PREVENTION & MANAGEMENT OF RESPIRATORY OUTBREAKS FOR COMMUNITY FACILITIES

CHECKLISTS for Respiratory Outbreaks

OVERVIEW

The Respiratory Outbreak Control Measure and Reporting portions of the Quick Reference Guide were revised in 2007-08. They are now presented as CHECKLISTS to initiate and maintain measures intended to assist in controlling the outbreak in a way that balances resident and staff protection with the least possible interference on facility function and resident well-being.

The CHECKLISTS are organized in the following way:

1. **PRE-SEASON PLANNING AND PREVENTION CHECKLIST - Though this is heavily influenced by preparation for Influenza outbreaks, it covers the basic principles of prevention and planning for other respiratory outbreaks. This year it includes Pandemic Influenza (pH1N1 flu virus) detection and management;**
2. **OUTBREAK DETECTION AND CONSULTATION CHECKLIST - This is designed to detect respiratory illness outbreaks and determine the causative organism or organisms. This applies to any respiratory virus outbreak up to the point of determining that it is caused by influenza or another organism. Note the importance of promptly reporting a suspect outbreak to your Outbreak Management Consultant;**
3. **CONTROL MEASURE CHECKLIST FOR OUTBREAK MANAGEMENT - The recommended Control Measures and Reporting Expectations vary with the nature of the outbreak and are organized and presented as:**
   - **A FLOW CHART with definitions: for assistance in selection of the best CHECKLIST for control measures (Scenario A1, A2, B or C)**
   - **SCENARIO A1—SEASONAL INFLUENZA OUTBREAK IN WHICH INFLUENZA IS KNOWN OR SUSPECTED AS CAUSE. [For Seasonal Influenza B, Seasonal Influenza A/H3N2 and Seasonal Influenza A/H1 OsR (oseltamivir resistant)],**
   - **SCENARIO A2—pH1N1 flu virus OUTBREAK IN WHICH pH1N1 flu virus IS KNOWN OR SUSPECTED AS CAUSE,**
   - **SCENARIO B--NON-INFLUENZA OUTBREAK CHARACTERIZED BY SERIOUS ILLNESS, and**
   - **SCENARIO C--NON-INFLUENZA OUTBREAK CHARACTERIZED BY MILD ILLNESS.**

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Though no single, simple protocol will cover all respiratory outbreaks optimally, the checklists provide rational approaches to influenza and non-influenza viral respiratory outbreak management.

WARNING: For each of the Outbreak Scenarios it is critically important to remain vigilant in surveillance in case the situation changes; for example, more than one virus may be causing illness in the same setting, additional laboratory testing may be indicated, a resident may have developed complications or a bacterial infection and need medical assessment, etc.

These checklists are provided as guides for the management of respiratory virus outbreaks. The checklists DO NOT substitute for:

- **Consultation regarding Outbreak Management (as needed) with your Medical Director/Superintendent and your Outbreak Management Consultant (Public Health Nurse or Infection Prevention and Control Practitioner)** **(pages 3, 15)**
- **Consultation with your Medical Director/Superintendent or with the Resident's Physician when warranted due to a specific resident's condition.**

REMEMBER! Respiratory viruses are smarter than these checklists (and the people who draft them). So be alert for indications to consult, send more samples for testing or modify your outbreak management strategy.

PRE-SEASON PLANNING AND PREVENTION CHECKLIST

AUGUST/ SEPTEMBER

- ☐ Update Physician **Pre-printed Orders** for influenza immunization, pneumococcal immunization (if needed), serum creatinine level and anti-influenza medications against influenza [oseltamivir (Tamiflu®) for all Influenza A and B outbreaks unless oseltamivir resistance is detected] (p. 3, Appendix C).
- ☐ Pre-determine residents' weights and estimated creatinine clearance for calculation of anti-influenza medication doses.
- ☐ Review **Peer Nurse Immunizer Program**, Handbook and Self Study Guide (posted on Internet at same location as this The FH Respiratory Outbreak Protocol).
- ☐ Review SOURCE CONTROLS: Engineering and Administrative (p. 5, Appendix P).

SEPTEMBER (pages 1-5)

- ☐ Receive and familiarize yourself with the current Fraser Health Respiratory Outbreak Protocol for Residential Facilities (at www.fraserhealth.ca – PROFESSIONALS – RESIDENTIAL CARE PROVIDERS –OUTBREAK GUIDELINES – RESPIRATORY section, select the resource you need from the choices.
- ☐ Assemble your Influenza Resource Kit (p. 4 and 5).
- ☐ Pick up influenza vaccine when it is available using the cold-chain method (p. 4, Appendix E).
- ☐ Order and pick up pneumococcal vaccine as required.
- ☐ Prepare for staff, volunteer and student education and information on influenza immunization and outbreak management. Provide staff with information on anti-influenza prophylaxis (page 1).
- ☐ Order outbreak laboratory specimen kits (p. 4):
  - ➔ Nasal swabs ('Six-Packs') by faxing a request on your letterhead with your shipping address and number of kits needed (usually one, as each kit has 6 swabs) to BCCDC at 604-707-2606.
- ☐ Make a list of important contact numbers. A template is provided (Appendix Q).
- ☐ For general information on the pH1N1 flu virus, refer to www.fraserhealth.ca and click on the H1N1 Information BOX.

