1 Purpose

1.1 This Standard establishes requirements for preparedness for, and prevention and control of influenza and influenza-like illness (ILI) in the Emirate of Abu Dhabi and mandates the following:

1.1.1 Infrastructure and equipment requirements for clinical care of patients with influenza and influenza-like illness.

1.1.2 Infection control measures to prevent and control transmission and spread of Influenza and Influenza-like illness in healthcare settings;

1.1.3 To protect the health and safety of employees, patients, visitors and contractors of Nominated Healthcare Providers as well as surrounding communities from healthcare-associated acute respiratory infections;

1.1.4 Report to HAAD suspected and confirmed cases of acute respiratory infectious diseases such as influenza and influenza-like illness via the HAAD e-Notification system;

1.1.5 Provide data that can be used to understand disease burden and the impact of influenza or influenza-like illness in relation to other diseases.

1.1.6 Identify and monitor groups at high risk for severe disease, in order to set priorities for use of resources.

2 Scope

2.1 This standard applies to all Healthcare Providers (including facilities and professionals) licensed by HAAD in the Emirate of Abu Dhabi.

2.2 This Standard must be read and applied in conjunction with

2.2.1 HAAD Standard for Reporting of Public Health Data ¹;

2.2.2 HAAD Standard for Active Influenza and Influenza-like Illness Surveillance;

2.2.3 HAAD Circular DG 48/13: Infection Control in Healthcare Facilities, 15/07/2013;

2.2.4 HAAD Policy for Infection Control in the Health Care Facilities²;

2.2.5 HAAD Standard Infection Prevention and Control Management for EHSMS Nominated Healthcare Providers;

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¹ Available at [http://www.haad.ae/HAAD/LinkClick.aspx?fileticket=Lily_JsGiKo%3d&tabid=820](http://www.haad.ae/HAAD/LinkClick.aspx?fileticket=Lily_JsGiKo%3d&tabid=820)

² Ref: PPR/HCP/P0010/07, dated May 2007
2.2.6 HAAD Standard Hand Hygiene for EHSMS Nominated Healthcare Providers;
2.2.7 HAAD Standard for Active Influenza and Influenza-like Illness Surveillance;
2.2.8 HAAD Standard for Inter-facility Patient Transfer; and
2.2.9 HAAD Standard for Mortuary Services.

3 Case Definitions
3.1 Suspected, probable and confirmed cases of influenza and influenza-like illness are defined as per Appendix A of this standard.

3.2 For the purpose of this standard the definition of influenza-like illness includes severe acute respiratory infectious diseases caused by new and emerging coronaviruses (e.g. MERS-CoV, SARS-CoV).

4 Duties of Health Care Facilities
4.1 Healthcare providers must comply with the requirements of this Standard and ensure that staff employed at their facilities comply with its requirements, including:

4.1.1 Providing the required infrastructure and equipment to care for patients with influenza and influenza-like illness as mandated by this standard;

4.1.2 Ensure that all healthcare workers (HCWs) newly employed, or to be employed at their facility(s) are aware and have been educated or trained in accordance to this Standard;

4.1.3 Ensure that all screening and medical examination regarding Influenza and Influenza-like Illness is provided only by a HAAD licensed healthcare facility;

4.1.4 Notify HAAD of any Influenza and Influenza-like Illness and complete the notification in accordance with the HAAD Standard for Public Health Data Reporting and HAAD Standard for Active Influenza and Influenza Like Illness Surveillance;

4.1.5 Ensuring that reporting of Influenza and Influenza-like Illness is undertaken by privileged staff via the e-Notification system for reporting Communicable Diseases (http://www.haad.ae/haad/tabid/871/Default.aspx);

4.1.6 Healthcare providers are accountable for ensuring that reported data are accurate, complete and reported HAAD within the time frames specified in the HAAD Standard for Public Health Reporting Data;

4.1.7 Keep all records of testing, vaccination and treatment, in accordance with HAAD policies and standards on managing medical records, including developing effective recording systems, maintaining medical records, maintaining confidentiality, adverse event management and reporting, privacy and security of information and fulfilling the requirements of consent;

4.1.8 All healthcare data must be managed in accordance with the data management policy Chapter VI, Health Regulator Policy Manual Version 1.0 available from HAAD website: http://www.haad.ae/HAAD/LinkClick.aspx?fileticket=VyAME-OjlOjlm8%3d&tabid=1276;

