issues. A lengthy reply was received from one indemnity organisation who informed that they do “not currently have any generally available advice for members on pandemic influenza, (but) as a service to members, can provide detailed advice to individuals dealing with their particular (medico-legal) circumstances”.

In response to the several medico-legal issues presented, general comments only were provided by the responding indemnity organisation in relation to four areas.

Duty of care; choices re seeing/not seeing patients
The most likely area of potential exposure for a GP, which could result in an increase in claims, is the alleged failure to prevent an infection from a pandemic agent.

At common law, a doctor has a duty to exercise reasonable care and skill in the diagnosis and treatment of patients and in the provision of advice and information to patients including the risks inherent in medical/surgical treatment.

To be successful in claim against a doctor, a patient who contracted influenza from another patient in a doctor’s waiting room would need to show that the doctor did not exercise reasonable care and skill in relation to that patient. Where steps have been taken by public health units in a State/Territory and/or by the Federal Government under its quarantine powers, on providing guidance to minimise the spread of pandemic influenza, a doctor who failed to implement these guidelines may be liable for an action in negligence, or disciplinary action.

As a result of tort law reform, there is now a statute which specifically states that a professional does not breach a duty arising from the provision of a professional service if it is established that the professional acted in a way that (at the time the service was provided) was widely accepted by peer...
professional opinion, by a significant number of respected practitioners in the field as competent professional practice.

A doctor does have a duty of care to treat a person in an emergency even if that person was not previously their patient. However, the standard is generally regarded as lower in circumstances of an emergency or extreme pressure because the Courts recognise that it would be unfair to judge a person on the basis of what would be expected in a normal situation when the circumstances are very different.

Occupational health, safety and welfare

An employer has an obligation to provide a safe working environment for their staff and without risks to health and well-being. Whilst the particular provisions in each state and territory are different, generally a failure to provide a safe place of work is an offence under the occupational health and safety legislation.

Employees who are injured at work may bring claims for worker’s compensation. In the likelihood that an employee could contract pandemic influenza at work, GPs should check whether their worker’s compensation insurance includes claims arising from contracting infectious diseases at work, including pandemic influenza.

**Refer to:** SafeWork SA website for more information [www.safework.sa.gov.au](http://www.safework.sa.gov.au)

Human resources (e.g. paying absentee staff, staff disability and death)

If a staff member refuses to come to work because the premises are deemed unsafe, or he/she is concerned about contracting pandemic influenza, and all precautions have been taken within the practice to address issues of staff safety, then whether the staff member is entitled to not work and still be paid, should be clarified with the Work Health and Safety Act 2012 (SA) and industrial relation laws.

In relation to an employee sustaining a disability as a result of contracting pandemic influenza, GPs should check whether their worker’s compensation insurance covers this.

In the event of the death of a staff member from pandemic influenza, allegedly through becoming infected whilst at work, and the potential likelihood of the deceased’s family pursuing a claim against the practice, GPs may wish to discuss their legal position in relation to this with their medical indemnifier.

Coverage for alternative patient care strategies

Under the doctrine of vicarious liability, an employer will be held liable for the negligence of its employees arising in the course of their employment. Thus, if a medical practitioner delegates aspects of clinical care to an employee with less training in the area (e.g. a practice nurse) and that employee is found to have acted negligently in their treatment of a patient, then the medical practitioner (as employer) may be liable for any injury and disability that may occur as a result of the procedure negligently performed by the employee.

If a medical practitioner fails to provide suitable education and training for staff then he/she may be liable in negligence for any injury and disabilities that may occur as a result of the procedure negligently performed by the nurse, and may also be liable for disciplinary action.

Medical practitioners need to ensure that nurses in their practice are properly trained and competent to perform the tasks required of them. They have a duty to establish triage protocols and properly train staff in the implementation of these to enable staff to be able to properly prioritise patients.
requiring treatment, and to know when to call a doctor if unsure about how quickly a patient needs to be seen.

The use of telephone triage and telephone patient management during a pandemic, as a strategy to minimize the risk of spread of influenza, is an area where there is the potential to inaccurately triage patients and for mistakes to be made in the assessment of patients without a physical examination. Clarification of the potential medico-legal/indemnity issues with telephone management of complex problems needs to be obtained prior to a pandemic.

NB: The general comments provided on medical indemnity are no substitute for individual clarification. GPs are advised to contact their specific medical indemnity organisation for detailed individual advice dealing with their particular medico-legal circumstances.

Formulating a Communication strategy

As there will be a lot of vital communication taking place during a pandemic, it is recommended that GPs connect to Broadband to ensure rapid, reliable and accurate information access, including to the DHA CDCB, Commonwealth Department of Health and other relevant websites.

Communication within the practice

There should be a clear process established for communication amongst practice staff in the event of a pandemic and to patients prior to and during an influenza pandemic.

> GPs must inform their current patients (i.e. those seen at least once in the previous 2 years) about practice arrangements during a pandemic and any changes as these occur. For example, what services the practice will and will not be providing during a pandemic, and under what circumstances they will be provided (i.e. non-essential appointments, home visits, repeat prescriptions etc.).

> Consider using automated phone messages that can be triggered when a patient rings the practice to provide information on a range of issues (including any changes in practice services).

> Be aware of key public health messages and advice.

> Gather information on a range of topics for staff including:
  - identifying pandemic influenza patients;
  - infection control measures;
  - what home quarantine involves and how patients will be supported during this process;
  - location of community flu clinics and vaccination centres.

> Ensure there are adequate supplies of practice consumables (e.g. FAX machine and computer printer cartridges) as these may become scarce to purchase during a pandemic.

Provision of educational information to practice patients

General practice should be a source of reliable information about all aspects of pandemic influenza, both directly, and by referring people to approved websites, telephone hotlines and printed information.