OCTOBER/NOVEMBER/DECEMBER/ (pages 6-7, Appendices A, B and J)

- ☐ Post appropriate signage (Appendix J):
- ☐ Vaccinate staff, volunteers and students, and check that contract workers are vaccinated (as advised by public health)—**this season, prepare for 3 rounds of immunization**: Seasonal influenza vaccine for staff/volunteers (age 65 years and over) and residents in October; pH1N1 virus vaccine in November and December; seasonal influenza vaccine for those under age 65 early in 2010 or as advised by Public Health.
- ☐ Make a list of staff/volunteers/students that have had this year's recommended influenza vaccines.
- ☐ Vaccinate residents **as soon as feasible** after the influenza vaccine is made available to you.
- ☐ Maintain a list of residents who have had this year's recommended influenza vaccine (or vaccines).
- ☐ Maintain a list of residents who have had pneumococcal vaccine, as recommended.
- ☐ Encourage visitors and others to be immunized as recommended against influenza.
- ☐ Review vaccination status as above for new residents on admission, including those admitted for respite care.

REMAINDER OF SEASON (pages 8-11)

- ☐ Complete annual record of immunization rates of both staff and residents (Appendices A and B).
- ☐ **Complete Facility Influenza Readiness Report - fax to local Health Unit by February 28 (Appendix G).**
- ☐ Stay ready throughout the Respiratory Outbreak season (pages 9-11).

OUTBREAK DETECTION AND CONSULTATION CHECKLIST

- ☐ **ISOLATE** symptomatic residents on Enhanced Droplet/Contact Precautions (Appendix J).
- ☐ **TAKE SPECIMENS FOR LAB TESTING** as soon as possible when there are 2 or more people with new or worse cough in a unit or area within a 7-day period (staff or residents). COLLECT NASAL SWAB SPECIMENS **(Appendices F1 & F2)** for testing from **up to 6** people with new or worse cough starting within the last 48 hours. Record specimens taken on the Resident and/or Staff Illness Report (Appendices H, I). Preview Personal Protective Equipment (PPE) for taking nasal swab. This is NOT considered to be an Aerosol Generating Medical Procedure (AGMP) so may be done using a procedure mask (p. 14, Appendices F1 and F2).
- ☐ Follow the instructions in the Fraser Health Respiratory Outbreak Protocol for Residential Facilities
  - ➔ For Nasal Swab specimens (p. 14 and Appendices F1 and F2)
    - ☐ Complete one BCCDC Nasal Swab Respiratory Outbreak Laboratory Form (Appendix F1).
    - ☐ Include the name and phone number of the person to whom you want the laboratory to call about/send the results from the swab(s). **Be sure to include an after-hours number as results are often called to you in the evening. Be sure the person who will take the call from the lab will know what to do with the result.**
    - ☐ Notify the Virus Isolation Lab by **faxing** completed Lab form to BCCDC at **604-707-2605**.
    - ☐ Fill out a BCCDC Virus Culture Requisition for **each swab**, mark it **"URGENT OUTBREAK-ASSOCIATED"** and send it with the swab (Appendix F2).
    - ☐ Call the Dynamex Courier at **604-432-7700**, bill to **Acct #23270** and specify the **"ON & GONE"** delivery mode to the BCCDC Virus Isolation Lab, 655 West 12th Avenue, Vancouver, BC.
- ☐ **NOTIFY** your **Outbreak Management Consultant** (Public Health Nurse or Infection Prevention and Control Practitioner) (pages 3, 15) when there are 2 or more people with new or worse cough in a unit or area within a 7-day period (in staff or residents):

