POLICY # IFC-66: Respiratory/Influenza Outbreak

Infection Control

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Policy:

It is the policy of Norview Lodge to implement a plan as soon as possible in the event of a suspected respiratory/influenza outbreak.

Respiratory infection outbreaks are caused by a variety of respiratory viruses such as influenza A and B, respiratory syncytial virus (RSV), parainfluenza, rhinovirus, human metapneumovirus, seasonal coronaviruses, enterovirus and adenovirus. Bacteria that occasionally cause respiratory outbreaks in institutions are Chlamydophila pneumoniae, Legionella spp. and Mycoplasma pneumoniae (Atypical Pneumonia).

Definition:

Upper Respiratory Tract Illness (Includes common cold, pharyngitis)

The Resident must have at least 2 of the following symptoms:

- Runny nose or sneezing
- Stuffy nose (congestions)
- Sore throat or hoarseness or difficulty swallowing
- Dry cough
- Swollen or tender glands in the neck (cervical lymphadenopathy)
- Fever/abnormal temperature for the Resident may be present but is not required.
- Tiredness (Malaise)
- Muscle aches (Myalgia)
- Loss of appetite
- Headache and chills

Pneumonia:

All of the following criteria must be met:

- Interpretation of a chest x-ray as pneumonia, probable pneumonia or the presence of infiltrate
- The Resident must have at least two of the signs and symptoms described under "Other Lowered Respiratory Tract Infections"
- Other non-infectious causes of symptoms, in particular congestive heart failure, must be ruled out.

Lower Respiratory Tract Infections (bronchitis, tracheobronchitis)
The Resident must have at least three of the following:

- New or increased cough
- New or increased sputum production
- Abnormal temperature for the Resident $\geq$ 38 degrees C
- Pleuritic chest pain
- New or increased physical findings on chest examination (Rales rhonchi, wheezes, bronchial breathing)

One of the following to indicate change in status or breathing difficulty:

1) New-increase shortness of breath
2) Respiratory rate greater than 25/minute
3) Worsening functional or mental status (deterioration in Resident's ability to perform activities of daily living or lowering of their level of consciousness)

Influenza-like Illness
Both of the following criteria must be met:

1. Fever ($\geq$ 38 degrees C)
2. The Resident must have at least three of the following signs or symptoms:
   a) Chills
   b) New headache or eye pain
   c) Myalgia
   d) Malaise or loss of appetite
   e) Sore throat
   f) New or increased dry cough

Clinical Evidence

An Acute Respiratory Infection (ARI) is defined as any new onset ARI that could potentially be spread through the droplet route (either upper or lower respiratory tract), which presents with:

- Symptoms of a new or worsening cough or shortness of breath and;
- Often fever (also known as febrile respiratory illness, or FRI)
- It should be noted that elderly people and people who are immunocompromised may not have a febrile response to a respiratory infection.

Criteria for a potential Outbreak:

Outbreak Case Definition

Confirmed Respiratory Infection Outbreak Definition

- Two or more Resident cases of test-confirmed acute respiratory infections (ARI) with symptom onset within 48hrs and an epidemiological link (e.g. same unit/floor/service area) suggestive of transmission within the setting

OR

- Three or more Resident cases of ARI with symptom onset within 48hrs and an epidemiological link suggestive of transmission within the setting AND testing is not available or all negative

Suspect Respiratory Infection Outbreak Definition

- Two Resident cases of ARI with symptom onset within 48hrs with an epidemiological link (e.g. same unit/floor/service area) suggestive of transmission in the setting AND testing is not available or all negative

Cases are not epidemiologically linked if they have different causative organisms identified.

When a Respiratory outbreak is suspected, PCR tests should be done to reveal the causative organism.