Consider using automated phone messages to convey some information when patients contact the practice.

Simple hygiene messages and posters are very important for the community to understand and act upon:
> put up patient education materials in the waiting room;
> provide a range of posters and patient information leaflets on:
  > minimising risk;
  > hand hygiene;
  > cough etiquette;
> what to do if they develop a fever following contact with a potential or confirmed case of pandemic flu;
> inform patients about how the practice will operate during a pandemic;
> encourage all patients to prepare their own home pandemic plan (especially high risk patients).
> Pandemic influenza is a notifiable disease as described under Section 30 of the Public Health Act 2011, and thus infection with this disease must be notified to the DHA CDCB 24 hour seven day telephone service 1300 232 272 or a completed Report of Notifiable Condition or Related Death form faxed to (08) 8226 7187.
> The reporting of these diseases enables the CDCB to monitor the disease in the community and help reduce the impact on others.
> Medical practitioners are obliged by the Public Health Act 2011, to notify the CDCB of cases suspected of having Pandemic Influenza as soon as possible, but in any event within three (3) days of suspicion of diagnosis.

Communication with other practices, health services, pharmacists, emergency services and local authorities

> Establish links with other practices within close proximity.
> Ensure there are rapid and reliable communication processes established with relevant organisations (e.g. Department for Health and Ageing, Communicable Disease Control Branch, local hospitals, and local authorities with key people identified for conveyance of information during a pandemic.

Role of Divisions of General Practice

It will be important to determine a process of communication for members of the Division of General Practice Network during an influenza pandemic and for the respective roles and responsibilities of all to be clarified.

The SA Divisions for General Practice Inc. (SADI) and the individual Divisions of General Practice may be able to provide assistance to GPs during a pandemic in the following ways:

> assisting practices with PI Planning;
> providing advice on particular issues;
> development of protocols;
> providing education/training;
> providing education materials;
> assistance with the purchase and distribution of PPE; and
> collection of surveillance data.
Triaging of patients

Pre-pandemic patient triage

- There are a number of triage processes which General Practices should consider prior to a declared Pandemic.
- General Practice reception staff, nurses and medical staff should familiarise themselves with triage and management protocols for potential pandemic influenza patients.
- General Practices should be prepared at all times for suspect patients with recent relevant travel history and flu-like illness as potential pandemic influenza patients.

Pandemic influenza practices

- It is recommended that all primary care practices prepare themselves for the arrival of a pandemic influenza patient. It is unlikely to be feasible for primary care practice to stop all potential pandemic influenza patients from presenting, especially if the disease is circulating widely in the community.
- General practices may consider whether they wish to triage/see potential pandemic influenza patients if a pandemic is declared.
- Some practices may be more appropriate to manage pandemic influenza patients than others, in terms of facilities and staffing, and as such may be referred more pandemic patients than other less well-equipped practices.
- They may wish to designate themselves as the “flu practice” whilst others may decide that they will not see potential pandemic influenza patients. However, it will be very difficult to identify and segregate potential pandemic influenza patients from those who are suffering seasonal influenza or a common cold.
- Any decision on not providing consultations for potential pandemic influenza patients needs to be clearly conveyed to all practice patients, as well as providing information on which practice they can attend instead.

Screening

- As soon as the first cases of suspected human transmission of pandemic-strain influenza occur in Australia, all primary care practices should be prepared for the presentation of a potential case of pandemic influenza.
- At this time, point of arrival screening and potentially; telephone screening should be implemented at practices.

Point of arrival screening

When the first cases of suspected human transmission of pandemic-strain influenza occurs in Australia, all primary practices will require point of arrival screening and triaging.

From this time the main entrance and arrival point of the practice should be equipped with:

- signage informing people about pandemic influenza, with a focus on informing patients with respiratory symptoms to:
  - wear a surgical mask;
  - observe cough etiquette; and
  - keep >1 metre from other patients.
(This signage should be in appropriate languages relevant to the practice location).

- a “hygiene station” installed for patients near the entrance:
  - with appropriate signage and supplies of surgical masks, alcohol-based hand hygiene product and tissues; and
  - a non-touch waste bin for disposal of contaminated tissues.

This equipment and signage should be placed within easy access of all entrances to the practice. For ease of screening, in the event of a pandemic it is recommended that primary care practices determine which entrance will be their main entrance, and leave only this entrance open. This will enable them to more easily monitor who enters and leaves the practice.

After entering the practice point of arrival, screening of patients should be performed by any staff member who is prepared to work at the front arrival of the practice. This may, for example, be the practice receptionist or a practice nurse. All patients who present should be screened, as should all visitors accompanying patients.

It is also recommended that all staff members who present for work, and all work related visitors such as pathology couriers are also screened.

Point of arrival screening should include at least the following:

- asking about symptoms of respiratory illness especially
  - fever
  - cough
  - sneezing;
  - sore throat;
  - sudden onset of tiredness.
- questions regarding
  - contact with potential influenza cases;
  - travel history.

Ideally a surgical mask should be provided to all who enter the practice during a pandemic influenza and patients informed that they should keep the mask on at all times whilst at the practice.

For people with respiratory symptoms, a surgical mask should be worn at all times whilst at the practice, and during transfer by ambulance to a hospital if this is required.

Persons required to wear a surgical mask should be provided with instructions regarding the safe use and disposal, including the following:

- How to put the mask on (graphic display would assist with this)
- Must cover mouth and nose
- Do not touch the front of the mask whilst wearing it
- Must be removed when it becomes moist or visibly soiled
- Must remove the mask with the loops or straps and disposed of immediately.

Consideration should be given to the provision of surgical masks with ear loops to enable easier application.

