Respiratory Infection (RI) Outbreak Guidelines for Residential Care Settings
September 2017
(Supersedes October 2016)

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Introduction

Respiratory infections (RI) are often spread when people cough or sneeze and droplets of their respiratory secretions come into direct contact with the mucous membranes of the eyes, mouth, nose, or airway of another person. Because micro-organisms in droplets can survive on other surfaces, droplet-spread infections can also be spread indirectly when people touch contaminated hands, surfaces and objects.

Outbreaks of RI can occur at any time during the year. A number of viruses and several bacteria can cause institutional RI outbreaks, such as Parainfluenza, Respiratory Syncytial virus (RSV), Coronavirus, Rhinovirus, Human metapneumovirus, Adenovirus, Streptococcus pneumoniae or Bordetella Pertussis. Influenza is a major cause of respiratory outbreaks and can occur at any time, but is largely limited to the period from November 1 – March 30. While no single protocol can cover all of the more detailed aspects that might be necessary for some specific organism outbreaks, all respiratory outbreaks, can initially be managed in a similar fashion with basic measures to prevent further respiratory transmission, at least until the organism is identified and more specific measures can be put into place (e.g. antiviral prophylaxis for influenza).

The goal of this document is to provide current best practice/ evidence –based guidelines for outbreak control and management of respiratory illness (RI) in Residential Care facilities with the information and tools required to prevent, identify and control outbreaks of RI in a way that balances resident and staff protection with the least possible interference on facility function and resident well-being. The document is organized into sections:

1. Pre-Outbreak Preparation
2. Outbreak Detection and Consultation
3. Outbreak Management
4. References
5. Tools, Forms and Resources

The guidelines apply to Interior Health (IH) Adult Residential Care Facilities and Privately Operated Adult Residential Care Facilities that are licensed through the Hospital Act or Community Care and Assisted Living Act. The principles in these guidelines may also be useful in acute care or assisted living settings.

NOTE: For management of staff in IH facilities during an RI outbreak please refer to AV1300 Staff Influenza Immunization and Exclusion Policy.

For non-IH facilities, follow your facility’s Influenza Immunization Policy or, for licensed facilities, the Residential Care Regulation.
1. Pre Outbreak Preparation

This section contains information to help prepare facilities to detect and manage outbreaks. The following is a quick checklist of activities for pre-season planning.

- Familiarize staff with the current IH Respiratory Infection Outbreak guideline.
- Pick up influenza vaccine and vaccinate Health Care Workers (HCW).
- Provide influenza vaccine and pneumococcal (as required) vaccine to residents.
- Maintain staff and resident influenza immunization records.
- Order and maintain a supply of infection control supplies required for outbreak management, including PPE, signage and outbreak documents.
- Provide education to staff and residents.
- Ensure there is an adequate number of staff available to work during the outbreak season.

A. Create an Outbreak Management Team (OMT)

Ideally, all facilities should have a designated Outbreak Management Team (OMT). The OMT is responsible for directing and reviewing outbreak control measures during an outbreak. The Director of Care or Most Responsible Person of the site sets up the OMT and schedules regular meetings of the group during an outbreak. Membership of the OMT may include:

- Medical Health Officer (Residential Facilities)
- IPAC Medical Director
- An administrator or Director of Care
- Infection Control Practitioner (IH Facilities)
- CD Specialist (if no ICP available for the facility)
- An Occupational Health Nurse or person responsible for Workplace Health and Safety
- Front line health care provider such as a Charge Nurse
- Housekeeping representative
- Food services supervisor
- Access and Flow representative

Optional:
- A medical advisor (if available)
- A Communications representative

The purpose of this group is to evaluate and modify outbreak control measures so the outbreak can be declared over as soon as possible.
B. Preparation for an Outbreak

Once an RI outbreak has been detected, the key to successful management is implementing all of the appropriate measures as soon as possible. All staff should be aware of how to put the measures into place. To be prepared:

- Know who to contact.
- Order swabs from PHSA by September 15. Swabs maybe ordered and replaced as needed.
  Fax Sample Container Order Form to PHSA BCCDC at 604-707-2606 or email to kitorders@hsssbca.ca.
- When the supply of swabs is received, discard any remaining stock which may have expired.
- Know who is immunized. Ensure new residents are vaccinated and pre-printed orders for oseltamivir are prepared.
  - Note: Routine annual serum creatinine is no longer required, as part of fall influenza preparedness activities. Please see the section on oseltamivir for further information.
- Ensure adequate infection control and cleaning supplies are available, such as hand soap/sanitizer, masks, goggles, gowns, linens, surface disinfectants, waste-bins with step-on lids and signage.
- The Outbreak Management Team lead should conduct a review annually and clarify the details of how to report a suspected respiratory infection outbreak for their geographic health service area with their facility staff. This annual review is best done in early October of each year.
  Templates for these activities are included under Tools for Pre-Outbreak Preparation.

C. Influenza Vaccine Delivery

Immunization of Health Care Workers (HCWs)

Influenza remains a significant cause of illness and death amongst the elderly and frail residents of care facilities. **Influenza vaccination of both residents and health care workers is the most effective measure for reducing the impact of influenza in residential facilities.** It reduces the risk of severe illness or death from influenza infection in individuals and it reduces the risk of influenza outbreaks.

Immunization of HCWs is critical to the care of vulnerable clients in order to achieve the best protection for them.

A HCW is any person carrying out paid or unpaid work in a healthcare facility. Persons who volunteer or undergo training in a health care facility for any period of time between October to April and all HCWs are eligible for free vaccine.
Vaccinations of HCWs should commence each year as soon as the vaccine becomes available. Instructions for ordering vaccine are sent to each facility by the local public health (PH) office prior to the influenza season. The vaccine will be available throughout the season and managers should ensure that staff is vaccinated whenever they commence working in a facility during the months October through April.

Staff may be vaccinated at their place of employment, through PH clinics, or by their family physician or pharmacist. All persons receiving the vaccine should be screened for contraindications. Influenza vaccine should not be given to people who have had an anaphylactic reaction to a previous dose of influenza vaccine.

Staff that decline immunization for a medical reason need to provide appropriate documentation from their physician to their supervisor (or designated Occupational Health Nurse in IH facilities). See link to sample letter on page 30.