What to do when you suspect someone is ill with an acute respiratory tract infection/ influenza

Nursing Department:

Case Management

All Respiratory viruses <u>EXCEPT</u> COVID-19

- Self isolate on Droplet and Contact Precautions until 5 days after the onset of acute illness OR until symptoms have been resolved (whichever is shorter)
- For a total of 10 days from symptom onset, cases should wear a well-fitted mask, if tolerated when receiving care and when outside of their room

Contact Management

Roommates who remain in the same room

- Self-isolate on Droplet and Contact Precautions for 5 days (including day zero) from the case's symptom onset

- For a total of 10 days, from the case's symptom onset, wear a well-fitted mask, if tolerated, when receiving care and when outside of their room

Non-roommate close contacts (i.e., Tablemate)

- Self-isolate on Droplet and Contact Precautions for 5 days (including day zero) from the case's symptom onset
- For a total of 10 days, from the case's symptom onset, wear a well-fitted mask, if tolerated, when receiving care and when outside of their room

All Residents in isolation should be supported to leave their room for walks in the immediate area with staff wearing appropriate PPE, to support overall physical and mental well-being.

Nursing Procedure

1. All Residents symptomatic with symptoms of an acute respiratory illness and/or have an elevated temperature over 38 degrees with no respiratory symptoms, will be placed on Droplet/Contact Precautions as soon as possible after symptoms are identified.
2. Initiate specimen collections of symptomatic Residents immediately. Obtain Naso-pharyngeal swabs (maximum 4) on all ill Residents to verify the causative agent. Complete swabs as per naso-pharyngeal procedure.
3. All symptomatic Residents will be PCR tested for COVID-19 and other respiratory viruses, and monitored once daily for symptoms (including vital signs – temp and O2) Rapid antigen tests may be used for outbreak management.
4. Staff will initiate droplet/contact precautions with anyone being admitted or returning from a social absence/LOA with symptoms of a respiratory illness (failed ARI screening via the Symptom Surveillance Screening question in the EMAR system completed on all shifts)
5. Additional precautions will be initiated (i.e. PPE container outside of the resident's room with appropriate PPE, linen and garbage bag inside the resident's room, droplet/contact precaution signage)
6. Initiate the droplet/contact checklist and document an Isolation Progress Note in Residents software system.
7. Obtain Sanuvox machine and place inside of resident's room to maintain/purify air quality.
8. Staff will notify the Medical Director and/or Nurse Practitioner for an evaluation, assessment, and diagnosis.
9. Notify Infection Prevention and Control.
10. Complete the shift surveillance form to submit to IPAC daily
11. A single room is preferred, however if this cannot be made possible symptomatic residents living in a basic room: Maintain a 2-metre spatial separation between Residents. Pull privacy curtains closed. Door to room may remain open.
12. All staff providing care or entering the room of a symptomatic resident are to wear Personal Protective Equipment.

13. Symptomatic Residents will be allowed to attend medically necessary appointments or activities, and it is recommended they wear a mask (as tolerated for respiratory illnesses). Receiving facility should be notified of the potential outbreak so appropriate precautions can be taken for the Resident on arrival.
14. If a Resident must be transferred to the hospital for further medical evaluation, the Registered staff will complete the Patient Transfer Authorization Form done via internet–Staff must notify the transportation service and the hospital receiving the Residents status, prior to transfer that we are experiencing a Respiratory outbreak so that precautionary measures can be taken on their end.
15. Notify Power of Attorney for Care to update them on the Resident's condition and diagnosis.
16. Staff should cohort in affected areas to minimize staff and Resident exposure.
17. The Registered staff will notify all the other departments of isolated Residents via DL-Norview e-mail. E-mail communication will also be completed when the Resident is removed from isolation.
18. Residents who are isolated will have all their nonessential appointments cancelled.
19. Isolated residents are able to have essential caregiver visits but are discouraged from participating in any social or temporary leaves of absence.
20. To prevent social isolation, 1:1 activity and therapy will be offered.
21. Frequent hand hygiene when entering and leaving the units, before and after break times and throughout the home.
22. Hand hygiene to be done completed per the 4 Moments and hand washing when hands are visibly soiled.
23. All reusable equipment will be cleaned and disinfected after each use. Whenever possible, disposable equipment will be used and discarded immediately upon exiting the room where care is delivered.
24. Dedicated equipment is preferred for the symptomatic Resident when able
25. Surfaces and equipment will be cleaned and disinfected (or discarded) by staff performing procedures in room before leaving the room and before removing personal protective equipment.
26. Documentation in the Resident Chart will include but not limited to: onset time and symptoms, vital signs, lab investigation including specimens collected and sent to The Public Health Unit, isolation if applicable, Doctor or Nurse Practitioner visits and other assessments/observations, as applicable.
27. Gowns, gloves, mask and eyewear are to be worn by all staff (and visitors) for Residents who are symptomatic.
28. Linen is to be kept separate - place all soiled linen in red isolation bags
29. If the Resident is leaving their room and/ or is non-compliant with isolation, the Resident should wear a mask, physically distance from others and perform hand hygiene.

