island health

During Influenza Season
A Checklist for Residential Care Facilities

Seasonal influenza is a serious cause of illness, disability and death in residents of care facilities. Each year, across Canada there is an average of 3500 deaths and 12,200 hospitalizations from influenza and its complications. Among vaccine-preventable diseases, influenza causes by far the most deaths, outpacing all other vaccine preventable diseases combined. Seniors and others in residential care are more vulnerable to influenza than the general population, because of their own compromised health status and the nature of congregate living and care giving.

To prevent influenza illness and outbreaks in your facility, there are several effective strategies to adopt. These include influenza immunization for staff and residents, outbreak preparation and plans, and staff education and policies about influenza prevention. (See the Getting Ready for Influenza Season Checklist)

When influenza activity increases and the influenza season begins, additional strategies are needed. These include augmented **infection control measures**, **monitoring for influenza-like illness** in your facility, and effective **management of influenza illness and outbreaks.**

This document outlines in checklist format tasks to complete during influenza season.

Infection Control Measures

- ❒ If not already in place, consider increasing access to hand sanitizers and/or hand washing facilities for staff, visitors and residents during influenza season. Also providing access to tissues and no touch garbage containers can decrease transmission.
- ❒ Increase messaging to staff, residents and visitors about hand washing and other personal infection control measures through various media (e.g. posters, newsletters, staff meetings, email).
- ❒ Ensure that masks and personal protective equipment(PPE) are available for unimmunized visitors and staff.
- ❒ Establish a plan for quickly accessing masks and other PPE in the case of a surge in demand at your facility (e.g.outbreak)

Monitoring for Influenza-Like Illness

- ❒ Review with staff periodically:
    - o Signs and symptoms of influenza in patients and staff, and appropriate follow up actions.

- The importance of reporting all respiratory illness in residents or staff immediately to the appropriate person for your facility (i.e. Director of Care, Infection Control).
- The importance of ill staff not reporting to work in your facility or any other care facility while they have symptoms.

❒ Review management of single cases and how to identify an outbreak.

Definitions:

a) Case of influenza-like illness (ILI):
New or worsening cough **and** fever* **and** one or more of: sore throat, arthralgia (sore joints), myalgia (sore muscles), runny nose, headache, prostration.

*Fever: temperature >38°C
or fever that is abnormal for that individual. Temperature <35.6° C or >37.4° C may be indicative of health conditions or medical therapy such as the use of anti-inflammatory medications, use of corticosteroids, etc. Temperature > 38° C may not always be present in infected elderly persons.

b) ILI Outbreak:
Within a long term care facility, or a geographic area of an acute care setting (e.g., **floor, unit)** the occurrence of**:**

- two or more cases of ILI in residents, patients, clients or staff within 7 days.

<u>Managing Influenza Illness & Outbreaks</u>

❒ **Review Management of Single Cases of ILI Among Residents**

a) If influenza is suspected, notify the resident's physician for assessment, including the use of antiviral medication which should be given in the first 48 hours for **treatment**.

b) Restrict the ill resident to their room and from group activities for **five** days from onset of symptoms, or until symptoms resolve, whichever is longer. Note: this recommendation is based on the known infectivity of individuals with influenza (five to seven days after onset of symptoms).

Arrange for tray service to deliver meals to the resident's room.

c) When providing care for a resident with known or suspected influenza, infection routine practices as well as *droplet and contact precautions* should be used (e.g. hand hygiene, gloves,

surgical mask and eye protection, and gowns if there is a risk of splashes). Ensure an adequate supply of equipment is available for care providers and visitors.

Residents who are not in single room accommodation should be managed in their bed space using droplet and contact precautions with privacy curtains drawn in addition to routine practices.

Aerosol generating medical procedures (AGMP) should be avoided, if possible, in patients with a respiratory infection. Use of an N95 respirator is required for providing care to patients with suspected or known airborne transmitted illnesses (e.g. TB) or performing AGMPs on people with SARS or other emerging infections.

d) Contact housekeeping to arrange for enhanced cleaning and more frequent disinfection of commonly touched surfaces or items (e.g. handrails, elevator buttons, phones, door handles) and safe disposal of waste (e.g. tissues).

e) Other actions to take in the facility:

- Observe roommates of a case and others in the facility for symptoms.
- If a resident case is not in a single occupancy room, move any residents from the room where possible to another single room.
- (Re)Offer influenza vaccine to any unvaccinated residents and staff.