It is important for each facility to keep an up-to-date record of who has received influenza vaccine. All staff is encouraged to keep their own record of immunization to show their employer especially when employed at multiple sites, when vaccination is obtained from the PH centre or physician’s office, or when received at an outbreak setting.

The most responsible person in the facility should review the immunization rates by the end of December. If staff rates are less than 60% and resident rates are less than 90%, the facility should develop a plan to increase immunization rates or mitigate the effect should an influenza outbreak be declared.

- IH Administrative Policy Manual AV1350 Influenza Prevention Policy
- IH Administrative Policy Manual AV1300 Staff Influenza Immunization and Exclusion Policy

Immunization of Residents of Adult Residential Care Facilities

Residents of any age are eligible for free influenza vaccine and require vaccination annually. Unvaccinated residents who catch influenza can become very ill and can spread the virus to other residents and staff in the facility. Immunization helps prevent illness and reduces shedding of the virus.

In addition residents are eligible for pneumococcal vaccine if in a risk group or over age 65. Facilities are encouraged to screen for vaccine eligibility on admission.

Records and Reporting

Facilities need to maintain annual records of HCW influenza vaccination status and have these records available in the event of an influenza outbreak.

Private and contracted facilities will need to send reports on vaccine coverage to the local PH center using the form at the end of these Guidelines. Workplace Health and Safety provides PH centers with staff vaccination coverage data for all IH Facilities.

IH Staff should refer to the IH Influenza Protection Program webpage for more information.


D. Antivirals

When the RI outbreak has been identified as an influenza outbreak (by lab confirmation, or based on the assessment of the Medical Health Officer (MHO)), antivirals are initiated, both for treatment and for prevention. It is important to work with the facility pharmacist and the Medical Director to ensure facilities are ready to provide antiviral medication as soon as possible after the influenza outbreak has been declared. The current recommendation is to use oseltamivir as it is effective against both Influenza A and B. Prior to the end of October each year the facility should:

- Identify individuals with a contraindication to oseltamivir. Note: **A recent (in the last 12 months) serum creatinine or creatinine clearance is not required before starting oseltamivir**, unless there is reason to suspect renal impairment. If renal impairment is not suspected, it can be assumed to be greater than 60 mL/min. If renal impairment is present (CrCl is 60 mL/min or less), oseltamivir dosage and regimen will need to be adjusted. (Refer to Association of Medical Microbiology and Infectious Disease Canada Guidelines: The Use of Antiviral Drugs for Influenza: Guidance for Practitioners 2012/2013). For residents who are on dialysis, consult the resident’s nephrologist or Interior Health Communicable Disease Unit for dosing regimen.

- Obtain Oseltamivir pre-printed orders:
  - Oseltamivir Prophylaxis Influenza A and B (# 829559)
  - Oseltamivir Treatment Influenza A and B Infection (# 829561)

  Both PPOs should be signed by the residents’ physicians and placed on the residents’ charts prior to the start of outbreak season.

- Ensure facilities’ pharmacies can supply the volume of oseltamivir required for prophylaxis all facility residents.

A suggested protocol for oseltamivir is included under **Tools for Outbreak Management and Reporting**.

E. When to use Anti-Viral Medication

Antivirals are not effective against respiratory infections other than influenza. Therefore, it is important to base decisions about their use on appropriate epidemiologic, clinical and laboratory data about the etiology of prevalent infection(s).

When the causative agent has been lab-identified as influenza or when a Scenario A outbreak has been declared by the MHO, the appropriate use of antiviral medication for the prophylaxis (prevention) and treatment of infections has been shown to be effective in controlling outbreaks due to influenza in residential care facilities. Antiviral prophylaxis should not replace annual influenza vaccination.
Vaccination remains the primary tool for the prevention of influenza infection and illness.

Oseltamivir should be used as follows:

**Residents:**

For **prophylaxis** of influenza:

- All symptom-free residents should receive prophylaxis once a Scenario A outbreak has been declared and it should continue until the outbreak is declared over. This date may be defined as a minimum of 8 days after the onset of illness in the last case.

For **treatment** of Influenza:

- All residents with influenza symptoms should receive treatment provided the medication can be started within 48 hours of onset of symptoms. Treatment should continue for 5 days.

**Health Care Workers (HCWs):**

- All symptom-free, unimmunized HCWs should receive influenza antiviral medication and/or vaccine as soon as possible.
- Antiviral prophylaxis should continue until the outbreak has been declared over (usually 8 days after the onset of illness in the last case) or until 14 days after immunization if the outbreak has not been declared over.
- HCWs may return to work as soon as they have received their first dose of antiviral medication.
- Staff to obtain a prescription for the antiviral medication from their family physician or Nurse Practitioner.
- A sample letter for staff to take to their physician is attached as a link on page 31.

**Oseltamivir:**

The recommended oral dose of oseltamivir for **prophylaxis** of influenza in persons greater than 13 years of age is 75 mg once daily. No dose adjustment is necessary if the eGFR is greater than 60 ml/minute. A dose adjustment for an eGFR less than 60 ml/minute is recommended as follows:

- eGFR 31 – 60 mL/min, give Oseltamivir 30 mg PO daily
- eGFR 10 – 30 mL/min, give Oseltamivir 30 mg PO every 48 hours
- Peritoneal dialysis: give Oseltamivir 30 mg PO before dialysis, then 30 mg every 7 days
- Hemodialysis: give Oseltamivir 30 mg PO before dialysis, then 30 mg after every alternate dialysis session
If the patient is receiving peritoneal dialysis or hemodialysis, Oseltamivir pre-printed orders should be faxed to the renal program and/or dialysis unit for their records.

The recommended oral dose of Oseltamivir for the treatment of influenza in persons more than 13 years of age is 75 mg twice daily for 5 days. No dosage adjustment is necessary if the eGFR is greater than 60 mL/minute. A dose adjustment for an eGFR less than 60 mL/minute is recommended as follows:

- eGFR 31 – 60 mL/min, give Oseltamivir 30 mg twice a day for 5 days.
- eGFR 10 – 30 mL/min, give Oseltamivir 30 mg daily for 5 days.
- Peritoneal dialysis: give Oseltamivir 30 mg x 1 dose before dialysis.
- Hemodialysis: give Oseltamivir 30 mg PO before dialysis, then 30 mg after each dialysis session x 5 consecutive days.

