Manual 9 - Infection Control	**Policy:** 9-6-2
Management of Respiratory Infection Outbreak	
Effective Date: October 28, 2016	
Approved by: March 23, 2022 by Strategic Leadership team	

Table of Contents

OUTBREAK DEFINITION

An outbreak should be suspected anytime that illness exceeds the normal baseline distribution in a given area, at a given time. Reporting of respiratory infection outbreaks is legislatively required under the Health Protection & Promotion Act (HPPA) from the following institutions: nursing homes, homes for the aged, acute and chronic care hospitals operating under the *Public Hospital Act*. Although not required under the HPPA, reporting of respiratory infection outbreaks in retirement homes is strongly recommended.

29.2 (1) Subject to subsection (2), a medical officer of health may make an order requiring a public hospital or an institution to take any actions specified in the order for the purposes of monitoring, investigating and responding to an outbreak of communicable disease at the hospital or institution.

NOTE: In the event of a Directive from the Ministry of Long-Term Care and/or Emergency Management Ontario and/or any other regulatory body, these directives will supersede this policy where applicable.

Suspect an outbreak whenever there are:

One single lab confirmed COVID-19 case in resident, or one or more cases of respiratory symptoms associated with COVID-19 such as but not limited to (change from time to time):

- new cough
- headache
- fever or chills
- sore throat/difficulty swallowing
- dyspnea
- nasal congestion or runny nose (new)
- pneumonia both lungs
- malaise
- nausea/vomiting/diarrhea/abdominal pain
- Change in taste and/or smell conjunctivitis
- Dyspnea/difficulty breathing
- rashes or skin discoloration toes/fingers
- fatigue

For those over 70 years of age, unexplained increased number of falls, delirium and/or exacerbation of chronic disease. **Two or more cases of acute respiratory symptoms occurring within 48 hours, in one geographic area.** Symptoms may include:

- abnormal temperature
- hoarseness/difficulty swallowing
- dry cough (new)
- chills
- productive cough (new)
- myalgia
- runny nose/sneezing
- malaise
- nasal congestion/stuffy nose
- headache
- sore throat
- decreased appetite

Criteria for a potential outbreak:

- Two or more laboratory confirmed case of COVID-19 (May include staff and/or resident(s)) and/or visitors within a 14 day period, that have an epidemiological link and where at least one person could have reasonably acquired their infection in the Home **OR**
- One laboratory confirmed case of influenza **OR**
- two cases of influenza-like illness occurring with 48 hours in a geographic area (i.e., neighbourhood) **OR**
- more than one neighbourhood having a case of acute respiratory illness with 48 hours

NOTE: The clinical presentation of influenza in an elderly, fully immunized population can differ from the usual clinical presentation of influenza. Because influenza in the elderly often causes tiredness (malaise), muscle ache (myalgia), loss of appetite, headache and chills, the incorporation of these symptoms into the case definition, if they occur, may be useful. In the elderly, fever could be absent or manifest as follows: abnormal temperature for the resident or a temperature <35.5°C or >37.5°C.

An outbreak can be declared at any time by the Medical Officer of Health, or their designate, or the ICP or designate for the LTCH. There should be a discussion between the Medical Officer of Health or designate and the Home regarding whether to declare a Home-wide outbreak or neighbourhood specific outbreak when the cases are on one neighbourhood and can be confined to that neighbourhood.

Upon the initiation of an outbreak, initiate the “Outbreak Start-ups Checklist and “Daily Outbreak Checklist” as per Addendum # 9-6-2-2.

- Complete IPAC checklist from PHO (ensure most recent document is being used)
- Complete Standard Operating Procedure
- Review most recent sustainability visit checklist

CASE DEFINITION

Different respiratory viruses often cause similar acute respiratory symptoms. As a result, **each respiratory outbreak requires its own case definition**. The case definition should be developed for each individual outbreak based on its characteristics. The case definition should also be reviewed during the course of the outbreak, and modified if necessary, to ensure that the majority of cases are captured by the definition.

A Case Definition Example

“Any resident or staff presenting with two or more of the following symptoms: fever, sore throat, cough and runny nose.”

(NOTE: Whenever there are two or more cases of acute respiratory tract illness within 48 hrs on one neighbourhood, or one case of COVID-19 in the Home (resident or staff), an outbreak should be suspected).

SPECIMEN COLLECTION –– NASOPHARYNGEAL SWABS

Once the outbreak has been declared, your Home will be assigned an outbreak number that will be used to identify all lab specimens collected for testing.

The outbreak number is: 2242 - 20XX - three digit number (e.g. 026)
(Health Unit - Year - Outbreak Number)

Specimen collection is critical to determining the causative agent in each respiratory outbreak. Ensure that staff are familiar with the procedure for the collection of nasopharyngeal swabs. See “Nasopharyngeal Specimen Collection” Policy 9-3-3. Check with Lambton Public Health staff regarding available to assist with education of staff on this procedure (i.e., videos).