Refer to: The national ‘Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting’ at http://www.health.gov.au
Screening questions

The suggested standard screening questions are detailed in Box 1. These questions may change as the pandemic progresses and becomes more widespread.

Box 1 Screening Questions – POINT OF ARRIVAL

<table>
<thead>
<tr>
<th>Screening questions by Practice Nurse or Receptionist:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Do you have fever with a cough and sudden onset of tiredness?</td>
</tr>
<tr>
<td>If yes:</td>
</tr>
<tr>
<td>2) During the last seven days before your symptoms began did you have contact with a person with a respiratory illness? Was the diagnosis of that person pandemic influenza?</td>
</tr>
<tr>
<td>3) Have you recently returned to/arrived in Australia from overseas? Where were you located?</td>
</tr>
<tr>
<td>4) Have you been in contact with a person who has recently returned from overseas (or known infected area)?</td>
</tr>
</tbody>
</table>

If a patient answers ‘yes’ to question 1 and either question 2, 3 or 4, they can be defined as higher risk for being potential pandemic influenza patients. Those who answer ‘no’ will be lower risk.

If possible, a designated room or partitioned section of the waiting room should be available for patients with respiratory symptoms and/or positive responses to any of the screening questions. At the minimum, social distancing should be applied, keeping patients at least 1 metre from each other.

Practices who are unable to segregate patients may consider having patients wait in alternative areas, for example:

- asking patients who have driven to the surgery to wait in their car until they are called in for a consult;
- providing waiting areas outside the practice in suitable covered locations.

Practices may also wish to consider the use of telephone screening, or telephone management where practical.

Telephone screening

Wherever it is practicable, patients who ring for appointments should also be asked screening questions. This is both to warn the practice of the arrival of a potential influenza case and potentially, to discourage potential pandemic patient from presenting at the practice by referring them elsewhere (for example to a flu assessment centre).

Practice receptionists will need to be informed of the standardised screening questions (see Box 2) and when to implement telephone screening. These decisions should be made in advance as part of the practice plan for pandemic influenza.

The decision to implement telephone screening could be initiated by the Practice Pandemic Influenza Coordinator, or by the GPs in the practice. The recommended telephone screening questions are similar to those used in a personal consult.
Box 2  Screening Questions - TELEPHONE

<table>
<thead>
<tr>
<th>Screening questions by Practice Receptionist:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Do you have fever with a cough and sudden onset of tiredness?</td>
</tr>
<tr>
<td><strong>If yes:</strong></td>
</tr>
<tr>
<td>2) Check patient’s telephone number and inform the patient that the GP or practice nurse will call back</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Screening questions by GP/practice nurse:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3) Do you have a fever?</td>
</tr>
<tr>
<td>4) Do you have a cough?</td>
</tr>
<tr>
<td>5) Do you have extreme weakness or tiredness?</td>
</tr>
<tr>
<td><strong>If yes to the above questions (1 to 3):</strong></td>
</tr>
<tr>
<td>6) Did your symptoms come on suddenly?</td>
</tr>
<tr>
<td><strong>If yes:</strong></td>
</tr>
<tr>
<td>7) During the last seven days before your symptoms began did you have contact with a person with a respiratory illness? Was the diagnosis pandemic influenza?</td>
</tr>
<tr>
<td>8) Have you recently returned to/arrived in Australia from overseas? Where were you located?</td>
</tr>
<tr>
<td>9) Have you been in contact with a person who has recently returned from overseas (or known infected area)?</td>
</tr>
</tbody>
</table>

If the person answers ‘yes’ to all questions 1 to 5 in the telephone screening and ‘yes’ to one of the questions 6 to 9 this indicates the patient is potentially suffering from pandemic influenza. The practice can then decide whether to advise the patient to attend the practice for assessment, or they may refer them elsewhere.

Patients who are advised on the phone to attend the practice and who are assessed as potentially suffering from pandemic influenza should be informed beforehand:

- to put on a surgical mask as soon as they arrive and that they will need to keep the mask on at all times whilst at the practice;
- of the cough etiquette and personal hygiene measures that will be required in the practice waiting room; and
- advised to minimise social contact during transport to the practice.

If the practice decides to implement telephone screening to discourage patients from presenting at the practice, these patients may be referred to:

- a Community Flu Clinic (when and where these are set up);
- the local “designated flu hospital” emergency department; or to
- the practice GP designated for telephone assessment and management.

The appropriate telephone management of patients who are assessed as at risk of suffering pandemic influenza from the telephone screening depends on the spread of pandemic influenza in South Australia.
In the early stages when there are only a small number of cases it will be important to ensure that patients have confirmation of suspected pandemic influenza by SA Pathology. If telephone screening indicates clinically assessment, it will be necessary for this to be undertaken and for a throat/nasal swab to be taken for diagnostic testing by SA Pathology (refer to the Diagnostic Testing sub-plan).

Where confirmatory diagnosis is less important due to pandemic influenza being widespread, less unwell patients should be encouraged to stay at home.

The decision to refer a patient to hospital should be based on the clinical status of the patient.

Any patients critically unwell with suspected pandemic influenza should be referred to the nearest “Flu designated hospital”. Primary Care Practices should contact SA Ambulance Service (SAAS) if the patient is seriously unwell.

Patients who are critically unwell due to illness likely to be unrelated to pandemic influenza should be referred to their nearest hospital/health service as per usual.

Patients who are less unwell due to issues likely to be unrelated to pandemic influenza may be able to be managed on the telephone. There are significant medico-legal responsibilities associated with this decision however, and this decision needs to be made individually by each practice before it is implemented.

Once Community Flu Clinics (CFC)s are set up as assessment centres, General Practices may wish to refer patients, assessed as potentially suffering from pandemic influenza, to these centres (refer to Community Flu Clinics sub-plan).