30. Resident cases may leave their room while on Droplet and Contact Precautions if they are able to perform hand hygiene and consistently wear a well-fitted medical mask at the discretion of IPAC and Public Health.

31. Complete daily IPAC audits in the outbreak home area (hand hygiene, PPE, Resident and Hygiene
32. Weekly IPAC audits for all other staff.

Role of the Infection Prevention and Control Lead and/or delegate

Role of the Infection Prevention and Control Supervisor and/or delegate

Required Steps in an Outbreak: When local Public Health declares a Suspect or Confirmed outbreak in the home, the following measures must be taken:

- Establish a case definition in consultation with Public Health.
- Obtain an outbreak number from Public Health
- Outbreak Management Team (OMT) is activated.
- Defining the outbreak area of the home and cohorting based on COVID-19 status (ie. Infected or exposed and potentially incubating)
- Assessing risk of exposure to residents/staff based on cases' interactions
- Ensuring Additional Precautions are in place for all symptomatic residents and those with suspect or confirmed COVID-19.
- Facilitate assessment of IPAC and outbreak control measures, as needed
- Ensures the outbreak home area remains co-horted to their unit for the duration of the outbreak. Group activities and communal dining should be conducted such that the outbreak unit is cohorted separately from unexposed residents and units.
- At the discretion of the PHU/OMT/IPAC, group activities and communal dining for cohorts (exposed separated from unexposed) may resume.
- Wherever possible, continuing group activities for exposed cohorts is recommended to support resident mental health and wellbeing.
- Ensuring staff remain in a single cohort per shift, wherever possible. If staff must work with more than one cohort during a single shift, it is recommended that staff work with unexposed residents first
- At the discretion of the PHU/OMT/IPAC, communal dining and group activities may be paused completely in the case of a facility-wide outbreak or where transmission is uncontrolled in a single home area, the rate of infection increases in cases or severity or illness is significant or unexpected and the benefits of closure of communal activities are deemed to be greater than the harms caused to resident wellbeing. This decision should be revisited as the outbreak progresses.
- IPAC will ensure enhanced symptom assessment (twice daily) of all residents in the outbreak area is conducted to facilitate early identification and management of ill residents.
- IPAC will deliver weekly audits for the duration of the outbreak. The results of these audits are reviewed by the OMT
- Ensure increased cleaning and disinfection practices (e.g., at least two times a day and when visibly dirty for high touch surfaces)

- Update signage - General visitors should postpone all non-essential visits to residents within the outbreak area for the duration of the outbreak
- For admissions or transfers, IPAC will consult with Public Health during an active outbreak.
- Provides direction on restrictions to admissions/transfers/discharges to the outbreak unit/institution.
- Implements IPAC measures to all departments in the home including universal masking for the affected home area for all respiratory outbreaks, enhanced monitoring of asymptomatic Residents and enhanced twice daily cleaning of high touch surfaces.
- Additional measures (e.g., increased use of masking by staff/visitors, increased frequency of infection prevention and control audits with feedback) to prevent respiratory virus transmission during high-risk periods.
- Identifies high risk activities which are recommended to be stopped during the outbreak.
- Implements integration strategies as required and changes to activities (if applicable) within the unit
- Provides direction on isolation of Resident cases.
- Provides direction on management of staff
- Facilitate assessment of IPAC and outbreak control measures, as needed.
- Assessing risk of exposure to residents/staff based on cases' interactions
- An Outbreak Management Team meeting will be held at the discretion of the Chair at the beginning of the outbreak, as necessary throughout the outbreak and when an outbreak has been declared over.
- Discuss with Public Health any additional IPAC measures that are required to be implemented.
- Notify the Ministry of Health and Long-Term Care of the outbreak via CIS – Critical Incident System when outbreaks are confirmed.
- Notify the other departments of the outbreak via e-mail. An email notification is sent to all persons within the home and applicable staffing agencies.
- Initiate signage at the front door of the home as well as the affected home area(s) in outbreak
- Update the outbreak assessment email, communicate PCR results, and will advise when the ill Resident(s) may come off isolation.
- Check the status of Influenza vaccine in Residents and offer the vaccine to eligible Residents if/when the vaccine is available.
- Maintain accurate records of all Residents affected
- Maintain accurate records of all Residents affected, inclusive of date time of onset and symptoms and if specimens have been obtained on the Respiratory Outbreak Line Listing Form and communicated with Public Health
- The Infection Prevention and Control Professional will follow up with notification to appropriate Ministry officials and the Public Health Department if the Employee reports an occupational illness.
- All Media questions are to be referred to the Administrator.
- The Medical Director, Pharmacy, JHSC, and applicable unions will be notified.