❒ **Review Management of Outbreaks of Influenza-Like Illness**

a) Contact Medical Director, Manager **and** Infection Control or Communicable Disease.

b) Outbreaks are to be reported within 24 hours. Affiliate facilities report to Vancouver Island Health Authority (VIHA) Public Health, Communicable Disease Program as follows:

South Island: 1-866-665-6626
Central Island: 1-866-770-7798
North Island: 1-877-887-8835

c) Amalgamate facilities under the VIHA umbrella report outbreaks to their Infection Control Practitioner. A contact list for VIHA Infection Control Practitioners can be found on the VIHA website at
https://intranet.viha.ca/departments/infection_prevention/Documents/communications/ICP%20Site%20Responsibilities.pdf

d) Publicly funded Assisted Living residences should contact the Home & Community Care Assisted Living Case Manager and other contacts on their facility notification list, such as

support staff supervisors/managers, and the Office of the Assisted Living Registrar (if applicable).

e) List names of symptomatic residents and staff on the appropriate *Outbreak Tracking Forms* (download from www.viha.ca/flu on the Residential Care Facilities page). Provide regular updates on outbreak to Infection Control/ Communicable Disease contact. Frequency and format of reporting will vary depending on the practitioner. Inquire about and record respiratory infection among staff ill during the week prior to the outbreak start.

f) After consultation with the Communicable Disease Program or Infection Control Practitioner, an ILI Outbreak Test kit may be requested and sent to the facility. If testing is initiated, please ensure that samples are taken as soon as possible after symptoms present.

See more information about laboratory testing in the section below.

f) Continue single-case management (as per section above).

g) Stop new admissions.

h) Readmissions are allowed **only** in consultation with Public Health (Affiliates) or Infection Control (Amalgamates); try to return these patients to unaffected units.

i) Verify immunization status of all residents. Consult with Communicable Disease and the Medical Director about administering antiviral prophylaxis for residents and vaccinating all unvaccinated residents. **Neuraminidase inhibitors (e.g. Oseltamivir) are the recommended choice for treatment or prophylaxis of Influenza A or B infection** in residents of long term care facilities**.**

j) Exclude any staff with influenza-like illness (ILI) for at least **five** days after the onset of symptoms OR until acute symptoms completely resolve whichever is longer.

k) Verify immunization status of all staff. Non-immunized staff are subject to exclusion from work until the outbreak is declared over by the Medical Health Officer.

l) An exception to exclusion of non-immunized staff may be made if the non-immunized staff member takes antiviral medication as prescribed and the antiviral medication is continued until the outbreak is declared over. These workers must be alert to the symptoms and signs of influenza, particularly within the first 48 hours after starting antiviral prophylaxis and should be excluded from the patient care environment if these develop.

Note that Oseltamivir is not provided free to staff by the Ministry of Health. Facilities may choose to refer staff to their family physician to obtain a prescription.

m) Staff who were not immunized prior to an outbreak of influenza, but who are immunized during the outbreak may return to work in the outbreak setting after 14 days have elapsed since vaccination or when the outbreak is declared over by the local Medical Health Officer. Staff may also return to work if antiviral medication is taken for the 14 days immediately after receiving their influenza immunization or until the outbreak has been declared over, whichever is sooner. These workers must be alert to the symptoms and signs of influenza, particularly within the first 48 hours after starting antiviral prophylaxis and should be excluded from the patient care environment immediately if these develop.

n) Non-immunized, excluded staff must not have developed ILI symptoms and must wait one incubation period (**four days or 96 hours**) from the last day they worked at the outbreak facility prior to working in *a non-outbreak facility*. This is because they may be incubating influenza. If ILI symptoms develop, staff must be excluded for at least **five** days after ILI onset or until acute symptoms completely resolve whichever is longer.