The number of tests conducted will depend on the suspected causative virus and is dependent on guidelines. Refer to coronavirus testing guidelines and requirements.

To identify the causative agent:

For suspected cases of COVID-19, collect samples as soon as possible on all individuals showing symptoms. Collect as many samples as required**.** Public Health may request testing of close contacts of symptomatic residents such as roommates.

1) It is best to collect nasopharyngeal specimens as early as possible from the most **acutely ill** residents and staff, preferably within the first 48 hours of onset of symptoms.
2) If possible, 5 specimens only should be obtained initially. Further specimen collection will be determined based on results and progress of outbreak.
3) Staff obtaining specimens must ensure correct labelling of specimens to ensure testing by the Lambton Public Health Lab. This includes the name of the case, date of birth, and the outbreak number on the nasopharyngeal specimen vial and requisition form. See: “Sample General Test Requisition Form” Policy 9-3-3.
4) Nasopharyngeal specimens must be refrigerated after collection until pick up and transport to the lab to ensure optimal results. Ideally it should be received by the lab for testing within 72 hrs of collection time.
5) The ICP at the Home will make arrangements for either pick up of samples or by delivering the samples directly to the Public Health Unit or other agency as designated.

NOTE For Influenza: Once a causative organism is identified, no further collections of nasopharyngeal specimens are recommended. For further testing, consult with Lambton Public Health.

Ensure the following equipment is available:

NP Swab kit from Lambton Public Health
Gloves
Mask
Goggles

*Refrigerate the specimen
**Fill out Public Health Laboratory Requisition Form completing all sections:

Health Card number
Agency Name and outbreak number
Test Requested: As directed by Lambton Public Health
Specimen type and site: Nasopharyngeal Swab

CONTROL MEASURES

Homes that suspect they have an outbreak should implement initial outbreak control measures to prevent further spread of illness. Once outbreak confirmed, MOHLTC must be notified by completing CIS report. Homes should consider establishing an **Outbreak Management Team** and meet regularly including all representatives who have decision making authority in the Home.

Members should include:

- Medical Advisor/Director
- Administrator
- Director of Nursing and Personal Care
- Infection Control Officer/Infection Control Nurse
- Public Health Nurse/Public Health Inspector
- Environmental Services Supervisor
- Nutrition Supervisor
- Rec & Leisure Supervisor
- Pharmacist

Infection Control Professional will arrange for Outbreak Management team to meet to review, discuss and implement outbreak procedures.

The following control measures are recommendations from Lambton Public Health:

Staff will complete a Point of Care Risk Assessment (PCRA) before entering any residents' room and before any interaction with any resident.

1. Isolation of Symptomatic Cases

- Place residents with symptoms on **CONTACT/DROPLET PRECAUTIONS** (signage on resident door and infection tower outside room).

For Residents with a positive COVID-19 test, they will be isolated to their room as per Public Health guidance.

If the resident's results are negative, they may be released from isolation as per the direction of Public Health Unit (is dependent on symptoms and length of time etc.)

A resident who is isolated due to a roommate being symptomatic but with a negative test, and they themselves tested negative and have no symptoms, may be released from isolation at the direction of Public Health Unit.

- In General e.g. Influenza, other respiratory viruses: Restrict cases (ill residents) to their room until 5 days after the onset of acute illness or until symptoms have completely resolved (whichever is shorter). For some pathogens the periods of communicability may be longer than 5 days, but for practical reasons, this could be applied to outbreaks caused by respiratory viruses other than influenza.

- Restriction of ill/symptomatic residents to their room is required. Seek assistance of 1:1 staffing or BSO resources if required.

2. Cohorting Residents/Staff

- Cohorting is defined as the grouping together of individuals in a specific area to limit the contact between infected cases and non-infected cases, in order to decrease opportunities for transmission of infectious agents.

- If cases are confined to one unit, all residents from that unit should avoid contact with residents in the remainder of the Home. Doors of the Home area should be closed, and residents are restricted as much as possible from leaving the area.

- If possible, exposed staff should remain caring for symptomatic cases on a daily basis and avoid transferring to another neighbourhood during the outbreak. If this is not possible, provide care to well residents before providing care to ill residents when at all possible.

- During non-influenza outbreaks, discuss the possibility of one staff member looking after only ill residents and others looking after only well residents. Alternatively, discuss the possibility of keeping staff members working on only one neighbourhood if possible. Attempts should be made to minimize movement of staff, students, or volunteers between neighbourhoods especially if some neighbourhoods are unaffected. These measures should not be required during influenza outbreaks where all persons are immunized or on an appropriate antiviral drug.

- May consider a designated isolation unit for treating residents with COVID-19 as per established guidelines.