If the patient is receiving peritoneal dialysis or hemodialysis, the signed Oseltamivir pre-printed orders should be faxed to the renal program and/or dialysis unit for their records.

To estimate renal function, creatinine retesting is not required if the estimated GFR (eGFR) was 60 mL/minute in the last 12 months and no renal dysfunction is suspected by the physician, if a recent creatinine is available (in the previous 4 weeks), or if the patient receives chronic hemodialysis or peritoneal dialysis. A creatinine is recommended if there has been no creatinine tested in the last 12 months or if the eGFR is less than 60 mL/minute or renal dysfunction is suspected by the physician. Note that the eGFR is automatically reported for each creatinine.

Oseltamivir should not be administered to patients with an Oseltamivir allergy or intolerance, or who refuse treatment.

In general, Oseltamivir is well tolerated, with the most common adverse effects being nausea, vomiting and diarrhea.

It is recommended that the two pre-printed orders be completed annually for each resident in advance of the Influenza outbreak season:

- Oseltamivir Prophylaxis – Influenza A and B – Residential Care # 829559
- Oseltamivir Treatment – Influenza A and B – Residential Care # 829561

**Surveillance of Side Effects from Antivirals:**

As with any medication, surveillance of adverse side effects should be documented in the resident’s chart. Particular or unusual concerns that arise should be reported to the Director of Care, Medical Director, or ICP as applicable.

More detailed information on the use of antivirals including indications for use, dosage, potential side effects can be found in the most current Compendium of Pharmaceuticals and Specialties (e-CPS).
2. Outbreak Detection and Consultation

This section contains information to assist facilities when they suspect an outbreak is caused by a Respiratory Infection (RI). Facilities need to be aware of staff and residents who meet the case definition for a respiratory infection.

If you suspect an RI Outbreak:

- Initiate Droplet & Contact Precautions.
- If you are an IH facility (check here) and have an assigned Infection Control Practitioner (ICP), consult with your ICP Monday to Friday during business hours.
- If your facility does not have an assigned ICP, consult the IH Communicable Disease Unit (CD Unit) 1-866-778-7736 during business hours (Monday to Friday 8:30am to 4:30pm).
- On weekends and holidays, notify the MHO on-call (1-866-457-5648).
- Notify the facility’s Most Responsible Person: the person with the highest level of administrative authority at the time of the outbreak. This may be the Director of Care, Clinical Manager, Patient Care Coordinator, Manager of Residential Services, or the Administrator on call. This individual will initiate the OMT.
- Take specimens, one nasal swab per person (up to six individuals, residents or staff) for lab testing to confirm causative organism. Send only when the outbreak has been declared.
- Send specimens to BCCDC along with the appropriate requisitions and forms.
- Initiate staff and resident surveillance tools.
- Designate an individual to be responsible for daily outbreak tracking and updates.

A. Surveillance for Illness

RI Outbreaks may occur at any time, but are much more frequent during the winter season due to common circulating viruses, including influenza. RI may have different presentations but a common symptom to watch for is a new or worsening cough.

Facility managers should make every attempt to ensure that both Health Care Workers (HCWs) and residents are monitored for the presence of new or worsening cough and other signs of respiratory illness. As part of outbreak readiness, designate 1 or 2 staff members to be responsible for maintaining records for an RI outbreak.
B. Case Definitions for Respiratory Infection (RI)

*Respiratory Infection (RI) Case Definition:*

New or worsening cough and a fever greater than 38°C or a temperature that is abnormal for that person. Additional symptoms may include myalgia/arthralgia, extreme fatigue, runny nose, sore throat, head ache.

There may be groups within the populations that would not meet this definition, yet are infected with an organism that can cause RI outbreaks. For example, young children, the elderly, the immune-compromised, or those taking medications such as steroids, NSAIDS, or ASA may not develop a fever, or may have a lowered temperature as a result of the infection. A temperature of less than 35.6°C or greater than 37.4°C in the elderly may be an indication of infection. The ICP/CD Unit/MHO may be consulted if you have an unusual cluster of illness in your facility that does not meet the case definition.

C. Definition of an RI Outbreak

*Respiratory Infection (RI) Outbreak Definition:*

Two or more cases of RI occurring in a unit/facility area within a 7-day period amongst staff and/or residents.

D. Identifying Causative Organism

When an outbreak is identified:

- Collect one nasal/nasopharyngeal swab from each ill resident (to a maximum of 6 different individuals) who meets the case definition for RI as per instructions in the swab kits.
  - Collect swabs within 48-72 hours of symptom onset.
  - Send swabs as soon as possible by courier (or by other local lab arrangements) to the Provincial Laboratory at the BC Centre for Disease Control.
  - Include the PHSA Laboratories Virology Requisition for each sample and one copy of the PHSA Laboratories Influenza-Like Illness (ILI) Outbreak Laboratory Form

Include the IH CD Unit (C09768) in the “Copy To” field on the requisition.

Information on collecting and sending specimens is included under Tools for Outbreak Detection and Consultation.
E. Reporting an Outbreak

A suspected respiratory outbreak needs to be reported as soon as possible to the Director of Care or the facility designated most responsible person and the ICP, if applicable, who will ensure outbreak measures are put in place.

The facility or the facility ICP must notify the CD Unit at 1-866-778-7736. The CD Unit is open Monday to Friday from 8:30am to 4:30pm. Information required by the CD Unit includes:

- total number of residents ill and the date of symptom onset
- total number of staff ill
- location of outbreak in facility
- number of swabs sent
- general outbreak measures initiated
- staff immunization rates
- resident immunization rates

If an outbreak is identified after business hours Monday through Thursday, report the outbreak to the CD Unit on the next business day. On weekends and holidays notify the MHO on call (1-866-457-5648)

Facilities licensed under the Community Care and Assisted Living Act are reminded that disease outbreaks are a reportable incident under the Residential Care Regulations. Operators should also notify the Licensing Program when any outbreak occurs.

F. Declaring an Outbreak

The MHO will declare the RI outbreak and will be guided by the type of illness presentation and by lab results to determine the type of management scenario.

When first declaring the outbreak, consideration should be given to whether the outbreak can be contained within one section/floor of the facility.