4.1.9 Ensure that necessary, appropriate and timely treatment and management is provided to all cases requiring clinical care in accordance with international evidence based best practices, HAAD Policies and Standards and Federal and Emirate Laws; and

4.1.10 Comply with HAAD requests to inspect and audit records and cooperate with HAAD authorized auditors, as required for inspections and audits by HAAD.
5 HAAD Role

5.1 HAAD will:

5.1.1 Set the requirements and specifications for preparedness for and prevention and control of influenza and influenza-like illness;

5.1.2 Specify and approve the Reference Laboratory (Central/Sentinel) for respiratory infection testing for pathogens causing influenza and influenza-like illnesses and establish necessary governing and contractual arrangements in support of satisfying the needs of a respiratory surveillance system;

5.1.3 Take responsibility for contact tracing and epidemiological studies, when required;

5.1.4 Monitor the information provided by HAAD licensed healthcare providers in order to progress contact tracing; and

5.1.5 Liaise and coordinate with other Abu Dhabi and Federal Government entities in support of monitoring of contact tracing and ensuring appropriate follow up and management has been effected to contain and manage potential spread of influenza and influenza-like illness and other acute respiratory infections.

6 Enforcement and Sanctions

6.1 Healthcare providers must comply with the requirements of this Standard. HAAD may impose sanctions in relation to any breach of requirements under this standard in accordance with Chapter IX, HAAD Policy on Complaints, Investigations, Regulatory Action and Sanctions, The Healthcare Regulator Policy Manual Version 1.0.

7 Service Standard 1: Preparedness for Influenza and Influenza-like Illness

7.1 All healthcare facilities must be prepared for providing care and medical services for patients with acute respiratory infectious diseases with pandemic potential, such as influenza A, B, and C, and influenza-like illness, including new and emerging coronaviruses (e.g. MERS-CoV, SARS-CoV).

7.1.1 All healthcare facilities must keep on stock standard/surgical face masks and respirators (N95 standard or equivalent). The number of face masks and respirators kept on stock must be based on an infection control risk assessment.

7.1.2 Inpatient healthcare facilities with Emergency Departments, Critical Care or Intensive Care units must provide the following:

7.1.2.1 An appropriate number of bed places equipped with medical ventilators and oxygen supply, based on risk assessment;

7.1.2.2 An appropriate number of airborne infection isolation rooms (AIIR, negative pressure rooms). The number of AIIR must be based on an infection control risk assessment and must not be less than 5% of total bed capacity; and

7.1.2.3 An additional minimum of 5% of total bed capacity must be available either as airborne infection isolation room (AIIR, negative pressure room), or as single rooms, able to be transformed within two hours into an AIIR by provision of exhaust air/recirculation air filtration by HEPA units.

7.2 Infection prevention and control measures as mandated by this and other relevant HAAD standards (EHSMS) must be followed and implemented to prevent transmission and spread of influenza and influenza-like illness in healthcare settings and to the wider community.
7.2.1 For further details and guidance see applicable guidelines and recommendations from World Health Organization (WHO), U.S. Centers for Disease Prevention and Control (CDC), and U.K. National Health Service (NHS).

7.3 All healthcare facilities must develop and implement policies and procedures for prevention and control of the transmission of influenza and influenza-like illnesses.

7.4 These policies and procedures must include:

7.4.1 An awareness/educational program for healthcare personnel, patients and visitors;

7.4.2 Infection prevention and control measures:

7.4.2.1 Standard precautions;

7.4.2.2 Patient screening and initial assessment;

7.4.2.3 Isolation precautions;

7.4.2.4 Staff;

7.4.2.5 Personal Protective Equipment (PPE);

7.4.2.6 Additional precautions for aerosol-generating procedures; and

7.4.2.7 Handling dead bodies.

7.4.3 Laboratory testing and diagnostic procedures;

7.4.4 Environmental and Engineering infection control:

7.4.4.1 Environmental cleaning & disinfection plan; and

7.4.4.2 Engineering controls.

8 Service Standard 2: Awareness/educational program for healthcare personnel, patients and visitors

8.1 This may include informational letters, electronic communication, signs, posters, flyers, leaflets, brochures, staff meetings, staff training sessions, or other suitable means of creating awareness and education.

