Respiratory Infection (RI) Outbreak Guidelines for Health Care Facilities September 2018

(Supersedes October 2017)

Table of Contents

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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 and Acute Care facilities with the information and tools required to prevent, identify and control outbreaks of RI in a way that balances resident/patient and staff protection with the least possible interference on facility function and resident well-being. The document is organized into sections:

1. General Principles and Pre-Outbreak Preparation
2. Outbreak Detection, Declaration and Investigation
3. Outbreak Management
4. References
5. Links
6. Tools, Forms and Resources

The guidelines apply to Interior Health (IH) Acute Care Facilities, 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 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. General Principles and Pre-Outbreak Preparation

I. *Pre-Outbreak Preparation*

- Provide yearly and/or ongoing respiratory infection outbreak education and/or training for staff, volunteers and residents.
- Advise staff to obtain and report receiving their influenza vaccine yearly.
- Ensure specimen collection containers are on-hand at all times. A process should be in place to ensure swabs are not expired. Specimen collection containers are obtained through Provincial Health Services Authority (PHSA) Public Health Laboratories and should be ordered by **September 15 annually**. Fax Sample Container Order Form to the BC Public Health Laboratory at 604-707-2606 or email to kitorders@hssbc.ca
- Ensure staff has easy access to and maintain an adequate supply of infection control supplies, including appropriate personal protective equipment, cleaning supplies, signage, and outbreak documents.
- Ensure there is an adequate number of staff available to work during the outbreak season.
- Keep all records and procedures together in a binder/folder at the nurse's station for easy access during an outbreak.
    - IH Respiratory Infection Outbreak Guidelines
    - Quick Reference Guide RI Outbreak in Residential Care Settings
    - Respiratory Illness Surveillance Tool
    - RI and GI Outbreak Report Form
    - Quick Reference RI Outbreak in Acute Care Facilities
    - Diagram 1 – Respiratory (RI) Outbreak – Acute Care Facilities
    - Diagram 2 – Respiratory (RI) Outbreak –IH Owned Residential Facilities
    - Diagram 3 – Respiratory (RI) Outbreak – P3 Residential Facilities
- In Residential Care facilities:
    - Provide influenza vaccine and pneumococcal (as required) vaccine to residents.
    - Ensure 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.
    - Maintain staff and resident influenza immunization records.

II. Create an Outbreak Management Team (OMT)

All facilities should have a designated Outbreak Management Team (OMT) responsible for directing and overseeing outbreak control measures during an outbreak. This includes reporting on the status of the outbreak as well as evaluating and modifying control measures as needed so the outbreak can be declared over as soon as possible. The structure also provides a systematic means to support coordinated communication and resolve issues. OMT's meet daily (7 days a week).

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.

The Residential Site Manager/Director of Care (or designate) or Acute Care Site Administrator (or designate) organizes the team, coordinates and chairs the meetings, and leads the team during an outbreak. These guidelines will refer to this person as the Most Responsible Person. Membership may include:

- Medical Health Officer (MHO) (Residential Facilities)
- Infection Prevention And Control (IPAC) Medical Director or designate (Acute Facilities)
- An administrator or Director of Care
- Infection Control Practitioner (ICP) (IH Facilities)
- Communicable Disease (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 physician representative (if available)
- A Communications representative

Tools to assist:

- Local Level One OMT – Acute Care
- Local Level One OMT – Residential Care

- Low Level One Quick Reference Guide
- Diagram 1 – Respiratory (RI) Outbreak – Acute Care Facilities
- Diagram 2 – Respiratory (RI) Outbreak –IH Owned Residential Facilities
- Diagram 3 – Respiratory (RI) Outbreak – P3 Residential Facilities

III. Surveillance

The Most Responsible Person will:

- Ensure implementation of control measures during outbreak.
- Ensure a line list of ill residents/patients is maintained to inform outbreak control measures as overseen by the OMT.
- Ensure completion of the RI and GI Outbreak Report Form and sending it to the CD Unit on a daily basis (and ICPs for IH facilities).

IV. 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 Healthcare 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 residents/patients 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.