- If staff can be cohorted to work only in the affected area where cases exist and residents can be contained within that area, then it is preferable to declare the outbreak in that area alone as opposed to declaring an outbreak for the entire facility.
- If staff (including RN’s and LPN’s) and residents cannot be cohorted, then the outbreak will be declared for the entire facility.

Scenario A

More severe respiratory illness known or suspected to be due to influenza.

(Equivalent to Scenario A, p 123, PICNetBC 2007 – Respiratory Outbreak Guidelines)
**Scenario B**
More severe respiratory illness known or suspected to be due to a non-influenza viral or bacterial infectious cause.
(Equivalent to Scenario B, p 124, PICNetBC 2007 – Respiratory Outbreak Guidelines)

**Scenario C**
Milder respiratory illness, known or suspected to be due to other non-influenza viral pathogens, most commonly rhinovirus and coronavirus.
(Equivalent to Scenario C, p 125, PICNetBC 2007 – Respiratory Outbreak Guidelines)

1. **Notification of Partners**
   Once an outbreak has been declared, fill out the top section and Section A of the [RI and GI Outbreak Report Form](#) and email to [cdunit@interiorhealth.ca](mailto:cdunit@interiorhealth.ca) or fax to 250-549-6310. Send a copy to your site ICP (IH facilities).

   The Most Responsible Person ensures that partners have been notified such as:
   - Community Care Licensing Officer
   - CIHS Administrator on Call
   - Staffing office (if there is ill staff, to arrange for adequate relief staff)
   - Hospital/Facilities to which residents have been recently transferred
   - Medical Director, and physicians of the residents
   - PHSA lab (via the PHSA Laboratories Influenza Like illness Outbreak Lab form) for specimens collected as part of the outbreak investigation
   - Other service providers as appropriate:
     - Patient Transport office, oxygen services, laboratory services, BC Ambulance, haemodialysis units, pastoral care, staffing, resident’s physicians etc.

2. **Roles and Responsibilities**
   **Director of Care or Most Responsible Person**
   - Organizes OMT meetings.
   - Ensures the facility notifies the CD Unit or IH facility ICP that an RI outbreak is suspected.
   - Ensures that outbreak control measures have been put into place and the RI Outbreak Guidelines for Residential Care Settings are being followed.
   - Ensures the RI and GI Outbreak Report form is reported daily to the Communicable Disease Unit and the ICP (IH facilities).
• Notifies partners (as above).
• Notifies other facilities where staff work, and hospitals to which residents/patients have been transferred within the last 72 hrs.
• Works collaboratively with WH&S to monitor and report staff illness.
• Ensures ongoing communication with all staff in the facility regarding the outbreak situation.
• When necessary, collaborates with the Communication representative in the event that media statements are required.

**Medical Health Officer**

• Declares the outbreak and determines which Scenario is to be used to manage the outbreak.
• Determines repatriation of residents, admissions and transfers of individuals into the facility under outbreak.
• The MHO has legislative authority and responsibility, according to the Public Health Act, to control the outbreak. The MHO has assigned this responsibility to the CD Unit Monday to Friday from 0830 to 1630. For IH facilities, this responsibility has been assigned to the facility ICP.

**Communicable Disease Unit**

• Receives the RI and GI Outbreak Report Form from the facility when the outbreak is declared, each day during the outbreak, and when the outbreak is declared over. Conducts surveillance for the outbreak.
• For non-IH facilities, the CD Unit follows-up with the facility to review the outbreak situation: e.g. outbreak definition is being met, lab specimens are being collected, outbreak control measures are in place, and PHSA lab has been notified of the outbreak.
• Notifies the MHO and stakeholders of an outbreak declaration, relevant, lab results, and when an outbreak is declared over.
• For non-IH facilities, the CDU declares the outbreak over as per the RI Guidelines or in consultation with the MHO when necessary.
• Provides outbreak education to the facilities in collaboration with ICP prior to outbreak season.

**Infection Control Practitioners (ICP)**

• For IH facilities, the ICP follows-up with facility to review the outbreak situation: e.g. outbreak definition is being met, lab specimens are being collected, outbreak control measures are in place, and PHSA lab has been notified of the outbreak.
• For IH facilities, receives a copy of the RI and GI Outbreak Report Form from the facility when the outbreak is declared, each day during the outbreak, and when the outbreak is declared over.

• For IH facilities, the ICP provides ongoing support and education to ensure control measures are implemented. The ICP collaborates with facility nursing staff to ensure the RI and GI Outbreak Report Forms are completed correctly.

• For IH facilities, the ICP declares the outbreak over as per the RI Guidelines or in consultation with the MHO when necessary.

• Ensures notification of all necessary stakeholders regarding outbreak situation including outbreak declaration, ongoing control measures and when outbreak is declared over.

• Provides an opportunity for debriefing following an outbreak if required.

• Completes IPAC Outbreak Summary Report and sends to facility Manager/Director of Care and IPAC Epidemiologist.

• Provides outbreak education prior to outbreak season in collaboration with the CD Unit.

Nursing Staff

• Works collaboratively with facility ICP (IH facilities) and facility manager to ensure early recognition of RI illness in residents and possible outbreaks occurring.

• Ensures timely implementation of outbreak control measures.

• Collects necessary specimens and sends them to BCCDC with completed requisition forms as well as the PHSA Laboratory ILI Outbreak Laboratory form.

• Maintains daily surveillance for new resident RI cases.

• **Completes the RI and GI Outbreak Report form** and sends it to the CD Unit and the ICP (if the facility has one assigned) when the outbreak is declared, each day during the outbreak, and when the outbreak is declared over.

All Employees

• Report RI illness to their supervisor and does not work for the duration of their illness.

Support Services

• Ensures additional resources including staff, supplies and enhanced cleaning are available and implemented during the outbreak.
Access and Flow

- Contributes information regarding repatriation of residents to their residential care facility.

Communication Representative

- Works collaboratively with the OMT representative (i.e. the Facility Director), the MHO and other key players involved in the outbreak to provide consistent, timely and accurate communication to the media when required.
3. Outbreak Management

This section contains information to assist facilities in managing an outbreak caused by a Respiratory Infection. The specific outbreak management strategies are applied based on the management scenario (A, B, or C) designated by the MHO.

Declaring the Outbreak Over

The CD Specialist (CD Unit) or the ICP in IH facilities will declare RI outbreaks over following the guidance provided for Scenarios A and B in these guidelines and consulting with the MHO as necessary.