8.2 The program must address healthcare personnel, patients and visitors.

9 Service Standard 3: Infection prevention and control measures

9.1 Standard Precautions

9.1.1 Standard precautions such as hand hygiene, prevention of needle-stick or sharps injury, safe waste management, cleaning, disinfection and sterilization of patient-care equipment and linen, and cleaning and disinfection of the environment must be routinely implemented as per applicable HAAD policies and standards.

9.2 Patient screening and initial assessment

9.2.1 Healthcare facilities must implement for Emergency Departments, outpatients health services/outpatient facilities, Internal Patient Wards, Critical Care and Intensive Units, Perinatal and Children Unit and Elderly Services Unit either passive or active screening for patients with influenza or influenza-like illness, or both.

9.2.2 Passive Screening: Post signs in emergency departments or ambulatory health services (AHS)/outpatient facilities, to request patients and accompanying individuals with signs and symptoms of acute respiratory infection (which may include sneezing, cough, shortness of breath, feeling feverish or having a fever
≥38.0 °C), to self-report such symptoms, and to direct them to separate waiting areas or rooms (at least 1 m distance to other patients/visitors).

9.2.3 **Active Screening:** Implement screening tool for Influenza-like illness (ILI):

9.2.4 **See also Appendix B:** Screening and Patient Management Algorithm for Influenza and Influenza-like Illness;

9.2.5 Procedure to assess such patients with high priority and in a timely manner; and

9.2.6 Have in place a written procedure for reporting suspected and confirmed cases of influenza and influenza-like illness to HAAD e-Notification system, as per HAAD Standard for Reporting Public Health Data.

9.3 **Isolation Precautions**

9.3.1 Patients with suspected or confirmed influenza or influenza-like illness (non-MERS-CoV, non-SARS-CoV) must be placed under contact and droplet precautions isolation.

9.3.2 For inpatient facilities, patients with probable or confirmed MERS-CoV or SARS-CoV infection must be placed under airborne precaution isolation, and in an airborne infection isolation room (AIIR, i.e. negative pressure room), if available.

9.3.2.1 If an AIIR is not available within the facility, the patient must be placed in an single room fitted with a mobile or fixed HEPA air filtration device, and doors kept closed.

9.3.2.2 In any case, the patient should not be placed in any room where room exhaust is recirculated to building HVAC system without high-efficiency particulate air (HEPA) filtration.

9.3.2.3 Once in an AIIR or single room with HEPA filtration, the patient’s facemask may be removed; the facemask should remain on if the patient is not in an AIIR. When outside of the AIIR, patients must wear a facemask to contain secretions.

9.3.2.4 Limit transport, movement and transfer of the patient outside of the AIIR to medically-essential purposes. Stretchers, wheelchairs, or strollers used for transport must be disinfected after use.

9.3.3 For transfer of patients with suspected, probable or confirmed influenza or influenza-like illness to other facilities, all facilities and individuals must adhere to HAAD Standard for Inter-Facility Patient Transfer and the following:

9.3.3.1 Notify the receiving healthcare facility of the patient’s diagnosis and necessary precautions as soon as possible before the patients’ arrival.

9.3.3.2 During transfer the patient must wear a surgical mask if they can tolerate it (i.e. not further compromising respiratory status).

9.3.3.3 Healthcare workers must use a respirator (N95 or equivalent). If respirators are not available healthcare workers must wear a surgical mask.

9.3.3.4 Stretchers, wheelchairs, or strollers used for transport as well as medical and other equipment and surfaces in close contact with the patient must be disinfected after use.

9.3.3.5 Perform hand hygiene routinely as indicated and as per **HAAD Standard for Hand Hygiene.**
9.3.4 Patients with suspected, probable or confirmed influenza, MERS-CoV or SARS-CoV infection are restricted from group activities until symptoms resolved and patients are no longer considered infectious.

9.3.5 Visitors in contact with patients with influenza or influenza-like illness must

9.3.5.1 wear a mask when in close contact (1 m) and upon entering the room or cubicle of the patient;

9.3.5.2 perform hand hygiene before and after contact with the patient and his/her surroundings and immediately after removal of the mask;

9.3.5.3 be limited to those who are important for the patient’s emotional well-being and stability; and

9.3.5.4 leave the room if aerosol-generating procedures are conducted (e.g. suctioning).