- During a COVID-19 outbreak, try to utilize fully vaccinated staff to the outbreak area whenever possible.

3. Hand Hygiene

- Hand hygiene stations should be set up at designated areas in the Home (i.e., entrances, outside elevators, patient/resident care areas)
- Hand hygiene should be performed:
    - Before initial patient/resident or patient/resident environment contact
    - Before sterile procedures
    - After body fluid exposure risk
    - After resident or resident environment contact
- Alcohol based hand rubs (ABHR) is the first choice for hand hygiene in clinical situations when hands are not visibly soiled. Using ABHRs is more effective than washing hands (even with an antibacterial soap) when hands are not visibly soiled.
- Residents, staff and volunteers should be instructed in proper hand hygiene to facilitate staff and visitor hand hygiene.

Refer to Policy #9-4-10 Routine Practices

4. Masking/Gowning/Gloving/Eye Protection is Required for Direct Patient contact of Sick/Isolated Residents. Guidance as per Public Health Guidelines

- The use of surgical masks, gowns, and gloves and eye protection/face shield is required for direct patient contact (e.g. when entering room) of ill/isolated residents.
- Staff must remove/change their PPE following donning and doffing routines before caring for another resident and when leaving the resident's dedicated space/room. Follow directives from Public Health.
- Visitors: If Universal masking guidelines are in place this must be adhered to for all visitors. If resident is in isolation, full PPE for required precaution must be used by visitors.
- Eye protection safety goggles or face shield) and appropriate mask is to be worn when there is a potential for splattering or spraying of blood, body fluids, secretions/excretions, including cough producing aerosol generating procedures while providing direct resident care. An N95 mask and a full face protective shield or goggles (not the combined mask/face shield type) must be worn for aerosol generating procedures (e.g. but not limited to, suctioning, CPAP, O2 6l/min or over, nebulizing treatments etc.)

Refer to Policy #9-7-1 Additional Precautions

5. Enhanced Environmental Cleaning/Sanitizing

- For COVID-19 prevention/outbreak, ensure cleaning and sanitizing of high touch environmental surfaces frequently contaminated by residents/staff (e.g. hand

rails, door knobs, call bells cords/buttons, faucets, bedrails, telephone, bedside table, chair arms, door handles, light switches, handwashing sink, bathroom sink, toilet and toilet handles and shower handles, faucets or shower chairs, grab bars, outside of paper towel dispenser is completed at least twice per day and when soiled. This should include all resident care areas/rooms, staff break areas high touch surfaces in common areas. (reference: Infection prevention and control for COVID 19: Interim guidance for Long Term Care Homes)

For other outbreaks, follow PHU guidance for ensuring cleaning and sanitizing of environmental surfaces frequently contaminated by residents/staff (i.e. hand rails, door knobs, bathroom units, furniture) is completed at least twice per day. This should include all resident care areas, staff break areas, and high touch surfaces in common areas. Refer to: PIDAC Best Practices for Environmental Cleaning for Prevention and Control of Infections and Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices.

- Ensure a process for proper disposal of contaminated materials; double bagging of waste is not required.
- Cleaning and sanitizing methods should be reviewed by Public Health Inspector.
- Disposable dishes and cutlery are not required but may be recommended for ill residents (isolated) during outbreak.

Reference for COIVD-19: Infection prevention and control for COVID-19: Interim guidance for long term care homes" https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevent-control-covid-19-long-term-care-homes.html#a14

6. Exclusion of Symptomatic Staff from Work/Home

- Exclusion of work by staff is depending on the suspected causative agent. Refer to PHU guidance documents and direction. Individual cases are as per the direction of Public Health Unit.
- Staff who meets case definition of Influenza are excluded from the Home for 5 days from onset of symptoms or until asymptomatic, whichever comes first; if the causative agent is known, other measures may apply.
- Flu vaccine is offered by individual Homes annually at all three Homes.
- For a confirmed influenza outbreak, ill staff, students or volunteers taking antiviral medication for treatment (not prophylaxis) Policy 9-4-7 Exclusion Statement 2.
- Other vaccinations may be offered to staff in all Homes as recommended by Public Health.

7. Limited Visiting - Visitor restrictions/limitations may be placed on the Home by the Public Health Unit. Seek guidance of Public Health at the beginning of and as needed during the outbreak.

- Any symptomatic (potentially infectious) visitors should be excluded at any time, especially during influenza season (signage at front entrance).
- Signs should be posted in the Home indicating that there is an outbreak and visitors should be warned that they may be at risk of acquiring infection within the

Home. Home may staff reception area with volunteers to limit visitors and provide visitors and family's updates.