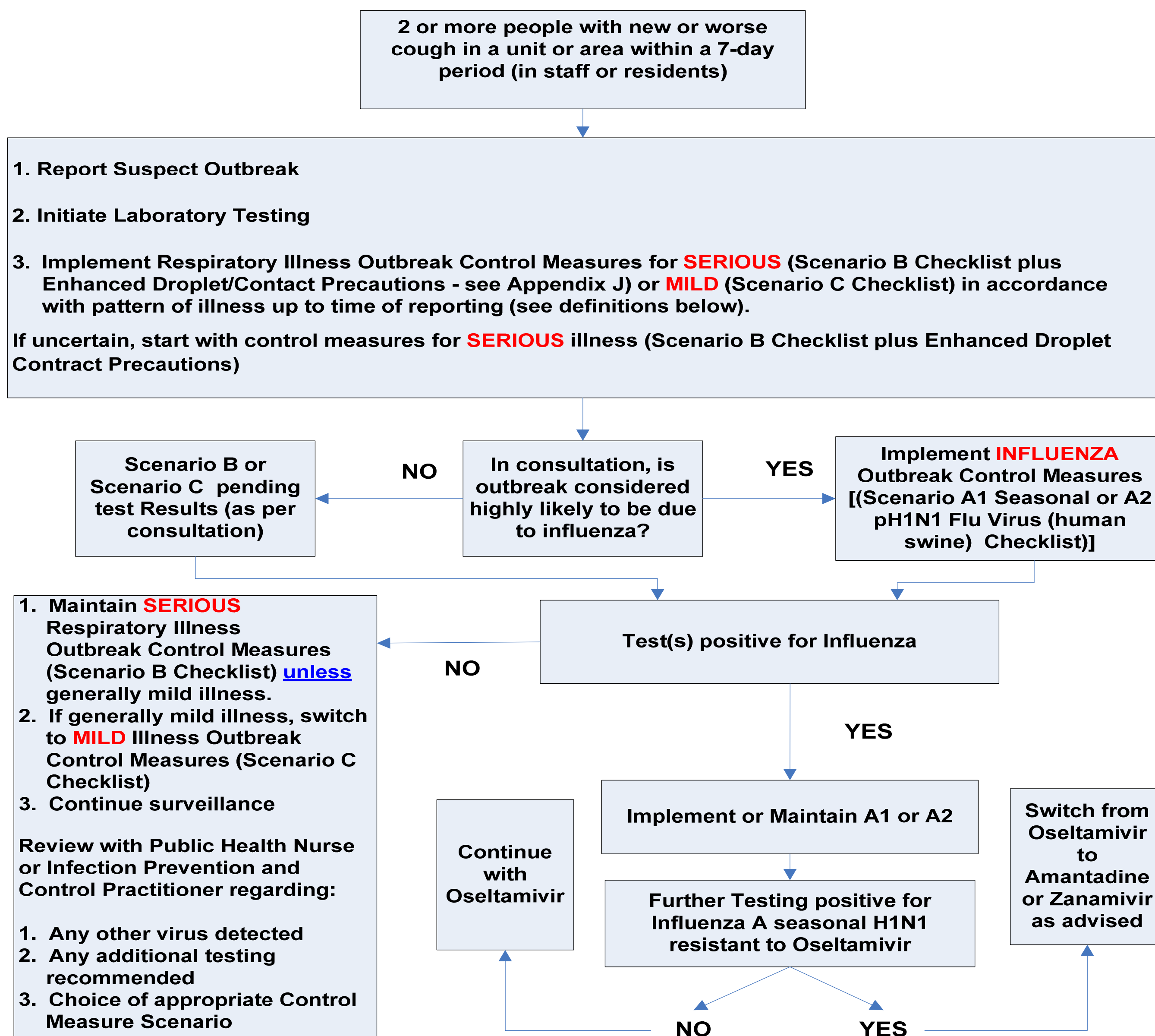
  For Contracted and Private Pay Residential Care Facilities and for Fraser Health Operated Specialized Residential Care Facilities with 20 or more residents (for example, Mental Health Facilities)
  - ➔ WEEKDAYS: Between 0830 and 1630, call and fax your local Public Health Unit.
  - ➔ WEEKENDS/STAT HOLIDAYS: Between 8:30 am and 4:30 pm, call the Medical Health Officer on call through the Fraser Health Public Health Answering Service at 604-527-4806.
  - ➔ EVENING/OVERNIGHT: Contact the Health Unit or Medical Health Officer as above, promptly on the NEXT day.

  For Fraser Health Operated Residential Care Facilities
  - ➔ WEEKDAYS: Between 8:00 am and 3:40 pm, call your Fraser Health Infection Prevention and Control Practitioner.
  - ➔ WEEKENDS/STAT HOLIDAYS: Between 8:30 am and 4:30 pm, call the FH Medical Microbiologist on call at 604-231-4411 (except for Fellburn in Burnaby, call the Medical Health Officer on call through the Fraser Health Public Health Answering Service at 604-527-4806).
  - ➔ EVENINGS/OVERNIGHT: Contact the FH Infection Prevention and Control Practitioner, FH Medical Microbiologist or Medical Health Officer as above, promptly on the NEXT day.
- ☐ Complete the Staff and Resident Respiratory Illness Reports daily (Appendices H, I) and fax to your **Outbreak Management Consultant** each weekday (pages 3, 15). For FH Operated Residential Care Facilities, also send Staff Illness forms to the Occupational Health Central fax: **604-953-5138.**(Surrey)
  - o Use a different sheet for each ward/area.
  - o For influenza, Staff and Resident Illness forms need to be updated daily (pages 15, 16). If the outbreak is assessed to be due to a virus other than influenza, the Public Health Nurse or Infection Prevention and Control Practitioner will assist in the decision as to whether to continue with outbreak management and reporting measures for a SERIOUS respiratory illness outbreak or a MILD respiratory illness outbreak.

  THIS MAY NEED TO BE REVIEWED DURING THE COURSE OF THE OUTBREAK.
- ☐ Designate a staff member (and back-up) to be responsible for daily outbreak tracking and updates.
- ☐ Order replacement swab kits by **faxing** a request on facility letterhead to BCCDC at **604-707-2606**.

FLOWCHART AND DEFINITIONS

FOR RESPIRATORY OUTBREAK CONTROL MEASURES



DEFINITIONS

Respiratory Outbreak (non-influenza) characterized by SERIOUS Illness (Scenario B Outbreak Management Checklist)

- Illness is more than "a bad cold" in many or most of those affected.
- Illness may be remarkable in its suddenness and accompanying extreme fatigue (prostration).
- Affected individuals generally are not up and about while ill.
- Eating and drinking are likely to be affected.
- Symptoms may persist.
- There are complications such as pneumonia (viral or secondary bacterial), heart failure or septicaemia in residents or staff for whom pre-existing frailty or underlying chronic illness is not a satisfactory explanation for such complications.
- Illness may be prolonged, with cases taking longer than expected to recover.