9.3.6 Infection prevention and control signage must be placed at the entrance of patient room indicating contact, droplet or airborne infection precautions as applicable.

9.3.7 Staffing policies must be implemented to minimize the number of personnel that must enter the room.

9.3.8 Cohorting (share rooms) is possible for patients infected with the same organisms, when single rooms are not available. Cohorting rooms must be in a well-defined area that is clearly separated from other patients care areas used for uninfected patients.

9.3.9 If possible, use either disposable equipment or dedicated equipment (e.g. stethoscopes, blood pressure cuffs, and thermometers). If equipment needs to be shared among patients, clean and disinfect it between each patient use. HCPs should refrain from touching their eyes, nose or mouth with potentially contaminated gloved or ungloved hands.

9.4 Staff

9.4.1 Staff must comply with all infection control procedures as detailed above and below.

9.4.2 A record must be maintained of all staff involved in the assessment, care and management of a suspected, probable and confirmed case.

9.4.3 A record sheet should be placed at the door and all staff entering must complete this.

9.5 Personal Protective Equipment (PPE)

9.5.1 Personal protective equipment must be available and accessible for use by patients, visitors and staff.

9.5.2 Personal protective equipment must be worn by all healthcare personnel according to patient isolation status (contact, droplet, airborne):

9.5.2.1 Gloves;

9.5.2.2 Gowns;

9.5.2.3 Eye protection (goggles or face shield); and

9.5.2.4 Respiratory protection that is at least as protective as a fit-tested NIOSH-certified N95 filtering face piece respirator. If a respirator is unavailable, a (surgical) facemask should be worn. In this situation respirators should be made available as quickly as possible.
9.5.3 PPE must be worn by HCP upon entry into patient rooms or care areas.

9.5.4 Upon exit from the patient room or care area, PPE must be removed and either discarded or, for re-usable PPE, cleaned and disinfected according to the manufacturers’ reprocessing instructions. Hand hygiene must be followed when taking of PPE.

9.5.5 Healthcare providers must ensure that a respirator fit test is undertaken every time a new model, manufacture type/brand, or size is worn, or on an annual basis, in compliance with CDC and NIOSH/OSHA guidelines. A fit test must also be undertaken where weight fluctuates or facial/dental alterations occur. All fit tests must be logged and records must be kept for audit purposes.

9.5.6 For detailed guidelines see WHO Interim Guidelines.

9.6 Additional precautions for aerosol-generating procedures for patients with suspected, probable or confirmed MERS-CoV/SARS-CoV infection

9.6.1 Aerosol-generating procedures include endotracheal intubation, aerosolized or nebulized medication administration, dental drilling, diagnostic sputum induction/collection, bronchoscopy, airway suctioning, positive pressure ventilation via face mask (e.g. BPAP and CPAP), high-frequency oscillatory ventilation.

9.6.2 Procedure to be performed only if medically necessary.

9.6.3 Procedure to be performed in airborne infection isolation rooms (AIIR) or room fitted with HEPA air filtration units, if available.

9.6.4 Limit the number of persons present in the room to the absolute minimum required for patient’s care and support.

9.6.5 Respirators and eye protection must be used by all HCP in the room.

9.6.6 Perform hand hygiene before and after contact with the patient and his or her surroundings and after PPE removal.

9.7 Handling dead bodies

9.7.1 A body bag must be used for transferring the body to the hospital mortuary.

9.7.2 Once in the hospital mortuary it is acceptable to open the body bag in order to view, examine, wash and prepare the body; however, those carrying out these tasks must wear full PPE, including respirator and facial/eye protection and long sleeved gowns and gloves, which must then be discarded.

9.7.3 Mortuary staff and funeral directors must be advised of the biohazard risk.

9.7.4 Provisions as per the HAAD Standard for Mortuary Services and the UAE Federal Law No. 27 of 1981 Concerning Communicable Disease Prevention, article 18, on conditions of transportation or burial of a body of a person who has died of a communicable disease apply.