For medico-legal reasons, documentation should be kept on a patient who has called the practice but has been referred elsewhere. The documentation should include at a minimum:

- patient details;
- nature of the advice given, particularly their likelihood of suffering from pandemic influenza; and
- the management course that was advised.

The patient should be given a copy of their health summary to take with them, including details of any other illnesses they have, their medication, dosages and allergies etc. If a dosette is used, encourage the patient to take it with them.

The practice should also inform the point of referral by telephone, or by letter/fax, that they have recommended a potential pandemic influenza patient to present there.

Individual practices can decide on methods of follow up for those patients who do not present to the practice.

Practices may also wish to use the telephone screening process to deter patients from attending for all other non-essential appointments by warning them of the potential infection risk they may face by attending.

Management of patients by telephone

Primary care practice

Primary care practices may wish to use patient management over the telephone as a strategy to minimise the risk of spread of influenza. General practitioners may manage patients over the phone in two settings:
managing suspected or confirmed pandemic influenza patients to reduce the risk of spread of infection; or

managing routine and non-urgent consultations for their current patients to reduce the risk of them being exposed to pandemic influenza and remembering that hospitals may have more restricted emergency and inpatient facilities in a pandemic situation.

General Practitioners who wish to undertake telephone patient management need to be aware of the inherent risk in assessing patients without a physical examination and the potential medico-legal/indemnity issues with telephone management of complex health problems. The following should be considered:

- logging details of all calls (time taken, length etc.) for patient care and in case of any potential indemnity issues or coronial matters;
- the billing/fee for service implications. General Practices cannot currently bill Medicare for telephone consultations. This issue will need to be resolved at a Commonwealth level;
- where to refer a patient if they do seem likely to be a potential case of pandemic influenza. In particular General Practitioners need to know the availability and location of local community flu clinics and flu hospitals;
- if patient is obviously very unwell the GP needs to know their local hospital capacity and transport availability. Hospital criteria for admission may change during a pandemic.

The type of telephone management will also depend on the phase of the pandemic influenza in Australia, whether it is contained or widespread:

- the GP may wish to recommend testing and antiviral prescription either at their practice, another GP practice or through a community flu clinic/flu hospital emergency department; or
- the GP may wish to recommend home care for differing reasons, depending on the stage of the pandemic.

healthdirect Australia – 1800 022 222

GPs may wish to consider providing information about healthdirect Australia to their patients via a flyer, or by an automated phone message for when a patient calls the practice and may be put on hold.

healthdirect Australia is a new free health advice line available 24 hours a day, 7 days a week from a landline phone, wherever you are in South Australia. It is a joint initiative of the Australian Government and the governments of the ACT, NSW, NT, SA and WA.

Registered nurses will help callers with their symptoms, health problems and will provide advice on when to see a doctor or health service and where to find them. Information can also be provided on late night pharmacies in the caller’s area.

The advice line will be able to take calls in relation to pandemic influenza, so if a caller is concerned they may have pandemic influenza, the nurse will ask specific questions which will identify whether they should see their doctor. Information will be given on the infection control precautions they need to take to avoid infecting others and where the nearest community flu clinic is that they can attend for assessment in relation to the where the caller lives.

Flu Hospitals

A number of hospitals in the metropolitan and rural areas may be designated as ‘flu hospitals’. Patients with suspected pandemic influenza are to be transported to these designated flu hospitals in the first instance (refer to Section 8 herein for more information on Patient Transport by Ambulance).
Infection Control

Infection control in General Practice

Strict adherence to good infection control practices is essential for protection of yourself, your staff and attending patients.

Refer to: the infection control sub-plan

The following general principles should be adopted.

Wherever possible, close contact with potentially infectious patients should be avoided by adopting social distancing and triage options outlined in previous sections within this Plan. In addition, physical barriers such as temporary perspex screens at reception desks should be considered as a means of minimising exposure for front-line staff. Instituting "source control" by asking symptomatic patients to wear a surgical mask, and wait in a separate room or area will also help to minimise exposure to staff and other patients.

When close contact is unavoidable, the basic principles for infection control in general practice are the same as in other areas of health care. These are:

- applying respiratory hygiene/cough etiquette to contain infectious droplets (see box Principles of Respiratory Hygiene);
- performing effective hand hygiene with either soap and water, or an alcohol-based hand hygiene product;
- wearing of personal protective equipment (PPE) appropriate to the task and risk of exposure;
- wherever possible maintaining a distance of greater than one metre from persons with respiratory symptoms; and
- performing effective environmental hygiene.

Principles of Respiratory Hygiene

To contain respiratory secretions, all persons with signs and symptoms of a respiratory infection, regardless of presumed cause, should be instructed to:

- cover the nose/mouth when coughing or sneezing;
- use tissues to contain respiratory secretions;
- dispose of tissues in the nearest waste receptacle after use; and
- perform hand hygiene after every contact with respiratory secretions and contaminated objects/materials.

In general, when caring for patients with pandemic influenza, health care workers should be particularly vigilant to:

- avoid touching their eyes, nose or mouth with contaminated hands (gloved or un-gloved);
- minimise the risk of self-contamination by ensuring:
  - careful placement of PPE prior to patient contact, thus reducing the need to adjust PPE during patient contact;
  - compliance with the recommended sequence for careful removal of PPE.
- avoid contaminating environmental surfaces that are not directly related to patient care (e.g. door knobs, light switches, etc.).
Some people are at a higher risk of influenza infection complications due to advanced age, medical conditions or pregnancy. HCW with these risks should not be involved with the direct care of confirmed or suspected cases of pandemic influenza.

**Use of Personal Protective Equipment (PPE)**

It is essential that all practice staff are instructed in the appropriate use of personal protective equipment.