Facilities can self-declare Scenario C outbreaks over after 4 days without a new case.

MHO consultation will still be required for outbreaks involving severe illness, unusual organisms, emerging pathogens or any unusual circumstances (e.g. a request to declare an outbreak over before the usual time period described in the guidelines).

If the possibility exists that an outbreak might be able to be declared over during a weekend/holiday, then the facility can consult with the MHO/CDU/ICP prior to the weekend and make arrangements to self-declare the outbreak over on the weekend/ holiday, should no new cases arise.

Scenario A – Specific Measures for Managing an Outbreak

More severe respiratory illness known or suspected to be due to influenza.

1. Initiate Antivirals
   - Initiate the recommended anti-viral treatment and prophylaxis (see When to use Antiviral Medication).

2. Ill Residents
   - Isolate ill residents in their room as much as possible while potentially infectious.
   - Provide meal tray service in room.
   - Ensure staff and visitors use appropriate Routine Practices and Additional Precautions
     - Use Droplet/Contact Precautions
     - Information on Droplet/Contact precautions can be found under Tools for Outbreak Management and Reporting.

3. Ill Staff
   - Recommend ill staff stay away from work for the duration of their acute symptoms or 5 days, whichever is longer.

4. Implement Infection Prevention And Control Practices
   - Point of Care Risk Assessment
• Must be done for any interaction with the resident: assess resident’s symptoms and cognitive ability, type of interaction that will occur, necessary Personal Protective Equipment (PPE) and potential for contamination of equipment or environment.

- Hand Hygiene
  - Provide hand sanitizer at all entrances and exits with signage on how to use.
  - Practice hand hygiene before and after contact with each resident.

- Respiratory Hygiene
  - Remind residents, visitors and staff to cover the nose and mouth when sneezing and coughing and to perform hand hygiene after coughing, sneezing or using tissues.

- Routine Practices and Additional Precautions
  - Use Routine Practices for interaction with all residents.
  - Use Droplet/Contact Precautions for interaction with residents showing symptoms of RI.

5. Cohort Staff
• Only immunized staff or staff taking antivirals may work in the facility/area under outbreak.

• Staff members should be cohorted to work with either ill residents or well residents. If this is not possible, staff should work with asymptomatic residents first and then with symptomatic residents. Strict hand hygiene and infection control practices should be maintained between residents. Healthcare providers entering the facility/area during an outbreak (e.g. laboratory staff or physicians) must:
  - be immunized;
  - provide care or services in the non-affected areas of the facility or with well residents first;
  - use strict hand hygiene measures; and
  - follow Droplet Contact precautions.

6. Cohorting of Residents
• Moving residents in a Residential Care facilities to achieve cohorting is not appropriate as displacement of residents from their own rooms will often cause anxiety and disorientation.

• When possible, cohorting is achieved by restricting the movement of residents between an area of the facility known to have RI cases (such as a pod or “neighbourhood”) and areas that do not have RI cases, for the duration of the outbreak.
7. **Enhanced Housekeeping**
   - Frequent disinfection of commonly touched surfaces or items such as handrails, elevator buttons and door handles. Use a product approved for use on viruses.
   - Provide sufficient receptacles for safe disposal of contaminated items such as tissues.
   - Clean and disinfect all equipment between use for different residents. This is a shared responsibility between all staff.

8. **Education**
   - Teach staff early signs of RI, how to prevent its spread and how to educate residents and their visitors.

9. **Immunization**
   - Offer vaccine to unimmunized residents and staff who do not have contraindications to influenza immunization.

10. **Exclusions of Well HCWs**
    - Initiate exclusion of unimmunized well HCWs.
      - In IH facilities, follow the exclusion criteria outlined in [AV1300 Staff Influenza Immunization and Exclusion Policy](#) for unimmunized staff.
      - For non-IH facilities, follow your facility’s Influenza Immunization Policy or, for licensed facilities, the [Residential Care Regulation](#).
    - HCWs that are unimmunized are at risk of contracting influenza and should be excluded for the duration of the outbreak, unless taking antiviral medication.

11. **Restrict Admissions And Transfers**
    - Restriction of admissions/discharges of residents to and from the facility will be implemented for the duration of the outbreak.
    - Should a transfer to an acute care facility be medically required, notify the receiving facility of the outbreak and the need to isolate the resident for an incubation period.
    - **Re-admission/Repatriation**: The MHO must be consulted for all re-admission issues.
      - If you are an IH facility, the facility ICP will consult with the MHO. If you are not an IH facility, the CD Unit will consult with the MHO.
      - In general, the re-admission of residents who met the case definition for RI prior to discharge/transfer is reasonable provided appropriate accommodations and care can be provided. It is the role of the Director of Care or Most Responsible Person in the facility to consult directly with the CD Unit/ICP regarding repatriation/re-admission issues. This is not the role of the Acute Care facility seeking re-admission/repatriation.
12. Restriction Of Group Activities

- Group activities for residents should be suspended within the affected area.
- Restriction of residents’ movements within the facility will be implemented (to wing or floor, depending on layout of the facility).
- Group exercise programs conducted by allied healthcare staff may continue for asymptomatic residents in the outbreak area, unless the OMT indicates restrictions are required.
- Consider cancelling non-critical volunteer services (e.g. hair dressing, animal visits, candy striper).

13. Visitor Restrictions

- In general, a complete closure of the facility to all visitors/volunteers is not recommended and should only be done in consultation with the MHO and with careful consideration of the risks/benefits to all residents.
  - If possible, notify family members of ill residents.
  - Advise visitors of the potential risk of acquiring infections within the facility and of re-introducing infections into the facility.
  - Advise visitors to reschedule visits if they are sick with respiratory symptoms.
  - Visitors, including family members, should be counselled about their ability to spread the virus.
  - As per IH policy, during flu season it is recommended that all visitors who are not vaccinated against influenza be offered a mask if they enter patient care areas.
  - All visitors are required to perform hand hygiene on arrival and immediately prior to leaving the resident’s room, follow respiratory hygiene processes, and are not to visit other residents in the facility.

14. Post Outbreak Signage

- Use signage to alert visitors of the outbreak and required precautions. Sample posters are included through a link on pg. 30.