10 Service Standard 4: Laboratory testing and diagnostic procedures

10.1 Indications for laboratory testing:

10.1.1 Potential causes of acute respiratory infections should be investigated as resources allow, in line with established case definitions, and based on clinical

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3 http://www.cdc.gov/niosh/nptl/topics/respirators/disp_part/RespSource3fittest.html
and epidemiological evidence to determine the presence of potential primary etiologies (e.g. *Streptococcus pneumoniae*, *Haemophilus influenzae* type b, *Legionella pneumophila*, mycoplasma, influenza virus, respiratory syncytial virus, MERS-CoV, SARS-CoV etc.).

10.2 A triage process must ensure that testing for MERS-CoV for example is only undertaken when there is clinical or epidemiological evidence that this virus may be the cause in an individual or cluster of patients so as to avoid the inappropriate generation of false positives and unnecessary activation of the public health response team. Priority for testing includes patients who require hospitalization.

10.3 Preferred respiratory specimens for influenza and influenza-like illness are nasopharyngeal aspirate, or dual collected throat swabs/nasopharyngeal swabs.

10.4 Preferred respiratory specimens for MERS-CoV are lower respiratory tract specimens such as sputum, endotracheal aspirate (ETA), or bronchoalveolar lavage (BAL).

10.5 Swabs for viral PCR should be placed into sterile universal transport media (UTM) and immediately placed on ice or cold packs or at 4-6 °C (refrigerator) for transport to the laboratory. Nasopharyngeal aspirate and endotracheal aspirate does not need to be placed in the UTM.

10.6 Specimen collection:

10.6.1 Swab specimens should be collected using swabs with a synthetic tip (e.g. UTM swab) and an aluminum or plastic shaft. Swabs with cotton tips and wooden shafts are not recommended.

10.6.2 For virus testing the swab specimen collection vials should contain 1-3 ml of viral transport medium.

10.6.3 Ensure that HCPs who collect specimens wear appropriate PPE.

10.6.4 Ensure that personnel who transport specimens are trained in safe handling practices and spill-decontamination procedures.

10.6.5 Place specimens for transport in leak-proof specimen bags (secondary container) that have a separate sealable pocket for the specimen (i.e. a plastic biohazard specimen bag), and a clearly written request form.

10.6.6 Deliver all specimens by hand whenever possible. Do not use pneumatic-tube systems to transport specimens.

10.6.7 State the name of the suspected infection of potential concern clearly on the accompanying request form. Notify the laboratory as soon as possible that the specimen is being transported.

10.7 Storing and shipping clinical specimens:

10.7.1 Store the specimen refrigerated at 4-6 °C, however, specimens should not be stored longer than 24 hours.

10.7.2 Clinical specimens for viral PCR should be shipped on ice or cold packs (avoid dry ice) in appropriate packaging (triple bag).

10.7.3 All specimens must be labeled clearly.

10.7.4 Clinicians must write on the laboratory request form if the patient is admitted or not and where (e.g. ICU).

10.7.5 Send the laboratory request form as soon as possible, but within 24 hours, together with the specimen to the laboratory.
For laboratory testing protocols and algorithms, interpretation of laboratory results, and biosafety requirements, applicable HAAD Standards, and, as necessary, WHO and CDC standards and guidelines must be applied, e.g.\(^5,6,7,8,9\).

11 Service Standard 5: Environmental and Engineering Infection Control

11.1 Environmental cleaning & disinfection plan

11.1.1 Standard procedures must be followed as per hospital procedures and manufacturers’ instructions, for cleaning and disinfection of:

- 11.1.1.1 Environmental surfaces and equipment. This includes cleaning/disinfection of all horizontal and frequently touched surfaces at least twice daily or when visibly soiled;
- 11.1.1.2 Textiles and laundry; and
- 11.1.1.3 Food utensils and dishware.

11.1.2 Hospital-grade cleaning and disinfection agents sufficient for inactivating influenza viruses and corona viruses must be applied.

11.1.3 Cleaning personnel must also follow droplet/airborne infection isolation precautions as applicable.

11.2 Engineering Controls

11.2.1 For inpatient facilities, Technical specifications of airborne infection isolations rooms (AIIR) must be in line with international best practice guidelines\(^10\) and ensure the following:

- 11.2.1.1 A minimum of 12 air changes per hour (> 12 ACH);
- 11.2.1.2 Pressure differential: greater than -2.5 Pascal;
- 11.2.1.3 Airflow direction: into the room; and
- 11.2.1.4 Filtration efficiency: supply air: ≥ 90%, return air: ≥ 99.97% (HEPA).