- Will ensure signs/alerts will be posted on the home area doors/wall, the external doors to the home and at the sign in table indicating that there is an outbreak and the potential for risk of infection.
- Complete own IPAC audits per policy and procedure
- Provide education and/or team huddles to staff during the outbreak
- Monitor ongoing illness in Residents via progress notes
- If there is a PCR confirmed case of Influenza, the pharmacy will be notified by the Infection Prevention and Control Professional to initiate anti-viral administration protocol to all Residents in the home area(s)
- Additionally, all unimmunized staff will be advised to start taking Tamiflu and provide proof for the entirety of the Influenza outbreak
- Notify the Ministry of Health and Long-Term Care of the outbreak via CIS – Critical Incident System when outbreaks are confirmed.

Every outbreak must be evaluated independently. Case definitions, control measures, and testing protocols outlined in these summaries will be reviewed and adapted by the outbreak management team in collaboration with Public Health authorities. This ensures that strategies are effectively implemented to mitigate risks and manage the outbreak effectively.

Personal Protective Equipment

1. **Gloves**
- Follow Routine Practices
2. **Gowns**
- Follow Routine Practices
3. **Eyewear:**
   In addition to Routine Practices**,** wear goggles/face shield when working within two (2) meters of the Resident.

Masking:

- All staff will perform a point-of-care risk assessment prior to any ill Resident interaction to determine their use of masking (surgical or N95 mask if COVID-19 is Suspected or Confirmed) and will include assessing the exposure risk specific to the care intervention being performed and the duration of the activity.
- For respiratory illnesses, if the Resident chooses not to wear a mask, or is unable to safely wear a mask, Staff should review their PCRA and adjust PPE accordingly.

Influenza

- Initiation of early empiric treatment with influenza antiviral medication.
- Antiviral prophylaxis will be started as soon as an influenza outbreak is declared and continued until the outbreak is over.

Anti-viral Medication

During an Influenza outbreak, anti-viral medication for prophylactic use shall be offered to all Resident's/ Staff whether vaccinated or unvaccinated until the outbreak has been declared over.

- Obtain Physician order for Resident's to receive the medication.
- Monitor all Residents who are taking the medication for signs of anti-viral toxicity including confusion, delusions, marked personality change, hostility, agitation, hallucinations, nausea and vomiting, and loss of balance. Should any of these develop medication should be discontinued.
- Treatment dose therapy is as per physician orders.
- Dosage calculation is provided by the pharmacist using annual creatinine levels and current weight.
- Prophylactic anti-viral will be discontinued once the outbreak is declared over.

Admissions and Transfers

- Public Health approval is not required for admissions/transfers, but Public Health Unit consultation is recommended when IPAC advice or risk mitigation is needed.

- In general, admissions and transfers in an outbreak should be avoided. However, if the risks of not admitting a resident are determined to outweigh the risks of admitting the resident into an outbreak, informed consent from the resident should be obtained.

- Enhanced monitoring for 10 days is implemented to all Resident admissions, re-admissions and transfers from hospital to quickly identify any new or worsening symptom.

Admissions/Transfers during an outbreak

Residents admitted to hospital prior to the outbreak, or admitted to hospital for reasons other than enteric illness may be admitted/re-admitted to the Long Term Care Home if the following conditions are met:

(a) The Resident or legally authorized substitute has been informed of the outbreak status and provided consent;

(b) The Residents physician has been informed of the outbreak status and provided consent (taking into consideration the severity of the particular outbreak relative to the Resident's condition).