15. Daily Outbreak Tracking

- Fax or email the RI and GI Outbreak Report Form to the IH CD Unit by the end of the business day. Fax to 250-549-6310 or email cdunit@interiorhealth.ca. Send a copy to the site ICP as well.
• For in-facility use only, update the resident and staff illness surveillance forms
• Reporting sheets are provided under Tools for Outbreak Management and Reporting.

16. Declaring The Outbreak Over
• The MHO/CD Unit/ICP will declare the outbreak over on the morning of the 8th day after the onset of illness in the most recent case and 4 days after the last symptomatic staff member worked in the facility.

Scenario B – Specific Measures for Managing an Outbreak

More severe respiratory illness known or suspected to be due to a non-influenza or bacterial infectious cause

1. No Antiviral Medication is Necessary

2. Ill Residents
• Isolate ill residents in their room as much as possible while potentially infectious.
• Provide meal tray service in room.
• Ensure staff and visitors use appropriate Routine Practices and Additional Precautions
• Use Droplet/Contact Precautions
  • Information on Droplet/Contact Precautions can be found under Tools for Outbreak Management and Reporting

3. Ill Staff
• Recommend ill staff stay away from work for the duration of their acute symptoms.

4. Implement Infection Prevention And Control Practices
• Point of Care Risk Assessment
  • Must be done for any interaction with the resident: assess resident’s symptoms and cognitive ability, type of interaction that will occur, necessary Personal Protective Equipment (PPE) and potential for contamination of equipment or environment.
• Hand Hygiene
  • Provide hand sanitizer at all entrances and exits with signage on how to use.
  • Practice hand hygiene before and after contact with each resident.
• Respiratory Hygiene
  • Remind residents, visitors and staff to cover the nose and mouth when sneezing and coughing and to perform hand hygiene after coughing, sneezing or using tissues.
• Routine Practices and Additional Precautions
  ▪ Use Routine Practices for interaction with all residents.
  ▪ Use Droplet/Contact Precautions for interaction with residents showing symptoms of RI.

5. Cohort Staff
• Staff members should be cohorted to work with either symptomatic residents or asymptomatic residents for the duration of their shift.
• If this is not possible, staff members should work with asymptomatic residents first, then with symptomatic residents. Strict hand hygiene and infection control practices must be used between residents at all times.
• Healthcare persons entering the facility during an outbreak (such as lab staff or physicians) must work in the non-affected areas of the facility or with well residents first, use strict hand hygiene measures and follow Droplet Contact precautions.

6. Cohorting Of Residents
• Moving residents in a Residential Care facility to achieve cohorting is not appropriate as displacement of residents from their own rooms will often cause anxiety and disorientation.
• When possible, cohorting is achieved by restricting the movement of residents between an area of the facility known to have RI cases (such as a pod or “neighbourhood”) and areas that do not have RI cases, for the duration of the outbreak.

7. Enhanced Housekeeping
• Frequent disinfection of commonly touched surfaces or items such as handrails, elevator buttons and door handles. Use a product approved for use on viruses.
• Provide sufficient receptacles for safe disposal of contaminated items such as tissues.
• Clean and disinfect all equipment when used between different residents. This is a shared responsibility between all staff.

8. Education
• Teach staff early signs of RI, how to prevent its spread and how to educate residents and their visitors.

9. Immunization
• If an influenza outbreak is suspected, offer vaccine to unimmunized residents and staff who do not have contraindications to influenza immunization.

10. Exclusion of Well HCWs
• There is no policy to exclude well HCWs under Scenario B or C RI outbreaks.
11. Restrict Admissions and Transfers

- **Consult the CD Unit/IH facility ICP regarding any potential admissions.** They will then consult with the MHO.
  - In general, admissions should be limited to those deemed to be essential and consider the receiving facility’s ability to provide suitable accommodation during the outbreak to prevent exposure (e.g. room in separate wing not affected by outbreak; private room).
  - Include resident/decision maker and attending physician in the decision to admit during an outbreak. They must be able to provide informed consent.
- If resident is transferred to acute care, notify the receiving facility of the outbreak so they can initiate appropriate precautions (including suitable accommodation and isolating the resident through an incubation period if necessary).
- **Consult CD Unit/IH facility ICP regarding any potential discharges/transfers to facilities other than acute care.** Discharge to a residential facility may be considered if the receiving facility is made aware and are able to isolate the resident through an incubation period.
- **Re-admission/Repatriation:** Consult CD Unit/IH facility ICP for all issues around re-admission of a resident. It is the role of the Director of Care or Most Responsible Person in the facility to consult directly with the CD Unit/ICP regarding repatriation/re-admission issues. This is not the role of the Acute care facility seeking re-admission/repatriation.

12. Restriction Of Group Activities

- Review group activities and consider cancelling or modifying to prevent spread. (i.e. cohorting ill-residents with ill-residents, and well-residents with well-residents).
- Weigh the importance of group activities for resident well-being against the needed infection control measures.
- Consider cancelling non-critical volunteer services (e.g. hair dressing, animal visits, candy stripers).

13. Visitor Restrictions

- In general, a complete closure of the facility to all visitors/volunteers is not recommended and should only be done in consultation with the MHO and with careful consideration of the risks/benefits to all residents.
  - If possible, notify family members of ill residents.
  - Advise visitors of the potential risk of acquiring infections within the facility and of re-introducing infections into the facility.
  - Advise visitors to reschedule visits if they are sick with respiratory symptoms.
  - Visitors, including family members, should be counselled about their ability to spread the virus.
- As per IH policy, during flu season it is recommended that all visitors who are not vaccinated against influenza be offered a mask if they enter patient care areas.
- All visitors are required to perform hand hygiene on arrival and immediately prior to leaving the resident’s room, follow respiratory hygiene processes, and are not to visit other residents in the facility.

14. Post Outbreak Signage
- Use signage to alert visitors of the outbreak and precautions to use. Sample posters are included through a link on page 30.