Details for the appropriate use of specific items of PPE can be found in the Infection Control Management of Infectious Diseases – Summary Table. The table included in this document is a summary chart of indications for use of various items of PPE according to disease and transmission-based precautions. The document can be found by clicking [here](#).

Collection of a nose and/or throat specimen in a suspected influenza patient would be considered a high risk of exposure, and it is essential that full PPE, including a properly fitted, high filtration (P2 or N95), disposable respirator mask is worn.

The Department of Health have produced a DVD on behalf of the Australian Government which instructs health care workers in the proper application and use of PPE, entitled “The Safe Use of Personal Protective Equipment (PPE)”. A copy of the DVD can be obtained from the Department of Health Infection Control Service, or it can be downloaded free from the Australian Government web site by clicking [here](#).

**Mask Fit Testing**

High filtration disposable respirator masks (P2 or N95) are only required to be worn when undertaking high risk procedures such as aerosol generating procedures. They must be individually tested for proper fit according to the wearer’s face shape and size. There are many brands and sizes of these masks on the market, but there is no mask that will truly “fit all”.

It is the employer’s responsibility under the *Work Health and Safety Act 2012 (SA)*, *Work Health and Safety Regulations 2012 (SA)*, Codes of Practice, and supporting policies and practices, to provide appropriate protective equipment, and training in its use, when required. This includes fit testing to determine the P2 mask that will provide optimum protection. The employee has an obligation under the same legislation to use the supplied PPE when required, and attend training in relation to the correct donning and doffing of PPE.

**Cleaning and waste disposal**

Used masks, gloves and disposable gowns should be disposed of into a plastic bag in the general waste stream. Reusable PPE such as protective eyewear or face shield must be cleaned and disinfected according to the manufacturer’s instructions.

Regular (at least daily) cleaning of the environment in which patients with respiratory symptoms have been waiting or examined should be performed using detergent and water, followed by a disinfectant such as 1000ppm sodium hypochlorite or an alcohol wipe.

*Refer to:*  [www.sahealth/preventionandmanagementofinfectioninhealthcaresettings](#)
Quarantine

Issues around quarantine

A pandemic is likely to affect different communities in Australia and South Australia at different times and with varying intensity. It may be necessary therefore, to quarantine areas within South Australia in an effort to contain the outbreak (e.g. a town) whilst quarantine may not be necessary in other areas. This will be advised by the South Australian Chief Quarantine Officer in conjunction with the Chief Medical Officer, or the Chief Public Health Officer or his/her delegate, if the Quarantine Act is invoked.

Persons suspected of having pandemic influenza will be required to be isolated, while the contacts of suspected/confirmed patients will be required to be quarantined.

During the peak of a pandemic quarantine and monitoring of contacts of all cases on an individual basis will no longer be feasible, but the principles of quarantine should be encouraged. Fact sheets about the prevention of pandemic influenza should be provided to cases and carers.

Home isolation and quarantine

The purpose of home isolation and quarantine is to reduce the spread of the pandemic influenza virus, reduce the burden on hospitals, and enable people to receive care in a setting more suitable to their needs.

Suspected and confirmed pandemic influenza patients should, if possible, be isolated from other members of the family (as much as is possible) until the diagnosis of pandemic influenza is excluded or the infectious period is over.

Contacts of these patients should remain in quarantine (usually in their home) until 7 full days have elapsed since the last exposure to pandemic influenza, providing the contact has not become symptomatic during that time. However, this time period depends on the incubation period.

Where contacts refuse to comply with quarantine voluntarily, legislative mechanisms may be required to ensure compliance.

Depending on the epidemiology of the influenza strain at the time of the pandemic, the quarantine period may be longer or shorter than 7 days and will be advised by the CDCB.

Visiting patients at home

General practices will need to decide whether they will visit patients at home during a pandemic, or cease to do so until the pandemic is over. If home visiting is to continue, some doctors within the practice may elect to undertake home visits, whilst others may elect not to. Appropriate infection control procedures should be followed for home visits.

Management and monitoring

GPs may or may not be involved in monitoring and caring for suspected cases of pandemic influenza and their contacts, depending on their residual capacity to take on additional duties.

If home visiting is not offered then an alternative process should be instituted to ensure that the patient’s or contact’s condition is monitored. This may be through phone or email contact to/by the practice nurse, or other designated person within the practice.
Practices should keep in touch with public health authorities to keep up-to-date with information and advice for patient care and monitoring during a pandemic.

**Patient Transport by Ambulance**

During an influenza pandemic, the normal SA Ambulance Service (SAAS) procedure will be followed for the transport of patients with an infectious disease to one of the designated flu hospitals. Under these arrangements, each hospital has a plan for receiving patients with a potential infectious disease.

Refer to: **the Transport sub-plan**

**GP practice to hospital**

During an influenza pandemic, GPs should follow their normal urgent ambulance attendance request calling process made to 000.

**Home to hospital**

GPs should inform their suspected or confirmed pandemic influenza patients that if their condition worsens rapidly they should call 000 for urgent ambulance attendance.

GPs should advise patients to inform SAAS, when calling for an ambulance, of their condition and diagnosis, if known, and the name of their GP.

**Vaccination**

General Practice is in an ideal position to deliver opportunistic vaccination in a pandemic. They will receive the pandemic vaccine through normal delivery processes, although there may be some changes to the ordering mechanism.

Given potential staff shortages and management of patient load it is anticipated that General Practitioners will not be asked to cease regular practice to undertake mass vaccination. However, GP involvement in mass vaccination against pandemic influenza will depend on local need and staff availability.

Refer to: **the Vaccination sub-plan**

**Dealing with deceased patients**

The management of the deceased will change during the course of a pandemic. The overall aim of the funeral industry and mortuaries will be to continue business as usual while preparing to manage increasing numbers of deceased persons as the outbreak unfolds with a potentially reducing workforce.