V. *Antivirals*

Residential Care Facilities

When the RI outbreak has been identified as an influenza outbreak (by lab confirmation, or based on the assessment of the 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, such as an oseltamivir allergy or severe intolerance. Note: **A recent (in the last 12 months) serum creatinine and eGFR are not required before starting oseltamivir**, unless there is reason to suspect renal impairment. If renal impairment is present (eGFR is 60 mL/min or less), a recent Scr and eGFR (in the previous 4 weeks) is required to adjust the oseltamivir dosage and regimen. (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 receive chronic dialysis, the Scr and eGFR are frequently assessed through the renal program and retesting is not required-see the oseltamivir pre-printed orders (PPOs) for the dose adjustment or consult the resident's nephrologist. Refer to the Oseltamivir Prophylaxis-Influenza A and B-Residential Care (No. 829559) and Oseltamivir Treatment-Influenza A and B-Residential Care (No. 829561) PPOs for full dosing information.
- 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.

Acute Care Facilities

Prophylactic antiviral administration to exposed susceptible patients maybe initiated by most responsible physician in influenza outbreaks in conjunction with the assessment of the Medical Director of IPAC (or designate). The most responsible physician assesses the indications for antiviral treatment for influenza infected patient.

VI. *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/Patients:

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):

- Antiviral prophylaxis may be recommended for staff during an RI outbreak regardless of immunization status and for their own individual benefit.
- Antiviral prophylaxis should continue until the outbreak has been declared over.
- Staff seeking antivirals for prophylaxis or treatment should obtain a prescription from their physician or nurse practitioner.
- A sample letter for staff to take to their physician is attached as a link on page 35.

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 or Medical Director.

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, Declaration and Investigation

I. Recognition

Facility staff must monitor for RI illness in their residents/patients. RI illness may present with: new or worsening cough, fever, fatigue, runny nose, sore throat muscle aches, headache or a combination of these symptoms.

- Place symptomatic resident/patient on Droplet & Contact precautions

II. Definitions

Respiratory (RI) Infection Case:	A case of respiratory infection is defined as:
	• **New or worsening cough *and***
	• **a fever greater than 38°C or a temperature that is abnormal for that person *and***
	• **at least one other symptom.** Additional symptoms may include myalgia/arthralgia, extreme fatigue, runny nose, sore throat, and/or headache.
	  • A temperature of less than 35.6°C or greater than 37.4°C in the elderly may be an indication of infection.
	  • 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.
	• **The ICP/CD Unit/MHO/Medical Director of IPAC or designate should be consulted if you have an unusual cluster of illness in your facility that does not meet the case definition.**
	*Source: Draft PICNET RI Infection Outbreak Guidelines for Healthcare Facilities

Respiratory (RI) Outbreak:	**Two or more cases of RI occurring in a unit/facility area within a 7-day period amongst residents/patients or staff**

III. Declaring an Outbreak

A suspected respiratory outbreak needs to be reported as soon as possible to ensure outbreak measures are put in place.

Residential Care Facilities:

For IH owned residential care facilities: contact the ICP, who will consult with the MHO; outbreak will be declared by the MHO.
For Private and Public-Private Partnership (P3) residential care facilities: contact the CD Unit, who will consult with the MHO; outbreak will be declared by the MHO

In **residential care facilities** the MHO 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.

Acute Care Facilities

For acute care sites: contact the ICP, who will consult with the Medical Director of IPAC (or designate); outbreak will be declared by Medical Director of IPAC (or designate).

IV. Reporting an Outbreak

ALL sites/facilities must report an outbreak of respiratory illness to:
IH Communicable Disease (CD) Unit weekdays *
Call 1-866-778-7736
then
Complete the top portion and **Section A of the IH**
RI and GI Outbreak Report Form
Fax the form to CD Unit at (250) 549-6310 or email to **cdunit@interiorhealth.ca**

For IH facilities and Acute Care sites:
email the ICP a copy of the RI and GI Outbreak Report form as well.

Information required by the CD Unit/MHO 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

***For weekends and holidays:**

- Acute care facilities contact the Medical Microbiologist on call via hospital switchboard
- Residential facilities notify the MHO on call (1-866-457-5648)

Ongoing Daily Reporting to the CD Unit and/or ICP's (IH facilities & Acute Care) is Required.

Review of new and ongoing cases within residents and staff must occur to understand the progress of the outbreak.

Residential Care Facilities:

Complete Section B of the IH RI and GI Outbreak Report Form daily

Fax the form to the CD Unit at 250-549-6310 or email to **cdunit@interiorhealth.ca**

Email copy to site ICP as well (for IH facilities)

Acute Care Facilities:

Review ongoing cases with the ICP. Daily reporting to the CD Unit is not required.