Respiratory Outbreak (non-influenza) characterized by MILD Illness (Scenario C Outbreak Management Checklist)

- Illness is mild and "common cold-like" in most of those affected.
- From onset (or within a day or two), activity levels, including eating and drinking, are not markedly different than usual.
- Note: There may be individual exceptions due to underlying pre-existing illness that makes certain individuals very susceptible to complications from any respiratory infection.

SCENARIO A1 CHECKLIST SEASONAL INFLUENZA A and B

Influenza is known or suspected as the cause of the Outbreak

Establish outbreak control measures including (pages 18-27):

- ☐ **MANAGEMENT OF ILL RESIDENTS/PATIENTS**: Isolate in their rooms as much as possible **with enhanced droplet/contact precautions** through their infectious period (5 days from onset). Provide meals in rooms, regular trays can be used. Ensure that workers and visitors use personal protective equipment when within 2 meters of an ill resident (as indicated on enhanced droplet/contact precautions sign). Follow standard protocols for laundry, utensils, garbage and medical waste. (Appendix O). If residents need to be transferred to acute care facilities, inform the BC Ambulance service at time of booking and the receiving institution of your outbreak. Resident should wear a mask (if tolerated) for transfer. Anyone accompanying the resident should wear a mask, eye protection and gloves during transport.
- ☐ **MANAGEMENT OF ILL HEALTH CARE WORKERS**: Exclude from the workplace until their symptoms are gone or they are five days from symptom onset, whichever is sooner. Practice good respiratory and hand hygiene on return to work.
- ☐ **IMMUNIZATION**: Influenza immunization for all non-immunized health workers and residents.
- ☐ **EDUCATION**: Teach health workers and volunteers early signs and symptoms of influenza, how to prevent spread of influenza and how to educate residents, their families and other visitors. Model and encourage recommended hand hygiene practices and respiratory etiquette. Post educational signs re: hand hygiene and respiratory etiquette (Appendix J).
- ☐ **EXCLUSION OF WELL HEALTH WORKERS**: It is unlikely that exclusion of well workers from the outbreak setting will be recommended prior to vaccine availability. If health worker prophylaxis is recommended, those who need it should be given a copy of the appropriate *Letter to Physician* to take to their doctor for a prescription (Appendix N). All workers should self-monitor for illness and be excluded as per ill worker if symptoms develop. Well workers not protected by seasonal influenza vaccination or anti-influenza prophylaxis cannot work in another health care setting until symptom-free for 72 hours after last working in the outbreak setting.
- ☐ **RESTRICTION OF ADMISSIONS/TRANSFERS**: Restrict transfers of residents into or out of the facility. Review how people and things move in and around the facility. Depending on the extent of the outbreak and the physical layout of the building, restrictions might be applied to one floor, one wing or the whole facility. Restrictions should be in place until the 8th day after the onset of symptoms in the last resident case [*or, if a health care worker is the last case, 3 days (72 hours) after ill worker last in setting]*.
- ☐ **IMPLEMENTATION OF OTHER RESTRICTIONS**: Social activities of groups of residents in the facility should be suspended; however, where feasible, within an affected area under outbreak control measures, consider cohorting residents for group activities (well with well, ill with ill). Visitors should visit only one resident. Non-immunized visitors, including family, should be advised to consider if visits are necessary since they can spread the disease before they realize they are infectious.
- ☐ **POSTING OF OUTBREAK SIGNAGE**: Use influenza alert posters to advise visitors of the outbreak and precautions to use (Appendix J for sample posters).
- ☐ **UTILIZATION OF COHORTING**: Assign groups of health workers to work in either affected or unaffected areas, but not both, or with either ill or well residents, but not both. If this is not possible, workers should work first in unaffected areas or with well residents, ensuring personal protective equipment (PPE) is used appropriately with strict hand hygiene in between residents and/or areas.
- ☐ **ADHERENCE TO INFECTION PREVENTION AND CONTROL PRACTICES**: Remind workers and visitors to practice hand hygiene before and after contact with each resident. Post signs requiring enhanced contact/droplet precautions with ill residents and use of PPE (gloves, gowns, masks and eye protection) appropriately (p.5, Appendix J for signage and method for donning and doffing PPE).
- ☐ **ENHANCEMENT OF HOUSEKEEPING**: Introduce enhanced cleaning regimens, including more frequent disinfection of commonly touched surfaces or items such as handrails, elevator buttons, door handles. Provide for safe disposal of contaminated items such as tissues. Ensure resident has a garbage can for used tissue (p. 5 and Appendix O).
- ☐ **CLEANING OF EQUIPMENT**: Clean/disinfect equipment between use for different residents or areas using a hospital grade cleaner with a Drug Identification Number (DIN) (see Residential Care Infection Control Manual: IC13).
- ☐ **NOTIFICATION OF INFLUENZA OUTBREAK**:
  - Public Health Nurse, Infection Prevention & Control Practitioner and Occupational Health Nurse, as applicable for setting. (p.15)
  - Community Care Facility Licensing (if a licensed facility)
  - Any facility/institution that may have admitted a resident from you (include transfers up to two days before onset of illness in the first case in your outbreak)
  - BC Ambulance, HandyDART, oxygen services, laboratory services, and other service providers of any outbreak control measures that may affect their provision of services if called to your facility
  - Your ACCESS Coordinator (or equivalent bed booking service such as Centralized Referral Coordinator for Mental Health Facilities) of any restrictions on admissions or transfers.
- ☐ **DAILY REPORTING**: Update Resident and Staff Illness Reporting forms each day (adding in new information). Fax each weekday to your **Outbreak Management Consultant** (Public Health Nurse or Infection Prevention Control and Practitioner) (pp.16,24, App. H, I). If Fraser Health Operated, also send Staff Illness Report forms to the Occupational Health Central fax: **604-953-5138** (Surrey #).
- ☐ **MAINTENANCE OF ONGOING SURVEILLANCE**: Remain alert for possible new cases. Daily surveillance of residents for symptoms is advised. When community or facility outbreaks occur, twice daily surveillance is recommended (p.24).
- ☐ **TREATMENT AND PROPHYLAXIS**: Your medical director or the resident's physicians will order treatment for resident cases for whom treatment may be beneficial. Use of anti-influenza medication for prophylaxis for well residents and well, unvaccinated workers will be determined on a situation-by-situation basis and your **Outbreak Management Consultant** will advise on the recommended use of prophylaxis. Start prophylaxis as advised by the **Outbreak Management Consultant** (and in consultation with your Medical Director, if applicable). Utilize pre-printed orders for prophylaxis. (pages 19-24 and Appendices D1, D2, K, L, M and N).
- ☐ **CALLING OUTBREAK OVER:** Consult with your **Outbreak Management Consultant** (pages 3, 15, 18, 27). An Influenza outbreak will usually be declared over on the 8th day after onset of illness in the most recent case and 3 days (72 hours) after the last time a staff member with symptoms worked in the facility (p. 27).