IPAC will consult regarding Admissions and Transfers with Public Health in the following circumstances:

- The Resident is from a health care facility in outbreak and is going to an institution that is not in outbreak and there are concerns with compliance of IPAC measures.

- The Resident is from the community or a health care facility not in outbreak and going to an institution in outbreak and any of the following apply
- New outbreak has been declared with an ongoing investigation
- Outbreak is uncontrolled/uncontained
- Admission/transfer to an area where many Residents are unable to follow IPAC measures or Resident is unable to isolate and/or follow IPAC measures
- Resident is severely immunocompromised
- Informed consent has not been obtained from the Resident.

Role of Public Health in Outbreaks

- The local public health unit will declare when an outbreak is over.
- The IPAC Lead and/or delegate will follow the direction of the public health unit in the event of a suspect or confirmed COVID-19 outbreak.
- The IPAC Lead and/or delegate will follow any guidance provided by the local public health unit with respect to any additional measures that must be implemented.
- The local public health unit is responsible for managing the outbreak response.
- Local public health units have the authority and discretion as set out in the Health Protection and Promotion Act to coordinate outbreak investigation, declare an outbreak based on their investigation, and direct outbreak control measures.

Declaring the Outbreak Over

The outbreak will be declared over in consultation with the Public Health Unit.

- To declare an outbreak over, there must be no new cases of Resident infection which meets the case definition for 8 days.
- Viral respiratory outbreaks may be declared over if no new cases have occurred in 8 days from the onset of symptoms of the last resident case.
- This “8-day rule” is based on the period of communicability (5 days) and an incubation period (3 days) for influenza and in general may apply to many other respiratory viruses associated with respiratory infection outbreaks as well

Nutritional Services Department

1. Hand hygiene as per Just Clean Your Hands Policy and Procedure and follow additional precautions.
2. Maintain consistent staff in areas when possible.
3. Initiate tray room service, if required, to all affected Residents.
4. Non-outbreak home areas will be served first, following the home area in outbreak to maintain a clean to dirty approach. Soup and cereal can be served first in each home area, then proceed with main courses etc.
5. The Dietary carts and all of the tables will be cleaned with disinfectant following each meal

Housekeeping Department

1. Hand hygiene as per Just Clean Your Hands Policy and Procedure and follow additional precautions.
2. Increase in cleaning procedures to be done throughout the home.
3. Housekeepers will increase cleaning to high touch surfaces in the outbreak home area and in ill Residents room and environment for the duration of the outbreak.
4. Enhanced cleaning of high touch surfaces will include: door handles, bed railings, handrails, light switches, elevator buttons, over bed tables, dining room tables and counters in the outbreak home area and ill Residents immediate environment twice daily.
5. Terminal cleaning the Resident room/environment when Droplet/Contact precautions are removed.
6. Maintain consistent staff in areas when possible.

Laundry Department

1. Wash isolated linen as per policy and procedure.
2. Hand hygiene to be done before and after each Resident contact and upon entering and leaving the home area.
3. Handle soiled laundry/linen as little as possible.
4. PPE must be worn when handling soiled laundry

Facilities Services Department

1. Air handler filters may require changing to prevent spread of infection.
2. Hand hygiene as per Just Clean Your Hands Policy and Procedure and follow additional precautions.

Programs

1. Symptomatic Residents or those on Additional Precautions are not recommended to participate in in-person group or social activities with other Residents.
2. Large group activities should be cancelled in affected units.
3. Outbreak home area will not integrate for the duration of the outbreak.
4. Co-horting of staff to be maintained as much as possible.
5. Hand hygiene is to be done before and after each Resident contact and upon entering and leaving the home area.
6. No visits by outside groups (entertainers/ volunteers) to the outbreak home area
7. Cleaning and disinfecting of shared equipment between Residents.

Contracted Services (Haircare/Podiatry/PT/OT)

1. Hand hygiene as per Just Clean Your Hands Policy and Procedure and follow additional precautions with the Residents who are displaying symptoms.
2. Conduct programs/therapy (1:1) – Personal Protective Equipment required for ill Residents.