*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.*

V. Notification of Partners

The designated Most Responsible Person, the person with the highest level of administrative authority at the time an outbreak is suspected, begins the notification process.

The Most Responsible Person may be the following:

- Administrator on call;
- Manager of Residential Care;
- Clinical Resource Nurse;
- Patient Care Coordinator;
- Clinical Manager;
- Director of Care;

- Assistant Director of Care.

Partners to notify:

- The CIHS Administrator on Call
- Communicable Disease Unit at 1-866-778-7736 or cdunit@interiorhealth.ca
- Infection Control Practitioner
- Others as appropriate; for example:
  - Service providers such as the Patient Transport Office, oxygen services, laboratory services, BC Ambulance, hemodialysis units, etc. of outbreak and control measures required.
  - PHSA Laboratory (Complete PHSA ILI Outbreak Lab Form) specimens will be processed as part of the outbreak investigation
  - Staffing office if there is ill staff, to arrange for adequate relief staff
  - Medical Director of the facility and physicians of the residents
  - Facility Licensing Officer
  - Hospital facilities to which residents have recently been transferred.

VI. Roles and Responsibilities

Facility Administrator / Manager or Director of Care or Most Responsible Person

- Organizes and leads OMT meetings
- Ensures that outbreak control measures have been put into place and the RI Illness Outbreak Guidelines for Healthcare Facilities are being followed
- Ensures the outbreak is reported to the Communicable Disease Unit and ICP (for IH facilities).
- Completes the RI and GI Outbreak Report form and sends it to the CD Unit (all facilities) and the ICP (for IH Facilities) when the outbreak is declared, each day during the outbreak, and when the outbreak is declared over.
- Notifies partners.
- 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 facility regarding outbreak situation

- When necessary, collaborates with Communication representative in the event that media statements are needed

Medical Health Officer

- Declares the outbreak, determines which Scenario is to be used to manage and control the outbreak, and declares the outbreak over in residential care facilities.
- Determines repatriation of residents, admissions and transfers of individuals into the residential care facility under outbreak.

Medical Director of IPAC or Designate (microbiologist on call)

- Consults with Infection Control Practitioner (ICPs) regarding outbreak declaration, control measures and declares the end of an outbreak in acute care facilities.
- Determines patient transfers associated with outbreak units in acute care facilities.

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 and attends the OMT: 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 CD Unit 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)

- Provides outbreak education prior to outbreak season in partnership with the Communicable Disease Unit using Outbreak Management Practice Assessment

  For IH Residential Facilities:

  - Follows-up with facility to review situation e.g. outbreak definition being met, clinical pattern is consistent with suspect viral cause, collection of lab specimens has been initiated, outbreak control measures are in place, and PHSA labs has been notified.
  - Consults with MHO regarding the outbreak declaration.
  - Provides ongoing outbreak support and education to facility staff.

- Declares the outbreak over in consultation with the MHO.
- Collaborates with the Most Responsible Person to ensure the RI and GI Outbreak Report Forms are completed correctly.
- Notifies necessary stakeholders regarding outbreak situation including outbreak declaration, ongoing control measures and when the outbreak is declared over.
- Provides opportunity for debriefing following outbreak. Examples of opportunities for improvement include:
    - Timeliness in recognizing and reporting outbreak.
    - Timeliness in implementing control measures.
    - Effectiveness of control measures in limiting the outbreak.
- Completes IPAC Outbreak Summary Report and sends to facility Manager/Director of Care and IPAC Epidemiologist.

For IH Acute facilities:

- Consults with the Medical Director of IPAC (or designate) to determine when outbreaks are declared on and declared over.
- Follows-up with facility to review situation e.g. outbreak definition being met, clinical pattern is consistent with suspect viral cause, collection of lab specimens has been initiated, outbreak control measures are in place, and PHSA labs has been notified.
- Provides ongoing outbreak support and education to facility staff.
- Collaborates with the outbreaks' most responsible person to complete the RI and GI Outbreak Report Forms only when the outbreak is declared on and declared over.
- Notifies necessary stakeholders regarding outbreak situation including outbreak declaration, ongoing control measures and when the outbreak is declared over.
- Provides opportunity for debriefing following outbreak. Examples of opportunities for improvement include:
    - Timeliness in recognizing and reporting outbreak.
    - Timeliness in implementing control measures.
    - Effectiveness of control measures in limiting the outbreak.