15. Daily Outbreak Tracking
- Fax or email the RI and GI Outbreak Report Form to the IH CD Unit by the end of the business day. Fax to 250-549-6310 or email cdunit@interiorhealth.ca. Send a copy to the site ICP as well.
- For in-facility use only, update the resident and staff illness surveillance tool
- Reporting sheets are provided under Tools for Outbreak Management and Reporting

16. Declaring The Outbreak Over
- The MHO/CD Unit/IH facility ICP will declare the outbreak over when greater than two incubation periods have passed since the onset of illness in the last case (anywhere from 4-14 days since the last case, based on the pattern of illness and the known or suspect causative organisms).
- Results from all tests routinely done on samples collected during an RI outbreak must be available prior to considering downgrading an outbreak from Scenario B to C (Influenza A, B, RSV results are negative but Multiplex results must be available as well).
- The outbreak can be declared over on the morning of the last day of the incubation period.
- Refer to PICNET Appendix 4: Common Viral and Bacterial Pathogens that Cause RI Outbreaks.

**Scenario C – Specific Measures for Managing an Outbreak**

Milder respiratory illness, known or suspected to be due to other non-influenza viral pathogen, most commonly rhinovirus and coronavirus

1. No Antiviral Medication Is Necessary
2. Ill Residents
   - Isolate ill residents in their room as much as possible while potentially infectious.
   - Provide meal tray service in room.
• Ensure staff and visitors use appropriate Routine Practices and Additional Precautions
• Use Droplet/Contact Precautions
  ▪ Information on Droplet/Contact Precautions can be found under Tools for Outbreak Management and Reporting

3. Ill Staff
• Recommend ill staff stay away from work for the duration of their acute symptoms.

4. Implement Infection Prevention and Control Practices
• Point of Care Risk Assessment
  ▪ Must be done for any interaction with the resident: assess resident’s symptoms and cognitive ability, type of interaction that will occur, necessary Personal Protective Equipment (PPE) and potential for contamination of equipment or environment.
• Hand Hygiene
  ▪ Provide hand sanitizer at all entrances and exits with signage on how to use.
  ▪ Practice hand hygiene before and after contact with each resident.
• Respiratory Hygiene
  ▪ Remind residents, visitors and staff to cover the nose and mouth when sneezing and coughing and to perform hand hygiene after coughing, sneezing or using tissues.
• Routine Practices and Additional Precautions
  ▪ Use Routine Practices for interaction with all residents.
  ▪ Use Droplet/Contact Precautions for interaction with residents showing symptoms of RI.

5. Cohort Staff
• Staff members should be cohorted to work with either symptomatic residents or asymptomatic residents for the duration of their shift.
• Staff members should work with asymptomatic residents first and then with symptomatic residents. Strict hand hygiene and infection control practices must be used between residents at all times.
• Healthcare persons entering the facility during an outbreak (such as lab staff or physicians) must work in the non-affected areas of the facility or with asymptomatic resident's first, use strict hand hygiene measures and follow Droplet Contact precautions.

6. Cohorting of Residents
• Moving residents in a Residential Care facility to achieve cohorting is not appropriate as displacement of residents from their own rooms will often cause anxiety and disorientation.
• When possible, cohorting is achieved by restricting the movement of residents between an area of the facility known to have RI cases (such as a pod or “neighbourhood”) and areas that do not have RI cases, for the duration of the outbreak.

7. ENHANCED HOUSEKEEPING
• Frequent disinfection of commonly touched surfaces or items such as handrails, elevator buttons and door handles. Use a product approved for use on viruses.
• Provide sufficient receptacles for safe disposal of contaminated items such as tissues.
• Clean and disinfect all equipment between use for different residents or areas.

8. Education
• Teach staff early signs of RI, how to prevent its spread and how to educate residents and their visitors.

9. Immunization
• If an influenza outbreak is suspected, offer vaccine to unimmunized residents and staff who do not have contraindications to influenza immunization.

10. Exclusion Of Well HCWs
• There is no policy to exclude well HCWs under Scenario B or C RI outbreaks.

11. Restrict Admissions and Transfers
• Must include resident/decision maker and physician in the discussion regarding admission during an outbreak. All parties must be able to provide informed consent.
• Consider isolation of incoming residents with pre-existing conditions which may make them more vulnerable to viral illness.
• If resident is transferred to acute care, notify receiving facility of the outbreak so they can initiate appropriate precautions.

12. Restriction Of Group Activities
• Review group activities and consider cancelling or modifying to cohort ill-residents with ill-residents and well-residents with well-residents.
• Weigh the importance of group activities to residents’ well-being against the needed infection control measures.
• Consider cancelling non-critical volunteer services (e.g. hair dressing, animal visits, candy striper).

13. Visitor Restrictions
• In general, a complete closure of the facility to all visitors/volunteers is not recommended and should only be done in consultation with the MHO and with careful consideration of the risks/benefits to all residents.
  • If possible, notify family members of ill residents.
- Advise visitors of the potential risk of acquiring infections within the facility and of re-introducing infections into the facility.
- Advise visitors to reschedule visits if they are sick with respiratory symptoms.
- Visitors, including family members, should be counselled about their ability to spread the virus.

- As per IH policy, during flu season it is recommended that all visitors who are not vaccinated against influenza be offered a mask if they enter patient care areas.
- All visitors are required to perform hand hygiene on arrival and immediately prior to leaving the resident’s room, follow respiratory hygiene processes, and are not to visit other residents in the facility.

14. Post Outbreak Signage
- Use signage to alert visitors of the outbreak and precautions to use. Sample posters are included through a link on page 30.

15. Enhanced Housekeeping
- Frequent disinfection of commonly touched surfaces or items such as handrails, elevator buttons and door handles. Use a product approved for use on viruses.
- Provide sufficient receptacles for safe disposal of contaminated items such as tissues.
- Clean and disinfect all equipment between use for different residents or areas.