Refer to: **Deceased and Mortuary sub-plan**. As this plan is confidential please contact emergencymangement@sa.gov.au to obtain a copy.

A GP may be required to attend a deceased patient in the home and to assist families with their grieving. This may well add significantly to the workload of GPs.

**Personal protection**

The pathogenicity of a newly emergent strain of pandemic influenza will not be known until that strain has emerged. However, it seems clear that the risk to GPs attending a deceased person at home,
workers in hospitals, the funeral and related industries, will be posed in the situation where respiratory secretions become aerosolised.

Patients who have died during the infectious period of pandemic influenza can be assumed to have infectious virus present in the respiratory tract.

Viable virus may be found within a cadaver for several days, possibly weeks after death, particularly if the body has been refrigerated. Therefore, it is important that:

- appropriate PPE should be worn by a GP when attending a deceased person to minimise the risk of transmission of the disease (i.e. gloves, surgical mask, eye protection and gown); and
- a surgical mask or cloth should be placed over the mouth and nose of the deceased to minimise the risk posed by residual infective droplets being expelled during any movement or examination of the body.

**Legal requirements**

**Coroner**

Section 3 of the Coroner’s Act 2003 identifies a number of circumstances under which a death within the State must be reported to the Coroner’s Office. These include the death of a person:

- by unexpected, unnatural, unusual, violent or unknown cause;
- occurring at a place other than a hospital but within 24 hours of the person having been discharged from a hospital after being an inpatient of the hospital.

The Coroner has discretion as to whether an autopsy is required and, if so, to what extent a post-mortem examination is necessary.

The identification of a deceased person will be conducted in accordance with normal procedures for deaths which are reported to the State Coroner.

**Identification processes**

The identification of a deceased person will be conducted in accordance with normal procedures for deaths which are reported to the State Coroner.

Currently there are legislated requirements for the identification of bodies prior to cremation (South Australia Cremation Regulations 2001 [Clause 11], under the Cremation Act 2000), but not for burial, and for which a penalty applies if not adhered to. Therefore, particular care needs to be taken to avoid identification mistakes occurring, especially in the busy scenario resulting from pandemic influenza.

- Where the death occurs at home with relatives, the process will be visual identification.
- Where the relatives may not be permitted access to the deceased, for example, where death occurs at a home address and the deceased is alone, other forms of identification may be utilised such as finger prints, dental, and circumstantial evidence will also be required.
- Accurate tagging and marking of the deceased will be required to ensure there is no confusion as to the identity of a body (for cremation, refer to the Cremation Regulations 2001, Clause 8).

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1 Refer to AHMPPI 2008, Assumption Table 6 page 92, *Survival of the virus*
Certification and notification of death

- The certification of death and notification to the Registrar of Births, Deaths and Marriages is a legislated requirement of medical practitioners who are required to attend the body and certify death.
- Death Certificates are mandatory and can only be issued by a medical practitioner or the Coroner.
- Notification of the death of a person suspected or confirmed of having pandemic influenza, must be made to the CDCB within 3 days (as per the Public Health Act)

Home burials

- Home burials are not allowed as specified in the Local Government Act 1934.

Assisting bereaved families

The principles of ‘psychological first aid’ should be used by GPs when helping families to deal with the death of a loved one (s). Refer to Appendix 2.

It may be that several members of a family have died from pandemic influenza and the distress within families will be significant. There may be delays in making funeral arrangements for a loved one if the number of deaths from pandemic influenza is high and the funeral industry is unable to cope with the high mortality rate. This will only compound the distress of relatives.

GPs may experience difficulties in assisting families with the grieving process and may themselves require some counselling. It is important that they monitor their own mental health and seek assistance if necessary.

In all interactions with relatives of deceased persons it is essential that GPs continue to practice standard infection control procedures.

Planning for particular needs

Patients with mental health needs and special needs

Mental health

During a pandemic people may become quite fearful about the risk of becoming infected and may worry about how they/their family will cope with their illness and with the possibility that they or members of their family may die.

It will be important for GPs and other primary care providers to be alert to patients who may be suffering anxiety or depression because of a pandemic and consider early intervention strategies to enable patients to cope during this time.

Refer to: Mental Health Pandemic Influenza sub-plan

Caring for special needs patients/clients/residents

All organisations providing care for people requiring special needs should develop a Pandemic Influenza plan which should ensure that all care can be continued in a safe environment and in a safe manner. Planning should include:

- infection control education and training for employees;
- maintaining client care;
- provision of PPE;
ensuring that consumables (e.g. medical supplies, medications, special dietary requirements) are maintained.

**Referral of patients for home care**

A Pandemic Influenza plan for people receiving care in a home setting should ensure that all care can be continued in a safe environment and in a safe manner. Planning should include:

> a responsible person has been identified to coordinate pandemic influenza planning;
> maintaining patient care:
  - a system is in place that identifies patients who will require care in the event of a pandemic influenza outbreak;
  - a system is in place that addresses the capacity for new referrals;
  - assess staffing levels in the event of a pandemic influenza outbreak;
  - planning for staff shortage due to illness or family commitments;
  - a monitoring system is in place for reporting influenza like illnesses amongst employees;
  - a monitoring system is in place for reporting influenza like illnesses amongst clients or families/carers.
  - infection control education and training for employees;
  - provision of Personal Protective Equipment;
  - maintaining a supply of consumable items;
  - information for patients and their families that includes preventing the spread of influenza, an adequate supply of food and medications;
  - key contact positions from the Department of Health, hospitals, General Practice and other community based organisations are identified and their contact details recorded;
  - information on the additional costs incurred by the organisation as the result of the outbreak;
  - post-outbreak support and counselling for staff.