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

Nursing Staff

- Works collaboratively with facility ICP (IH facilities) and facility manager to ensure early recognition of RI illness in residents/patients 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/patient RI cases and reviews with the Most Responsible Person and OMT.

All Employees

- Report RI illness to their supervisor and does not work for the duration of their acute systemic 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.

VII. Collection and Transportation of Specimens

**Testing of clinical specimens may be offered at IH labs. Please contact your local lab to see if it is available. Otherwise, samples should be sent to BCCDC Public Health Laboratories.

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 the BC Public Health Laboratory at 604-707-2606 or **email** to kitorders@hssbc.ca.

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 – or test results will not be processed

- PHSA Laboratories Influenza-Like Illness (ILI) Outbreak Laboratory Form for each outbreak (up to 6 residents listed on the form). Fax this to PHSA Public Health Laboratory at 604-707- 2605 AND include a copy with the specimens.
- 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**

- Specimens may be shipped directly to PHSA Laboratory Services via courier or sent via the local hospital lab's routine shipping process, depending on local agreements. Please contact your local lab to see if there is an agreement in place.
- Keep specimens at refrigerator temperature (2°C to 8°C). Do not freeze specimens.

- Assemble the swabs and ship them together with the ILI Outbreak Laboratory Form and the Virus Isolation Requisition in a cooler marked Diagnostic Specimens. Include an icepack if possible.
- Ensure the ILI Outbreak laboratory form is faxed to PHSA - BCCDC at 604-707-2605.
- 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:

  BCCDC: Public Health Laboratory
  Virology Laboratory
  655 West 12th Avenue
  Vancouver, BC V5Z 4R4
  Courier: DHL/Loomis Express, 1-855-256-6647, bill to account M45579

3. Outbreak Management

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

Acute care RI outbreak management will be directed by the Medical Director of IPAC or designate (see acute care section – specific measures for managing an outbreak).

3.1 Outbreak Management in Residential Care Settings

I.Routine Practices

Routine Practices should be used to prevent the transmission of infections in health care settings. **Routine practices should be used with all residents/patients at all times**. Close attention to Routine Practices is fundamental to preventing transmission of microorganisms among residents/patients and health care providers in all health care settings.

- Interior Health Infection Control Guidelines on Routine Practices

II.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**
   - Symptomatic staff should not be at work for 5 days after symptom onset or for the duration of their acute systemic symptoms (eg. Fever, fatigue, general aches) 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 as directed in AV1300 - Staff Influenza Immunization and Exclusion Policy
- 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. Cohort 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 unimmunized 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.
  - HCW's may return to work as soon as they have received their first dose of 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.**
- For IH facilities, the facility ICP will consult with the MHO. For non- IH facilities, 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 residential care 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.

- The re-admission of residents who **did not meet the case definition** for RI prior to discharge/transfer is not advisable during an outbreak. However, if a resident who is not a case leaves the facility for a short period of time during an outbreak (e.g. medical appointment, ER visit or a family visit), it is acceptable for them to return to the facility without MHO/CDU consultation. A short period of time is defined as a few hours, not more than one day, and less than one incubation period if the causative organism is known.

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).
- The OMT will make decisions regarding group rehabilitation program modification requirements.
- 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. Outbreak Signage

- Use signage to alert visitors of the outbreak and required precautions. Sample posters.

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 surveillance tool
- 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.
- 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 CDU/ICP prior to the weekend and make arrangements to consult with the MHO on the weekend or to self-declare the outbreak over on the weekend/ holiday, should no new cases arise.

III. 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

- Ill staff should not 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 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:
  - 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. Cohort 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, transfers, discharges to facilities other than acute care. 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).
- **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 Residential Care 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. Outbreak Signage

- Use signage to alert visitors of the outbreak and precautions to use. Sample posters are included through a link on page 35.

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/ ICP will declare the outbreak over when 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).
- The outbreak can be declared over on the morning of the last day.
- 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 CDU/ICP prior to the weekend and make arrangements to consult with the MHO on the weekend or to self-declare the outbreak over on the weekend/ holiday, should no new cases arise.
- 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).
- Refer to PICNET Appendix 4: Common Viral and Bacterial Pathogens that Cause RI Outbreaks.

IV.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**
   - Ill staff should not 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 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:
  - 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. Cohort 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. 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.

10. 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 stripers).