16. Daily Outbreak Tracking
- Fax or email the RI and GI Outbreak Report Form to the IH CD Unit by the end of the business day. Fax to 250-549-6310 or email cdunit@interiorhealth.ca. Send a copy to the site ICP as well.
- For in-facility use only, update the resident and staff illness surveillance tool
- Reporting sheets are provided under Tools for Outbreak Management and Reporting

17. Declaring The Outbreak Over
- The facility can self-declare the outbreak over when there is a period of 4 days since the onset of the last case.
- The outbreak can be declared over on the morning of the 4th day since the date of onset of the last case.
4. References

British Columbia Centre for Disease Control. (2007). Communicable Disease Policy Committee (October 10, 2007)


5. Links

- IH Influenza Protection Program
- IH Infection Prevention and Control Webpage
- Sample Container Order Form
- Respiratory Illness Outbreak Laboratory Form
- PHSA Virus Isolation Requisition
- Provincial Infection Control Network of British Columbia (PICNet BC) Respiratory Infection
- BC Ministry of Health Policy Communiqué Health Care Worker Influenza Control Policy 2013
- IH Administrative Policy Manual AV1350 Influenza Prevention Policy
- IH Administrative Policy Manual AV1300 Staff Influenza Immunization and Exclusion Policy
6. Tools Forms and Resources

A. Tools for Outbreak Detection and Consultation

✓ Interior Health Public Health Contact Information
  Weekdays - 0830 to 1630
  Interior Health Communicable Disease Unit
  Phone: 1-866-778-7736
  Fax: 250-549-6310
  Email: cdunit@interiorhealth.ca
  Weekends and Holidays
  IH MHO on call: 1-866-457-5648
  Medical Health Officers
  • Dr. Trevor Corneil
  • Dr. Kamran Golmohammadi
  • Dr. Sue Pollock
  • Dr. Silvina Mema

✓ Infection Control Team Contact Information
✓ Respiratory Illness Outbreak: Nasal Swab Collection and Shipping Information
✓ Respiratory Illness (RI) Surveillance Tool
✓ Overview of Respiratory Outbreaks Process
✓ “Common Viral and Bacterial Pathogens That Cause RI Outbreaks” PICNET Appendix 4
✓ PICNET Respiratory Infection Outbreak Guidelines for Healthcare Facilities

B. Respiratory Illness Outbreak: Nasal/Nasopharyngeal Swab Collection and Shipping Information

1. Nasal/Nasopharyngeal Swab Collection Kits
   Respiratory outbreak kits from BCCDC may be ordered by September 15 of each year. To order:
   • Fax Sample Container Order Form to PHSA BCCDC at 604-707-2606 or email to kitorders@hsssbc.ca.
   • OR mail a written request as above to:
     Attn: Shipping and Receiving, PHSA Laboratory Services
     Virus Isolation Laboratory
     655 West 12th Avenue
     Vancouver BC V5Z 4R4
2. Nasal/Nasopharyngeal Swab Specimen Collection

NOTE: For personal protection it is recommended that gloves and a mask be worn when collecting specimens.

NOTE: Collect the specimens within 48-72 hours of symptom onset.

- Assemble sterile supplies – PHSA Respiratory Outbreak swab.
- Have patients with copious discharge gently clean their nose with a tissue or by washing.
- Incline the patient’s head as required and insert the cotton swab provided 2-3 cm into the nostril.
- Swab around the inside of the nostril and along the nasal septum, a minimum of 6 times.
- Place the swab into the accompanying vial of transport media and tighten the lid securely.
- Label the container with the patient’s full name and date of birth.

3. Complete the Accompanying Documentation

- Send one PHSA Laboratories Influenza-Like Illness (ILI) Outbreak Laboratory Form for each outbreak (up to 6 residents listed on the form).
- Send one PHSA Laboratories Virology Requisition for each nasal swab taken.
  - Under Examination Requested, enter “Respiratory Outbreak”
  - under Return Address, enter the full name and billing number of facility (or physician) to whom the final report will be sent
  - under Copy Report To, enter IH CD Unit C09768

4. Transportation of Nasal/Nasopharyngeal Swabs

- Keep specimens at refrigerator temperature (2°C to 8°C). Do not freeze specimens.
- Assemble the swabs and ship them together with the Outbreak Laboratory Form and the Virus Isolation Requisition in a cooler marked Diagnostic Specimens. Include an icepack if possible.
- Fax the Outbreak laboratory form to PHSA - BCCDC at 604-707-2605 and the CD Unit at 250-549-6310.
- Specimens may be shipped directly to PHSA Laboratory Services via courier or sent via the local lab’s routine shipping process, depending on local agreements. Please contact your local lab to see if there is an agreement in place.
• If there is concern that specimens may not be sent out in a timely manner (For example, specimens that are collected just prior to a long weekend) and the results may have significant impact on patient care or operations, please contact the CD Unit. In these rare cases, specimens may be able to be shipped out via an expedited process depending on local resources. There may be additional associated costs charged to the facility.

• If sending specimens via courier, send by routine same day or overnight delivery to:
  PHSA Laboratory Services
  Virus Isolation Laboratory
  655 West 12th Avenue
  Vancouver, BC V5Z 4R4
  Courier: DHL/Loomis Express, 1-855-256-6647, bill to account M45579

C. **Tools for Outbreak Management and Reporting**

✓ Quick Reference: RI Outbreak in Residential Care Settings
✓ Stop – We Are Experiencing an Outbreak Sign (807909)
✓ Interior Health Outbreak Information Brochure (810203)
✓ Droplet/Contact Precautions Sign (807904)
✓ Physician Letter – Oseltamivir Influenza Antiviral Prophylaxis Letter (Staff)
✓ Oseltamivir Prophylaxis Pre-Printed Order (829559)
✓ Oseltamivir Treatment Pre-Printed Order (829561)
✓ RI and GI Outbreak Report Form (823076)

D. **Tools for Pre-Outbreak Preparation**

✓ Influenza Immunization Health Care Worker Record
✓ Medical Exemption Letter
✓ Influenza Immunization Resident Record
For Facility Use Only

INFLUENZA IMMUNIZATION - HEALTH CARE WORKER RECORD

FACILITY:

UNIT/FLOOR/DEPARTMENT:

List all health care workers employed per unit/floor/department. Enter the date of influenza vaccine or indicate medical contraindications. If no date is entered, the employee is assumed to be unvaccinated. Please keep this record on file.

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<tr>
<th>Name</th>
<th>Vaccine</th>
<th>Lot #</th>
<th>Site E.G., LA/RA</th>
<th>Immunization Date</th>
<th>Provider Initials</th>
<th>Medical Contraindication</th>
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INFLUENZA IMMUNIZATION - RESIDENT RECORD

List all residents per unit/floor/department. Enter the date of influenza vaccine or indicate medical contraindications. If no date is entered, the resident is assumed to be unvaccinated. Please keep this record on file.

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<th>Name</th>
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<th>Lot #</th>
<th>Site E.G., LA/RA</th>
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