SCENARIO A2 CHECKLIST PANDEMIC H1N1 INFLUENZA (pH1N1 flu virus)

pH1N1 flu virus is known or suspected as the cause of the Outbreak

Establish outbreak control measures including (pages 18-27):

- ☐ **MANAGEMENT OF ILL RESIDENTS/PATIENTS**: Isolate in their rooms as much as possible **with enhanced droplet/contact precautions** through their infectious period (7 days from onset). Provide meals in rooms, regular trays can be used. Ensure workers and visitors use personal protective equipment when within 2 meters of the resident, as indicated on enhanced droplet/contact precautions sign. Follow standard protocols for laundry, utensils, garbage and medical waste. (Appendix O). If transfer to acute care is required, inform BC Ambulance Service and the receiving institution that the resident has the pH1N1 flu virus. Resident should wear a mask (if tolerated) for transfer. Anyone accompanying the resident should wear a mask, eye protection and gloves during transport.
- ☐ **MANAGEMENT OF ILL HEALTH CARE WORKERS**: Exclude from workplace until their symptoms are gone, including fever (without anti-fever medication), or they are seven days from onset of symptoms, whichever is sooner. Early oseltamivir treatment, if conditions that put worker at risk of serious illness.
- ☐ **IMMUNIZATION**: Recommend pH1N1 flu virus immunization (when available and as indicated) for health workers and residents.
- ☐ **EDUCATION**: Teach health workers and volunteers early signs and symptoms of influenza, how to prevent spread of influenza and how to educate residents, their families and other visitors. Model and encourage recommended hand hygiene practices and respiratory etiquette. Post educational signs re: hand hygiene and respiratory etiquette (Appendix J).
- ☐ **EXCLUSION OF WELL HEALTH WORKERS**: It is unlikely that exclusion of well workers from the outbreak setting will be recommended prior to vaccine availability. <u>If</u> health worker prophylaxis is recommended, those who need it should be given a copy of the appropriate *Letter to Physician* to take to their doctor for a prescription (Appendix N). All workers should self-monitor for illness and be excluded as per ill worker if symptoms develop. Well workers not protected by pH1N1 flu virus vaccination or anti-influenza prophylaxis cannot work in another health care setting until symptom-free for 72 hours after last working in the outbreak setting.
- ☐ **RESTRICTION OF ADMISSIONS/TRANSFERS**: Restrict transfers of residents <u>into or out of</u> the facility. Review how people and things move in and around the facility. Depending on the extent of the outbreak and the physical layout of the building, restrictions might be applied to one floor, one wing or the whole facility. Restrictions should be in place until the 8th day after the onset of symptoms in the last resident case [*or, if a health care worker is the last case, 3 days (72 hours) after ill worker last in setting]*, OR as advised by your **Outbreak Management Consultant**.
- ☐ **IMPLEMENTATION OF OTHER RESTRICTIONS**: Social activities of groups of residents in the facility should be suspended; however, where feasible, within an affected area under outbreak control measures, consider cohorting residents for group activities. Visitors should visit only one resident. Non-immunized visitors, including family, should be advised to consider if visits are necessary since they can spread the disease before they realize they are infectious.
- ☐ **POSTING OF SIGNAGE**: Use influenza alert posters to advise visitors of the outbreak and precautions to use (App J for samples).