11. 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.

12. Outbreak Signage

- Use signage to alert visitors of the outbreak and precautions to use. Sample posters.

13. 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.

14. 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 emailcdunit@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

15. Declaring The Outbreak Over

- The facility can self-declare the outbreak over on the morning of the 4th day since the onset of the last case.

3.2 Outbreak Management in Acute Care Settings

1. Initiate Antivirals

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

Prophylactic antiviral administration to exposed susceptible patients may be initiated by most responsible physician in influenza outbreaks in consultation with the medical director of IPAC or designate. The most responsible physician assesses the indication for antiviral treatment for influenza infected patient(s).

2. Ill Patients

- Isolate ill patients on Droplet & Contact Precautions

3. Ill Staff

- Ill staff should not 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 patient: assess patient'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 patient and patient environment.
- Respiratory Hygiene
  - Remind patients, 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 patients.
  - Use Droplet/Contact Precautions for interaction with patients showing symptoms of RI.
  - Ensure personal care supplies are patient specific.
  - Ensure no shared food or drink (i.e. nursing station, lounges)
  - Ill patients should not access the patient kitchen or public lounge

5. **Cohort Staff**

- Staff to work in the non-affected areas of the facility prior to working in outbreak area

6. Cohort Patients

- Cohort ill patients together in same room if appropriate. Avoid admitting asymptomatic patients to a room with patient ill with RI symptoms.
- Consult Infection control and/or Medical Director of IPAC or designate for patient placement/movement. Strategies may include blocking beds, dedicating wings for ill patients, limiting patient movement.

7. Enhanced Housekeeping

- Schedule enhanced cleaning throughout the day to include commonly touched surfaces or items such as handrails, elevator buttons and door handles. Additional workload will be needed for the duration of the outbreak for increased high touch cleaning.
- Declutter affected unit and bed space to facilitate enhanced cleaning.
- Clean and disinfect all equipment between use for different patients. This is a shared responsibility between all staff.

8. Education

- Teach patients and visitors to do hand hygiene and follow respiratory etiquette
- Review RI outbreak measures during unit huddles

9. Admissions and Transfers

- Avoid transferring patients who have been exposed to an ill patient to another room or area of the facility.
- Avoid admitting well patients into a room containing exposed patients.
- Contact site ICP regarding admissions/transfers/closures Monday – Friday. After hours and on weekends & holidays, contact Medical Microbiologist on call through hospital switchboard

10. Visitor Restrictions

- 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 patients in the facility.

11. Outbreak Signage

- Use signage to alert visitors of the outbreak and required precautions.

12. Daily Outbreak Tracking

- Daily tracking using RI Outbreak Surveillance Tool done by most responsible person and sent to Infection Control
- Use separate form for patients and staff

13. Declaring The Outbreak Over

- The Medical Director of IPAC or designate in consultation with ICP will declare the outbreak over:
  - for influenza, outbreak declared 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
  - for non-influenza outbreaks, outbreak declared over according to the pathogenic organism

14. Immunization

- Offer vaccine to unimmunized patients and staff who do not have contraindications to influenza immunization.

15. 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.
  - HCW's may return to work as soon as they have received their first dose of antiviral medication.

4. References

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

Canadian Pharmacists Association. (2007). *Compendium of Pharmaceuticals and Specialties*.

Provincial Infection Control Network of British Columbia (PICNet BC). (February 2011). *Respiratory Infection Outbreak Guidelines for Healthcare Facilities.* Retrieved from https://www.picnet.ca/practice-guidelines

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
- ✓ "Common Viral and Bacterial Pathogens That Cause RI Outbreaks" PICNET Appendix 4
- ✓ PICNET Respiratory Infection Outbreak Guidelines for Healthcare Facilities

B. Tools for Outbreak Management and Reporting

- ✓ Quick Reference: RI Outbreak in Residential Care Settings
- ✓ Quick Reference: RI Outbreak in Acute Care Facilities
- ✓ 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)

C. 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.

Name	Vaccine	Lot #	Site E.G., LA/RA	Immunization Date	Provider Initials	Medical Contraindication

For Facility Use Only

INFLUENZA IMMUNIZATION - RESIDENT RECORD

FACILITY:
UNIT/FLOOR/DEPARTMENT:

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.

Name	Vaccine	Lot #	Site E.G., LA/RA	Immunization Date	Provider Initials	Medical Contraindication