11.2.2 For inpatient facilities, if an AIIR is not available, an appropriate number of single rooms with anteroom and fixed or mobile HEPA filtration units, or exhaust air HEPA filtration must be made available.

11.2.3 For inpatient facilities, AIIR and single rooms for patients with influenza or influenza-like illness must be fitted, if feasible, with private toilets and must have a designated patient sink, wall-mounted liquid soap and tissue paper dispensers, and a medical waste container with foot control.

11.2.4 Designated staff hand washing sinks and paper towels for hand drying must be available.

11.2.5 Alcohol-based hand rub dispensers are available for use throughout clinical areas.

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\(^6\) WHO. Laboratory testing for novel coronavirus. Interim recommendations. 21 Dec 2012
\(^8\) CDC. Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Middle East Respiratory Syndrome (MERS-CoV). Available at: http://www.cdc.gov/coronavirus/mers/interim-mers-lab-biosafety-guidelines.html
### Definitions and Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>ACH</td>
<td>Air changes per hour</td>
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<tr>
<td>ARDS</td>
<td>Acute Respiratory Distress Syndrome</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infection: Any new onset acute respiratory infection that could potentially be spread by the droplet route (either upper or lower respiratory tract), which presents with symptoms of a new or worsening cough or shortness of breath and often fever. Note: Elderly people who are immunocompromised may not have a febrile response to a respiratory infection</td>
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<tr>
<td>AIIR</td>
<td>Airborne infection isolation room</td>
</tr>
<tr>
<td>BPAP</td>
<td>Biphasic Positive airway pressure</td>
</tr>
<tr>
<td>CDC</td>
<td>U.S. Centers for Disease Prevention and Control, Atlanta, GA, USA</td>
</tr>
<tr>
<td>CPAP</td>
<td>Continuous positive airway pressure</td>
</tr>
<tr>
<td>HEPA</td>
<td>High efficiency particulate air (filtration)</td>
</tr>
<tr>
<td>HCP</td>
<td>Healthcare personnel</td>
</tr>
<tr>
<td>HVAC</td>
<td>Heating, ventilation, and air conditioning</td>
</tr>
<tr>
<td>Influenza</td>
<td>Infectious diseases of birds and mammals (including humans) caused by RNA viruses of the family Orthomyxoviridae, the influenza viruses.</td>
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<tr>
<td>ILI</td>
<td>Influenza-like Illness - an acute respiratory infection that is usually characterized by fever, cough and other symptoms, and caused by other (non-influenza) viruses, e.g. rhinoviruses, respiratory syncytial virus (RSV), adenoviruses, parainfluenza viruses, coronaviruses (including MERS-CoV, SARS-CoV), and, less commonly, bacteria such as <em>Legionella</em>, <em>Chlamydia pneumoniae</em>, <em>Mycoplasma pneumoniae</em>, and <em>Streptococcus pneumoniae</em>.</td>
</tr>
<tr>
<td>NHS</td>
<td>United Kingdom National Health Service</td>
</tr>
<tr>
<td>Medical ventilator</td>
<td>A machine designed to mechanically move breathable air into and out of the lungs, to provide the mechanism of breathing for a patient who is physically unable to breathe, or breathing insufficiently.</td>
</tr>
<tr>
<td>MERS-CoV</td>
<td>Middle East Respiratory Syndrome Coronavirus</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
</tr>
</tbody>
</table>
| PPE          | Personal Protective Equipment. This may include:  
  - Gloves  
  - Gown (clean, non-sterile, long-sleeved)  
  - Face mask/surgical mask or Respirator (at least as protective as a fit-tested NIOSH-certified N95 filtering facepiece respirator)  
  - Eye protection (i.e. goggles or a face shield)  
  - Apron (impermeable, for some procedures with expected high fluid volumes that might penetrate the gown) |
| SARS-CoV     | Severe Acute Respiratory Syndrome Coronavirus |
| UTM          | Universal Transport Media |
| WHO          | World Health Organization |
## Appendix A: Case Definitions for Influenza and Influenza-like Illness (MERS-CoV and SARS)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Influenza</strong></td>
<td>See HAAD Standard for Public Health Reporting Data, Appendix 2: Communicable Diseases Case Definitions¹¹</td>
</tr>
</tbody>
</table>
| **Influenza Like Illness (ILI)**               |  • Sudden onset of a fever ≥ 38°C, AND  
  • Cough or sore throat, AND  
  • An absence of other diagnoses.                                                                 |
| **Middle East Respiratory Syndrome Coronavirus (MERS-CoV)** | **Probable case**                                                                            |
|                                                 |  • A person with a febrile acute respiratory illness with clinical, radiological, or histopathological evidence of pulmonary parenchymal disease (e.g. pneumonia or Acute Respiratory Distress Syndrome)  
  AND  
  Testing for MERS-CoV is unavailable or negative on a single inadequate specimen  
  AND  
  The patient has a direct epidemiologic-link with a confirmed MERS-CoV case, OR  
  • A person with a febrile acute respiratory illness with clinical, radiological, or histopathological evidence of pulmonary parenchymal disease (e.g. pneumonia or Acute Respiratory Distress Syndrome/ARDS)  
  AND  
  An inconclusive MERS-CoV laboratory test (that is, a positive screening test without confirmation)  
  AND  
  A resident of or traveller to Middle Eastern countries where MERS-CoV virus is believed to be circulating in the 14 days before onset of illness, OR  
  • A person with an acute febrile respiratory illness of any severity  
  AND  
  An inconclusive MERS-CoV laboratory test (that is, a positive screening test without confirmation)  
  AND  
  The patient has a direct epidemiologic-link with a confirmed MERS-CoV case.                                                                 |
|                                                 | **Confirmed Case**                                                                            |
|                                                 |  • A person with laboratory confirmation of MERS-CoV infection                                |
| **Severe Acute Respiratory Syndrome (SARS)**    | See World Health Organization: Case Definitions for Surveillance of Severe Acute Respiratory Syndrome (SARS)¹³ |