o) Post signs alerting visitors to the outbreak. Implement other communications about the outbreak according to your facility's communication plan.

p) Impose visitor restrictions as advised by Communicable Disease/Infection Control. Visitors such as family members who still wish to visit residents should not visit anyone else in the facility. They must be informed of the outbreak and preferably be immunized.

q) Cohort staff working with symptomatic residents as much as possible. Staff working with symptomatic residents should avoid working with residents who are well when possible. Strict hand hygiene should be practiced between residents at all times.

r) Enhance cleaning and more frequent disinfection of commonly touched surfaces or items (e.g. handrails, elevator buttons, phones, door handles) and safe disposal of waste (e.g. tissues).

s) Document a summary of the outbreak and distribute to Infection Control/Quality Committee.

❒ **Review Laboratory Testing**

a) Nasopharyngeal swabs, not washes, are now the recommended technique for the diagnosis of influenza in residents of long term care facilities. Testing is best performed within 72 hours of onset of symptoms, but the lab will accept specimens from seriously ill patients taken after the 72 hour period.

b) LifeLabs laboratories will not do the microbiology on these specimens. Please send specimens directly to VIHA labs for fastest processing.

c) "Influenza-like-illness Outbreak kits" (6 swabs/kit) and instructions on how to handle specimens are available for all facilities from the VIHA microbiology laboratory during an outbreak situation. Outbreak testing kits will be released to facilities in consultation with Infection Control/Communicable Disease. Infection Control/Communicable Disease staff will contact the VIHA microbiology lab directly to request kits.

d) There is no cost to any facility for the "Outbreak kits" however, they will be released *only* in the event of an outbreak. Delivery by taxi may be arranged through the hospital laboratory at no charge to the facility.

❒ **Review use of antiviral medication for prevention of influenza**

In general, prophylaxis is only indicated for use during outbreaks in long-term care facilities for residents and unvaccinated staff. Prophylaxis will continue until the outbreak is declared over. Healthcare workers who require prophylaxis should attend their family physician to receive a prescription.

Neuraminidase inhibitors (Oseltamivir and Zanamivir) remain the recommended drugs of choice for treatment or prophylaxis against influenza A or B for this season. Due to persisting resistance to Amantadine® among the majority of circulating influenza strains, it is not recommended for treatment or prophylaxis at this time.

Treatment Dosage of Oseltamivir® for individuals 13 years and older:

Begin treatment within 48 hours of onset of influenza symptoms
1. Renal function normal or CrCl >60ml/min: 75 mg po twice daily x 5 days
2. Impaired renal function (CrCl 30-60 ml/min): 30 mg po twice daily OR 75 mg po once daily x 5 days
3. Severely impaired renal function (CrCl 10-30 ml/min): 30 mg po once daily x 5 days
4. Renal failure (CrCl <10 ml/min): 75 mg po ONCE during illness

Prophylaxis Dosage of Oseltamivir® for individuals 13 years and older:

Begin prophylaxis within 48 hours of exposure
1. Renal function normal or CrCl> 60 ml/min: 75 mg po once daily until prophylaxis no longer required

2. Impaired renal function (CrCl 30-60ml/min): 75 mg po on alternate days or 30 mg po daily until no longer required.
3. Severely impaired renal function (CrCl 10-30 ml/min):30 mg po on alternate days until no longer required

Oseltamivir is available in 75 mg capsules as well as a powder that can be reconstituted into an oral suspension at 12 mg/mL.

A current creatinine clearance is not required prior to prescription of Oseltamivir when there is no suspicion of renal failure. However, there may be concerns about renal function among frail residents. **To facilitate prompt ordering of Oseltamivir prophylaxis during an influenza outbreak, please ensure that a creatinine clearance is ordered for residents** unless there is a creatinine clearance on record that was performed during the past year and/or no reason to suspect impairment in renal function. Alternatively, ensure that a plan is in place for lab services to draw STAT creatinine (within 24 hours of an outbreak declaration) on all vulnerable residents in the event of an outbreak.