- ☐ **UTILIZATION OF COHORTING**: Assign groups of workers to work in either affected or unaffected areas, but not both, and with either ill or well residents, but not both. If this is not possible, workers should work first in unaffected areas or with well residents, ensuring personal protective equipment (PPE) is used appropriately with strict hand hygiene in between residents and/or areas.
- ☐ **ADHERENCE TO INFECTION PREVENTION AND CONTROL PRACTICES**: Remind workers and visitors to practice hand hygiene before and after contact with each resident. Post signs requiring enhanced droplet/contact precautions with ill residents and use of PPE (gloves, gowns, masks and eye protection) appropriately (p.5 and Appendix J for signage and method for donning/doffing PPE).
- ☐ **ENHANCEMENT OF HOUSEKEEPING**: Introduce enhanced cleaning regimens (two times per day), plus more frequent cleaning of commonly touched surfaces (e.g. handrails, door handles, etc.). Provide for safe disposal of contaminated items such as tissues. Ensure resident has a garbage can for used tissue (see p.5 and Appendix O).
- ☐ **CLEANING OF EQUIPMENT**: Clean/disinfect equipment between use for different residents or areas using a hospital grade cleaner with a Drug Identification Number (DIN) (see Residential Care Infection Control Manual: IC13).
- ☐ **NOTIFICATION OF INFLUENZA OUTBREAK**:
  - Public Health Nurse, Infection Prevention & Control Practitioner and Occupational Health Nurse, as applicable for setting. (see p.15)
  - Community Care Facility Licensing (if a licensed facility)
  - Any facility/institution that may have admitted a resident from you (include transfers up to two days before onset of illness in the first case in your outbreak)
  - BC Ambulance, HandyDART, oxygen services, laboratory services, and other service providers of any outbreak control measures that may affect their provision of services if called to your facility.
  - Your ACCESS Coordinator (or equivalent bed booking service) of any restrictions on admissions or transfers.
- ☐ **DAILY REPORTING**: Update Resident and Staff Illness Reporting forms each day (adding in new information). Fax each weekday to your **Outbreak Management Consultant** (Public Health Nurse or Infection Prevention Control and Practitioner) (pp.16,24, App. H, I). If Fraser Health Operated, also send Staff Illness Report forms to the Occupational Health Central fax: **604-953-5138** (Surrey #).
- ☐ **MAINTENANCE OF ONGOING SURVEILLANCE**: Remain alert for possible new cases. Daily surveillance of residents for symptoms is advised. When community or facility outbreaks occur, twice daily surveillance is recommended. (see p.24).
- ☐ **TREATMENT AND PROPHYLAXIS**: Advice from your **Outbreak Management Consultant** will be provided for pH1N1 flu virus. Your medical director or the resident's physicians will order treatment for resident cases for whom treatment may be beneficial. Use of anti-influenza medication for prophylaxis for well residents and well, unvaccinated workers will be determined on a situation-by-situation basis and your **Outbreak Management Consultant** will advise on the recommended use of prophylaxis. Start prophylaxis as advised by the **Outbreak Management Consultant** (and in consultation with your Medical Director, if applicable). Utilize pre-printed orders for prophylaxis. (pages 19-24 and Appendices D1, D2, K, L, M and N).
- ☐ **CALLING OUTBREAK OVER:** Consult with your **Outbreak Management Consultant** (see pages 3, 15, 18, 27). A pH1N1 flu virus outbreak will be declared over on the 8th day after onset of illness in the most recent resident case and 3 days (72 hrs) after the last time a health care worker with symptoms worked in the facility **<u>unless advised otherwise by your Outbreak Management Consultant.</u>**

SCENARIO B CHECKLIST (SERIOUS RESPIRATORY ILLNESS)

Non-Influenza respiratory virus outbreak that is characterized by SERIOUS illness

Establish outbreak control measures including:

- ☐ **MANAGEMENT OF ILL RESIDENTS/PATIENTS**: Isolate in their rooms on droplet/contact precautions while infectious. Provide tray service meals. Ensure that workers and visitors use appropriate infection control measures when giving care or visiting. *When using Scenario B measures for the short period while awaiting influenza results, use enhanced droplet/contact precautions (App J).*
- ☐ **MANAGEMENT OF ILL HEALTH CARE WORKERS**: Recommend that ill workers stay away from work for the duration of their acute symptoms or 5 days, whichever is shorter, and practice good respiratory and hand hygiene on return to work.
- ☐ **EDUCATION**: Teach staff and volunteers early signs of the specific disease, how to prevent its spread and how to educate residents and their families and other visitors.
- ☐ **EXCLUSION OF WELL HEALTH CARE WORKERS**: When influenza has been ruled out as being involved in a respiratory illness outbreak, there is no policy to exclude well health care workers not immunized against influenza from working in your facility or other health care settings. However, any such workers who develop signs or symptoms of respiratory illness should be off work as above and should notify immediately any facility in which they have worked in the previous week.
- ☐ **RESTRICTION OF ADMISSIONS/TRANSFERS**: Recognize that this may be affected by the severity of illness and facility ability and layout. Generally, limit transfers of residents into or out of the facility to those that are deemed to be very important. Receiving facilities should be aware of the outbreak and able to isolate the individual through an incubation period. Residents may be transferred to acute care facilities, but you must inform the receiving institution of your outbreak. In residential care settings, incoming residents or their decision-makers should be aware of the outbreak and be able to provide informed consent regarding the admission. Ideally, the incoming resident's physician should be included in this discussion. When making a decision, please consider any health conditions that may place the incoming resident at increased risk of complications if infected. Also consider potential risk to Outbreak Management from admitting a potentially susceptible resident.
- ☐ **IMPLEMENTATION OF OTHER RESTRICTIONS**: Review group activities involving residents in the facility. Consider the potential infection control benefits of canceling or modifying group activities and weigh these against the importance of the group activities to resident well-being. As feasible, within an affected area under outbreak control measures, consider cohorting residents for group activities (well with well, ill with ill). Actions will depend on the situation, severity and rapidity of spread of infection and the nature of the group activity. Visitors should limit visiting to only one resident.
- ☐ **POSTING OUTBREAK SIGNAGE**: Use viral respiratory outbreak alert posters to advise visitors of the outbreak and precautions to use. DO NOT USE influenza signage as this causes confusion (Appendix J for sample posters).
- ☐ **UTILIZATION OF COHORTING**: Assign groups of workers to work in either affected or unaffected areas, but not both. If this is not possible, staff should work first in unaffected areas or with well residents, using strict hand hygiene in between residents or areas.
- ☐ **ADHERENCE TO INFECTION PREVENTION AND CONTROL PRACTICES**: Remind workers and visitors to practice hand hygiene before and after contact with each resident. Post signs noting infection control practices for visitors and staff (p.5 and Appendix J).
- ☐ **ENHANCEMENT OF HOUSEKEEPING**: Introduce enhanced cleaning regimens, including more frequent disinfection of commonly touched surfaces or items (e.g., handrails, elevator buttons, door handles) and safe disposal of contaminated items (e.g., tissues).
- ☐ **CLEANING OF EQUIPMENT**: Clean/disinfect equipment between use for different residents or areas (p. 5 and Appendix O).
- ☐ **NOTIFICATION OF**:
  - Public Health Nurse, Infection Prevention & Control Practitioner and Occupational Health Nurse, as applicable for setting (p. 15).
  - Community Care Facility Licensing (if a licensed facility)
  - Any facility/institution that may have admitted a resident from you (include transfers up to two days before onset of illness in the first case in your outbreak). Note the respiratory pathogen causing outbreak, if known. Note that the outbreak is not thought to be influenza. Inform if significant change in determination of cause of outbreak.
  - HandyDART, oxygen services, laboratory services, BC Ambulance and other service providers of any outbreak control measures that may affect their provision of services.
  - Your ACCESS Coordinator (or equivalent bed booking service) of any restrictions on admissions or transfers.
- ☐ **DAILY REPORTING**: Update the Resident and Staff Illness Reporting forms each day (just adding in new information). **For Contracted, Private Pay and Fraser Health Operated Specialized Residential Care Facilities,** fax each weekday to Fraser Health (FH) Research Officer/Decision Support (Abbotsford fax number: 1-604-556-5077). Provide your email address so Serious Respiratory Illness Outbreak graphs (Epidemic Curves) can be sent to assist you in managing the outbreak. **For FH Operated Residential Facilities,** send both Staff and Resident Illness reports to your Infection Prevention and Control Practitioner and fax Staff Illness reports to the Occupational Health Central fax: 604-953-5138 (Surrey number) (p. 16).
- ☐ **MAINTENANCE OF ONGOING SURVEILLANCE**: Remain alert for possible new cases. Generally, it will not be necessary to do additional testing for virus identification once the causative agent has been identified. However, in addition to the potential for bacterial infection as a complication in those affected by the viral illness, another virus may also be causing illness. At times, respiratory viruses, alone or in combination, may cause outbreaks that have more serious illness than might have been expected and/or are prolonged and/or have very high attack rates. If a significant difference in pattern or severity of illness is noted during an outbreak (for example, new cases are affected differently than early cases), additional viral testing may be valuable and should be reviewed with your Public Health Nurse or Infection Prevention and Control Practitioner and Medical Director/Superintendent or other clinician consulting in management of the outbreak. Remain alert to the potential for secondary bacterial infections (pages 15, 16).
- ☐ **CALLING OUTBREAK OVER**: Consider the outbreak over at 8 to 14 days after onset of illness in the most recent case. This may vary depending on knowledge of the virus or viruses causing the outbreak. The outbreak curve (graph) of your outbreak will be helpful in deciding when the outbreak virus has stopped spreading in the facility. Consult with your Medical Health Officer or Infection Prevention and Control Practitioner about declaring the outbreak over. Send a fax using your facility letterhead indicating OUTBREAK OVER to Public Health (Abbotsford number 1-604-556-5077).