**Aboriginal and Torres Strait Islanders (ATSI)**

The needs of ATSI people vary widely around South Australia depending on circumstances, but Aboriginal and Torres Strait Islanders are likely to be severely affected in any pandemic.

Refer to: the Aboriginal Health Services sub-plan

**Recent arrivals and cultural and linguistically diverse groups (CALD)**

**Special characteristics**

People with different cultural backgrounds may react differently to a pandemic depending on their religious and cultural beliefs. It will be important for GPs to be cognisant of this when caring for these patients.

During a pandemic, foreign nationals residing or travelling in Australia will be provided with treatment in accordance with the strategy of the pandemic phase at the time.

**Working with interpreters**

The Doctors Priority Line, a service of the Commonwealth Department of Immigration and Citizenship (DIAC) through Translating and Interpreting Services (TIS) National, can be used by doctors during a
consultation to help them communicate with patients who do not speak English, or by a medical practitioner’s reception staff to arrange appointments and provide results of medical tests.

The Doctors Priority Line:
- is a free telephone interpreting service for doctors and specialists in private practice providing a service to a non-English speaking patient who is an Australian citizen or permanent resident;
- can only be used where the service provided can be claimed under Medicare;
- provides a prompt telephone interpreting service for medical practitioners and their eligible (Medicare) patients;
- gives priority access to a national panel of more than 1300 professional interpreters, not just those in the doctor’s local area;
- panel covers more than 130 languages and dialects;
- is available 24 hours a day, 7 days a week, anywhere in Australia for the cost of a local call;
- cannot be used for a consultation with a non-Medicare patient (e.g. a tourist).

Doctors are required to register for the Doctor’s Priority Line before interpreting services are provided. It is suggested that they register in advance to avoid delays when needing to use the service.

Registration can be done either by telephone (1300 131 450) or by sending a completed registration form (available from the website) to the Client Registration and Promotions Team in TIS.

Refer to:  www.immi.gov.au/tis

Homeless

Special characteristics

Homeless populations have a high prevalence of disease, including mental illness and immune-compromising chronic diseases. They have poor access to health care services, frequently have inadequate community supports, and spend much of their time on basic needs such as finding food or shelter. Homeless people tend to live in public places as well as gather in large groups, such as at meals times in a day centre or sleep in groups of 6 or more in overnight shelters. These characteristics put them at significantly increased risk of acquiring and transmitting infection, and increased morbidity/mortality from pandemic influenza. They may be important vectors of disease transmission for the wider community.

Issues of care

This group will be more likely to miss out on early medical assessment, antiviral treatment and immunisation. Isolation and quarantine will be logistically difficult. Hence, pre-identified safe places with meal and nursing/social work support are essential. As the homeless population is heterogeneous and not always identifiable on sight, Primary care providers will need to keep this possibility in mind, particularly when registering new patients.

Working with providers

The main service providers for the homeless in metropolitan Adelaide are the RDNS, Street to Home (a service of the Ambulatory & Primary Care Services directorate at Central Northern Adelaide Health Service), Nunkuwarrin Yunti (for Aboriginal & Torres Strait Islander people) and the Burdekin Clinic (27 Selby Street, Adelaide). Homeless people will most easily access and be accessed through these services. These providers are ideally placed to deliver education, mass-vaccination, or to assess
homeless people with a febrile illness. They need to be consulted in regard to a shared understanding of Pandemic Influenza Plan implementation.

**Transients**

**Special characteristics**

Transients are those who are not usual residents of South Australia. Although travel will be may be restricted during a pandemic, they could be visiting for tourist, personal or work reasons. Some may be from overseas with variable health insurance cover. Addressing the acute health care needs of this population will be important for the containment of spread of infection.

**Issues of care**

Anecdotally, this group gets care from different sources. Some utilise mainstream General Practice, some accommodation facilities have arrangements with GPs to provide on-site visits, and some attend hospital emergency services. In general, this group is likely to have considerable difficulty accessing mainstream General Practice during a pandemic.

It may be most efficient for tourist and temporary accommodation facilities to ensure as part of their planning, that they have arrangements with locum medical services. Alternately, this group should be directed to a community flu clinic.

**Recovering from a Pandemic**

**Preparedness for a ‘second wave’**

Key actions in the stand-down and recover phase where the pandemic is controlled in Australia are to restore the health system as quickly as possible. The duration of the phase is dependent on how long the health system takes to return to normal and whether there is a second peak or wave(s) of a pandemic. Whilst a pandemic may have subsided, there is a very real chance that a pandemic may flare up again at short notice within 4 to 6 weeks, as this has been the pattern in previous pandemics.

Nationally there will be:

- enhanced vigilance for a subsequent wave;
- increased vigilance for cases; and
- increased monitoring of the virus (to look for genetic mutations).

An important aspect of preparation for general practice is being able to re-adjust their services in readiness for the likelihood of a second wave. To minimise the risk of disease transmission to staff and patients, infection control and prevention activities must be continued during the stand-down and recovery phase.

**Resumption of full practice operations**

Once it is apparent that a pandemic is truly subsiding and there is no threat of additional waves of disease, the full recovery process can then begin. The main issues for general practice are:

- business recovery of full practice functions (some of which may have been scaled down during the pandemic); and
- individual recovery (both staff and patients).
Practices should keep their local Division of General Practice informed of their progress during this time and may need to engage the assistance of their Division in effecting resumption of full practice operations.

Community Pharmacists

Providing advice to the public

Community pharmacists will have an important role in:

> educating the public about reducing their risks of contracting pandemic influenza;
> about good infection control measures, and
> when people should consult a doctor if they feel they are may have pandemic influenza.