3. Cleaning and disinfecting of shared equipment between Residents

All Staff

1. All staff and Residents must perform proper respiratory etiquette to prevent the spread of respiratory infection.
2. The Manager of Nursing and Personal Care and Supervisors of other departments will determine staffing considerations.
3. Staff should monitor themselves for signs and symptoms of an infectious disease.
4. Symptomatic staff should self-isolate at home, and not go into work; staff should report being ill to their Supervisor
5. Staff who develop respiratory symptoms at work are recommended to perform respiratory hygiene practices (wear mask, cough into sleeve/elbow) and leave work as soon as possible.
6. For respiratory illness, staff should immediately leave and be directed to self isolate at their own home until symptoms have been improving for 24 hours (48 for gastrointestinal) and no fever present.
7. For 10 days after the date of specimen collection or symptom onset, whichever is earlier/applicable, Staff should adhere to workplace measures for reducing risk of transmission (i.e., masking for source control) and avoid caring for Resident at highest risk of severe respiratory illness, where possible.
8. During a respiratory outbreak, staff working at two facilities should inform their employers that they are working at a facility with an outbreak. Staff are encouraged to change their uniform between facilities.
9. Staff are not to come to work if they are ill. They are to remain off work for 5 days from onset of symptoms or until 24 hour symptom free or with symptoms improving for 24 hours; whatever comes first. If the causative agent is known, other measures may apply.

Influenza Outbreaks (all staff)

1. Immunized, well staff have no restrictions on their ability to work at one or more facilities.
2. The staff member must change their uniform between facilities.
3. Non-immunized staff receiving Tamiflu may work as soon as they have started to take the medication.
4. Staff who are taking Tamiflu but have flu symptoms should remain off work for 5 days from onset of symptoms or until symptom free, whichever is shorter
5. Non-immunized, well staff not receiving Tamiflu must wait 3 days since they last worked at the outbreak facility/unit prior to working in a non-outbreak facility.
6. During an influenza outbreak, non-immunized exposed staff, who choose not to take the influenza vaccine and or recommend anti-viral agent, must cease work at another facility for the incubation period of 3 days to ensure they remain asymptomatic and avoid the outbreak transmitted to the home.

7. Staff protected by either immunization or anti-viral have no restrictions on their ability to work at other facilities.

Non-Immunized staff are contacted and are informed of outbreak. “Influenza Outbreak – Staffing” policy and procedures is implemented.

Staff illness with a known link to the outbreak will be reported as an occupational illness and reported to the Ministry of Labour only upon submission of an employee incident report.

Volunteers

Volunteers are not allowed in the home when Residents are displaying Acute Respiratory Infection symptoms to limit community contact.

Visitors

- General visitors are encouraged to postpone their visit.
- Caregivers should be educated on the potential risk of exposure when visiting a symptomatic Resident.
    - Must wear PPE (mask, gown, gloves, appropriate eye protection) and perform hand hygiene with ABHR before donning and doffing PPE when visiting a symptomatic Resident.
- Perform hand hygiene before and after visits and as applicable.
- Keep internal traffic to a minimum and only visit their Resident and no other Resident.
- Wear the required PPE as required.
- Not to visit if they themselves are ill.
- 1:1 visits with essential caregivers or visitors may continue if Additional Precautions are followed.

Education

- Training of staff/volunteers/student placements on the use of PPE and IPAC protocols.
- This policy will be given with orientation to all new employees and reviewed annually via Surge Learning for all staff.
- This policy will be reviewed by Resident Council, Family Council and Public Health as required.

Communications:

- LTCHs must keep staff, Residents and families informed, including frequent and ongoing communication during outbreaks.
- Issuing a media release to the public is the responsibility of the Administrator and will be done in collaboration with the public health unit.

- This policy will be reviewed and tested annually and within 30 days of an outbreak being declared over.
- A written record of the testing of this policy and any changes of this policy will be kept.
- A copy of this policy is posted on the Norview Lodge Website and hard copies will be made available upon request.

References

Ministry of Health and Long-Term Care. Control of Respiratory Infection Outbreaks in Long Term Care Homes.

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