September 14, 2009

RE: Occupational infection prevention and control guidelines for the 2009 pandemic H1N1 influenza in British Columbia

This letter is to clarify British Columbia's position on guidelines to be used in healthcare settings in BC for dealing with the pandemic H1N1 influenza. It is critically important that a consistent Provincial approach is taken to ensure the safety and confidence of BC healthcare workers that will allow them to deliver excellent healthcare during this pandemic. The position of the provincial medical officer's of health is as follows:

1. BC will follow the Public Health Agency of Canada (PHAC) guidance in dealing with the 2009 H1N1 influenza pandemic. The key documents are the Annex F of the Canadian Pandemic Influenza Plan and the interim guidance for healthcare workers that PHAC releases from time to time, most recently on July 28th.

2. Annex F and the up-to-date PHAC interim guidance describe the level of preparedness and protection considered appropriate in BC during the 2009 H1N1 pandemic.

3. Both Annex F and interim guidance call for organizational risk assessments and point of care risk assessments. As a result of these assessments healthcare organizations and healthcare workers might elect a higher level of preparedness or protection than the minimum outlined in the current versions of such documents.

4. Fully implemented exposure control plans with detailed engineering and administrative controls are the cornerstone for protecting healthcare workers from exposure to H1N1.

5. The latest available versions of Annex F and PHAC guidance differ in their recommendation for respiratory personal protective equipment while providing direct care (within 2 meters) to patients with suspected influenza. The respiratory protection outlined in the interim guidance is the minimum level acceptable at the current time and it will change if PHAC elects to revise its interim guidance.

…3

Ministry of Healthy Living And Sport

Office of the Provincial Health Officer

4-2, 1515 Blanshard Street
Victoria BC V8W 3C8
Tel: (250) 952-1330
Fax: (250) 952-1362

Notes:

1. Experts from BC in infection prevention and control, public health and occupational hygiene have been directly involved in development of both Annex F and the interim guidance for pandemic H1N1. The guidance developed by this group is based on current, available scientific evidence about this emerging disease and is designed to minimize or prevent the transmission of all infections, including pandemic influenza in all settings where healthcare is provided. It should be noted that the guidance provided by PHAC for pandemic H1N1 infection control is consistent with guidance from the WHO, Australia, the UK and New Zealand, several US States and has been advocated by organizations such as HICPAC, APIC, SHEA and IDSA in the US.

Current US CDC guidelines however focus on the PPE required by HCWs in the absence of consideration of organizational measures to prevent exposures. The US guidelines recommend use of a N95 respirator for all persons who enter the room of a patient with suspect or confirmed H1N1 infection. In addition a recent Institute of Medicine panel was convened to provide advice to the US CDC on the specific issue of respiratory protection for HCWs in the workplace against novel H1N1. This report focused on the scientific and empirical evidence regarding the efficacy of various types of personal respiratory protection technologies. This report addresses the important gap in data from experimental conditions in research laboratories to that of effectiveness of recommendations in actual clinical care. While recognizing that use of an N95 respirator has not been shown to effectively prevent transmission of influenza in the clinical setting, they recommended that given the scientific data on superior filtration properties in controlled conditions of respirators over facemasks US CDC not change their guidance at this time.

2. Professional judgment will dictate that in certain circumstances the minimum level of protection ought to be increased. If for example healthcare workers are providing care in an open ICU with a high number of acutely ill patients with influenza then it may be appropriate to wear a N95 respirator along with eye protection, gloves and hand hygiene all the time and not only while performing aerosol generating medical procedures (AGMP).

3. The PHAC guidance is based on a risk assessment approach that looks at organizational risks as well as individual risks of each patient encounter. This focus on management of organizational risks using the fundamental principles of engineering controls first, administrative controls second and personal protective equipment where engineering and administrative controls are not sufficient is based on experience in Canada on proven protective measures for prevention of transmission of infection in healthcare settings. The PHAC guidelines are also explicit on the need for HCWs to consider the workplace environment, the individual patient and the specific interaction they are going to have with the patient in determining the level of protection they need (POC risk assessment) for each patient encounter. By having a comprehensive infection control program that addresses the critical engineering and administrative controls and identifies areas where the risk of exposure may be greater the number of encounters where a respirator may be needed can be minimized. This improves the safety of both the HCW and the patient. This guidance is clear as well on the need for appropriate supplies to be available to the HCW to enable them to act on their individual risk assessment.

4. The primary and most important measure to ensure protection of healthcare workers is the identification of potentially infectious patients at first point of contact with the health system. Engineering controls such as optimal management of HVAC systems, provision of barriers in certain areas (i.e. triage areas) and signage to detect potentially infectious patients are effective measures that reduce the potential for exposure to infectious agents including influenza. Isolation in a single room and administrative measures such as reducing the time spent in close contact (within 2 metres), reducing the number of people in the room with the patient, and restriction of HCWs and visitors with febrile respiratory illness are also important. Administrative guidance must also ensure that those HCWs who are not providing direct care avoid exposure (e.g. ensuring housekeepers do not enter a room where AGMPs are being performed).

Yours truly,

P.R.W. Kendall
OBC, MBBS, MHSc, FRCPC
Provincial Health Officer