Referral to GPs/flu clinics

During a pandemic, the DHA will be providing information to the Pharmacy Guild of South Australia for distribution to all pharmacies, informing them of the status of the pandemic and where people can be referred to for assessment of influenza like symptoms.

Refer to: the Antiviral Distribution sub-plan
Appendix 1: General Practice Pandemic Influenza Coordinator

Suggested Person and Role Specification for PIC

Person

> Basic understanding of infectious diseases
> Sound working knowledge of infection control procedures
> Good written and verbal communications skills
> Competency in the use of a computer (including word processing, Excel spreadsheets)
> Ability to keep accurate records
> Experience in arranging and conducting meetings

Role

> Work with principal GP to develop a practice PI plan in accord with SA Department of Health (DH) and Commonwealth Department of Health & Ageing (DoHA) guidelines
> Work closely with the practice infection control person
> Establish and maintain close contact with relevant DH units and local Division of General Practice
> Attend necessary PI in-services including PI planning and PPE use
> Train other staff (including cleaners) on relevant aspects of PI and PPE use
> Train another staff person as back-up PIC in the event of absence/illness
> Advocate for and implement PI preparedness changes within the practice
> PPE acquisition, secure storage, maintenance & eventual safe disposal
> Take the lead role in implementing the practice PI plan according to official advice
> Develop/adapt practice PI information sheets/phone messages/posters
> Provide regular PI situation reports for practice staff
> Organize periodic readiness exercises for the practice
> Assist promotion of pneumococcal & regular influenza vaccinations for practice staff, and those patients at high risk from PI
> Promote self-care preparedness to households of vulnerable patients
> Data recording of patients:
  - currently suffering from PI and those they live with
  - under surveillance for onset of PI symptoms
  - receiving anti-viral drugs
  - known to have had PI
  - vaccinated against PI
Appendix 2: Psychological First Aid

CORE ACTIONS

Contact and engagement
Goal: To respond to contacts initiated by survivors or initiate contacts in a non-intrusive, compassionate, and helpful manner.

Safety and comfort
Goal: To enhance the immediate and ongoing safety and provide physical and emotional comfort.

Stabilisation, if needed
Goal: To calm and orient emotionally overwhelmed or disorientated survivors.

Information gathering: current needs and concerns
Goal: To identify immediate needs and concerns, gather additional information, and tailor psychological first aid information, and tailor psychological first aid interventions.

Practical Assistance
Goal: To offer practical help to survivors in addressing immediate needs and concerns.

Connection with social supports
Goal: To help establish brief or ongoing contacts with primary support persons or other sources of support, including family members, friend, community helping resources.

Information on Coping
Goal: To provide information about stress reactions and coping to reduce distress and promote adaptive functioning.

Linkage with Collaborative Services
Goal: To link survivors with available services needed at the time or in the future.
## Appendix 3: Pandemic Preparedness Checklist

The following checklist should be used to prepare for a possible influenza pandemic.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>In Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you familiar with your state government’s pandemic preparedness plan?</td>
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<tr>
<td>Are you familiar with your local government’s pandemic preparedness plan?</td>
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<tr>
<td>Are you familiar with your Local Public Health Unit’s pandemic preparedness plan?</td>
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<tr>
<td>Have you been in contact with your professional organisation to determine what information or assistance they may be able to offer?</td>
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<tr>
<td>Have you developed your own pandemic plan to:</td>
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<tr>
<td>Identify the role your business will undertake, including your critical business processes and essential services and any interdependencies you have on others? (i.e. suppliers)</td>
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<tr>
<td>Make contingency arrangements to enable you to meet demand when there may be staff and supply shortages?</td>
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<tr>
<td>Provide for efficient communications to ensure the flow of critical information?</td>
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<tr>
<td>Implement effective infection control policies and procedures.</td>
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<tr>
<td>Strengthen links with your Local Public Health Unit to clarify arrangements to apply during a pandemic.</td>
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<tr>
<td>Business Contingency arrangements:</td>
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<tr>
<td>Are employee’s personal and contact information, including emergency contact phone numbers and next of kin, up-to-date?</td>
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<tr>
<td>Have strategies been developed to deal with staff absenteeism (e.g. use of rosters, multi-tasking and training staff in alternative roles and pooling resources with other providers)?</td>
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<tr>
<td>Has consideration been given to ensuring adequate supplies of essential inputs or alternative suppliers?</td>
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<tr>
<td>Communications:</td>
<td>Yes</td>
<td>No</td>
<td>In Progress</td>
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<tr>
<td>Has the capacity of existing systems (including IT infrastructure) to cope in a pandemic been reviewed?</td>
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<tr>
<td>Have mechanisms been identified to communicate with staff and patients e.g. web page, notice boards and protocols for how to deal with customers/patients.</td>
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<tr>
<td>Are the details of useful contacts (e.g. local public health units, local hospital etc.) recorded and displayed prominently for staff.</td>
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<tr>
<td>Infection Control:</td>
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<tr>
<td>Have staff been provided with up-to-date information about infection control and appropriately trained?</td>
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<tr>
<td>Is personal health information that might reduce the risk of spreading the virus (hand washing, sneezing/coughing etiquette and the use of cleaning products) ready to be disseminated? - E.g. posters around the premises.</td>
<td>☐</td>
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<tr>
<td>Have protocols been developed for staff to manage a suspected case of pandemic influenza (e.g. screening questions for reception, procedures if patient enters premises, and instructions for home quarantine).</td>
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<tr>
<td>Will staff have access to personal protective equipment, and are measures in place to appropriate disposal (eg waste disposal bins)?</td>
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<tr>
<td>Has the physical layout of the premises been reviewed and options considered of how to manage patient flow to reduce the risk of spreading the virus (e.g. use of telephone screening, single entry point, temporary partitions and removal of non-essential items).</td>
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