SCENARIO C CHECKLIST (MILD RESPIRATORY ILLNESS)

Non-Influenza respiratory virus outbreak that is characterized by MILD illness

PLEASE DO NOT use this CHECKLIST without having read the GUIDE FOR USE OF THE OUTBREAK CHECKLISTS

Establish outbreak control measures including:

- ☐ **MANAGEMENT OF ILL RESIDENTS/PATIENTS**: Isolate in their rooms as much as is reasonable during acute illness (coughing and sneezing). Provide tray service meals while isolated.
- ☐ **MANAGEMENT OF ILL HEALTH CARE WORKERS**: Recommend ill workers be off work during acute stage of illness and practice good respiratory and hand hygiene on return to work.
- ☐ **EDUCATION**: Review spread of common respiratory viral illnesses with workers and volunteers. Promote teaching on hand hygiene and respiratory etiquette for residents and their families and other visitors.
- ☐ **EXCLUSION OF WELL HEALTH CARE WORKERS**: When influenza has been ruled out as being involved in a respiratory illness outbreak, there is no policy to exclude well health care workers not immunized against influenza from working in your facility or other health care settings. However, any such workers who develop signs or symptoms of respiratory illness should be off work as above and should notify immediately any facility in which they have worked in the previous week.
- ☐ **RESTRICTION OF ADMISSIONS/TRANSFERS**: Recognize that this may be affected by the severity of illness. Generally, proceed with transfers and admissions as usual, except provide incoming resident/patient or receiving facility notification of your outbreak of mild respiratory illness and consider isolation for incoming residents with pre-existing conditions that make them particularly vulnerable to viral illnesses that normally cause only mild illness in others. In residential care settings, even when the outbreak is mild, 'common-cold like' illness, the facility/setting should consider making incoming residents or their decision-makers aware of the outbreak and able to provide informed consent regarding the admissions. Ideally, the incoming resident's physician should be included in this discussion. When making a decision, please consider any health conditions that may place the incoming resident at increased risk of complications if infected.
- ☐ **IMPLEMENTATION OF OTHER RESTRICTIONS**: Review group activities involving residents in the facility. Recognize that this may be affected by the severity of illness and complications. Consider the potential infection control benefits of canceling or modifying group activities and weigh these against the importance of the group activities to resident well-being. Generally, continue with most group activities, excluding only those residents/patients who are acutely ill and being managed in their rooms. As feasible, within an affected area, consider cohorting residents for group activities (well with well, ill with ill). Visitors should visit only one resident or, at least, avoid visiting a well resident after visiting an acutely ill resident.
- ☐ **ADHERENCE TO INFECTION PREVENTION AND CONTROL PRACTICES**: Workers and visitors should be reminded to practice hand hygiene before and after contact with each resident (p. 5 and Appendix J).
- ☐ **POSTING OUTBREAK SIGNAGE**: Decide if there is value to be gained from the use of viral respiratory outbreak alert posters to advise visitors of the outbreak and precautions to use. DO NOT USE influenza signage as this will confuse the situation (Appendix J for sample posters).
- ☐ **ENHANCEMENT OF HOUSEKEEPING**: More frequent cleaning regimens should be used, including more frequent disinfection of commonly touched surfaces or items such as handrails, elevator buttons, door handles and safe disposal of contaminated items such as tissues (p. 5 and Appendix O).
- ☐ **CLEANING OF EQUIPMENT**: Equipment should be cleaned/disinfected between use for different residents or areas.
- ☐ **NOTIFICATION OF**:
  - Public Health Nurse, Infection Prevention & Control Practitioner and Occupational Health Nurse, as applicable for setting (p. 15).
  - Community Care Facility Licensing (if a licensed facility)
  - Your ACCESS Coordinator (or equivalent bed booking services) of restrictions on admissions or transfers, if any.
- ☐ **DAILY REPORTING**: Use the daily reporting forms for monitoring within the facility as a useful tool in assessing the course of your outbreak and effectiveness of your outbreak management. Daily reporting of Staff and Resident Illness to Public Health, Infection Prevention and Control Practitioner or Occupational Health is **not** expected (p. 16).
- ☐ **MAINTENANCE OF ONGOING SURVEILLANCE**: Remain alert for possible new cases. Generally, it will not be necessary to do additional testing for virus identification. However, in addition to the potential for bacterial infection as a complication in those affected by the viral illness, another virus may also be causing illness. At times, respiratory viruses, alone or in combination, may cause outbreaks that have more serious illness than might have been expected and/or are prolonged and/or have very high attack rates. If a significant difference in pattern or severity of illness is noted during an outbreak (for example, new cases are affected differently than early cases), additional viral testing and/or switch to SERIOUS respiratory outbreak control measures may be valuable and should be reviewed with your Public Health Nurse or Infection Prevention and Control Practitioner, Medical Director/Superintendent or other clinician consulting in management of the outbreak (p. 24).
- ☐ **CALLING OUTBREAK OVER:** Consider the outbreak over at 8 to 14 days after onset of illness in the most recent case. This may vary depending on knowledge of the virus or viruses causing the outbreak. Without the help of an anti-influenza agent like that used for an influenza outbreak, it is difficult to specify an exact case-free interval to be used to call the outbreak over. It will not be unusual to see sporadic cases for some period of time after the outbreak settles. Alert your Public Health Nurse or Infection Prevention and Control Practitioner when you assess the outbreak to be over.

ADDITIONAL NOTES REGARDING THIS CHECKLIST:

1. Even in outbreaks of generally mild illness, some frail residents may develop complications due to underlying illness and/or secondary infection.
2. It will not be unusual for intermittent cases or clusters to occur for some time. If you are concerned in such instances, consult with your Public Health Nurse or Infection Control Practitioner. Two or more new cases identified after the outbreak was considered over should be investigated as a new suspect outbreak.