¹¹ [http://www.haad.ae/HAAD/LinkClick.aspx?fileticket=wuPj4izeZ-M%3D&tabid=820](http://www.haad.ae/HAAD/LinkClick.aspx?fileticket=wuPj4izeZ-M%3D&tabid=820)  
Appendix B: Screening and Patient Management Algorithm for Influenza and Influenza-like Illness

**Start**

Ask Patients if they sneeze, cough or have shortness of breath?  
No

Instruct Patient/individual to perform hand hygiene using an alcohol-based hand sanitizer, and to put on a mask

Yes

Ask Patients if they have a fever or felt feverish within the last 24 hours?  
No

Take the patient’s temperature and manage the patient as Influenza-like Illness (ILI), regardless of temperature measurement and inquire about other symptoms of ILI

Yes

Take the patient’s temperature  
No

Routine practices for upper respiratory tract infections

Yes

Does patient have evidence of lower respiratory tract involvement (e.g. pneumonia or ARDS)?

No

Routine Practices

Yes

Manage the patient as Influenza-like Illness (ILI)

Is the patient a resident of, or traveler to, Middle Eastern countries where MERS-CoV is believed to be circulating in the 14 days prior to onset of illness? (or close contact to such an individual)

No

Start

Yes

Is testing for MERS-CoV positive?

Yes

- Continue Droplet/Contact precautions or pathogen-specific precautions  
- Discontinue N95 respirator and AIIR

No

- Continue Droplet/Contact precautions plus N95 respirator and AIIR  
- Report to HAAD  
- Initiate investigation and exposure follow up

Routine Practices

- Initiate Droplet/Contact precautions plus N95 respirator and airborne infection isolation room (AIIR)  
- Notify facility infection control team and Health Authority - Abu Dhabi (HAAD)  
- Test for viral/bacterial respiratory pathogens (including MERS-CoV) and send the following specimens to a laboratory, as applicable:  
  - For influenza/influenza-like illness: nasopharyngeal aspirate, or dual collected throat swabs/nasopharyngeal swabs  
  - For MERS-CoV: Lower respiratory tract specimens (sputum, endotracheal aspirate, or bronchoalveolar lavage (BAL))  
  - Urine  
  - Blood for serology, acute and convalescent  
  - Blood in EDTA for PCR  
  - Stool, if diarrhea, in dry sterile container