- During an outbreak, visitors should visit only their own friend/relative, in their own room (not in a common area), and should perform hand hygiene before and after the visit at hand hygiene stations in the Home.
- Lambton Public Health does not recommend closing the Home to visitors/volunteers; only in the case of extremely virulent disease would the Medical Officer of Health order the Home to be closed to the public.
- Active screening may be implemented on direction of PHU. Visitors may be limited to 'essential visitors' upon direction of the PHU. Physical distancing guidelines may be implemented.

8. Suspension of Social Activities and dining routine

- As much as possible, all social activities should be restricted to each respective neighbourhood and follow the guidance of PHU. The Outbreak Management Team must find a balance between restricting activities to control the spread of infection, and providing therapeutic opportunities from social activities.
- Visitation by outside groups, e.g., entertainers, meetings, community groups, etc., shall not be permitted. Also, visitation of multiple residents shall be restricted.
- Onsite adult and childcare programs may continue provided there is no interaction between residents and participants of the program or they may be canceled at the direction of PHU or if staff are needed to assist the LTC Home(s).
- PT or PTA will be restricted to each neighbourhood.
- Restrictions may be placed on communal dining during outbreak.

9. Restrict New Admissions, Re-Admissions and Transfers

- During a COVID-19 outbreak, admissions/readmissions are not permitted.
- Admissions, readmissions and transfers between health care facilities are based on the direction of the Public Health Unit.
- Restricting admissions unnecessarily will create a backlog in acute care or other community Homes; on the other hand, admitting persons who are susceptible into an outbreak situation poses a risk to their health. During influenza outbreak, no admissions or readmissions will be done as per Medical Officer of Health.
- Residents can be transferred from the outbreak Home to a hospital with prior notification to Hospital Infection Control Officer or designate.
- Residents with respiratory illness admitted from the outbreak Home to hospital can be re-admitted to the LTCH at any time, provided that appropriate care/accommodation can be given.
- New admissions (from community), residents admitted to hospital prior to the outbreak, or admitted to hospital for reasons other than respiratory illness may be admitted/re-admitted to the LTCH if the following conditions are met (this is dependent on the Medical Officer of Health):
    - the resident or substitute decision-maker has been informed of the outbreak status and provided consent;

  - the resident's 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)
  - if the outbreak is due to influenza, the resident is protected from influenza by vaccination and an anti-viral drug
- Resident transfers from anywhere in the Home to another Long-Term Care Home is not recommended during an outbreak. Possible exception of this recommendation should be discussed with the Medical Officer of Health on an individual basis. **Note:** A resident's bed will be kept for up to 30 days while he/she receives treatment in an acute care Home, or 60 days for psychiatric leave. In the event that a resident's hospital stay exceeds 30 days due to a closure of a Long-Term Care Home because of an outbreak, the Ministry of Health and Long-Term Care will extend the period for time the resident may remain away from the Home.

10. Advise Hospital Infection Control Staff of Outbreak Prior to Transferring a Resident

- Prior to transfer of residents to hospital, designated staff at the outbreak Home should contact the Infection Control Professional/Emergency Department directly by phone to inform them that the resident is coming from an outbreak situation.
- Inform them of the outbreak, the pathogen if known and if the resident is symptomatic or not.

11. Working at Other Homes

- The PHU will provide guidance for staff working at multiple Health Care Facilities (i.e. a single employer may be implemented).
- During respiratory outbreaks (i.e. Influenza), direction will be provided by the Public Health Unit on whether and/or when staff/volunteers can work at alternate employers. If asymptomatic staff chooses to work at another Home, they must wait one incubation period (i.e., 72 hours) after working the last shift at the outbreak Home (if the causative organism is known, the waiting period may differ). Staff working at 2 Homes must inform the ICP (Infection Control Professional) or DONPC (Director of Nursing and Personal Care). Direction for staff working at different Homes is provided by Lambton Public Health, and the Home's adhere to this.
- During an Influenza A or B outbreak, previously immunized staff (> 2 weeks prior to outbreak) has no restrictions on their ability to work at other Homes, provided the individual changes their uniform between Homes unless directed by Lambton Public Health.

However, unimmunized staff must wait one incubation period (72 hours) from the last day they worked at the outbreak Home prior to working in a non-outbreak Home, to ensure that they are not incubating influenza unless directed by Lambton Public Health.

Note: If influenza isolates that have been strain characterized indicate a different lineage than is contained in the influenza vaccine for the current season, recommendations for staff working at other Homes may vary from above.

12. Medical Appointments

- Non-urgent appointments made before the outbreak shall be rescheduled.

DECLARING OVER

The length of time from the onset of symptoms of the last case until the outbreak is declared over can vary and is dependent on whether the last case was a resident or staff. Prior to the Public Health Unit declaring an outbreak over, the Home must not have experienced any new cases of infection (resident or staff) which meet the case definition for the period of time as defined by the Outbreak Management Team (OMT). As a general rule, respiratory outbreaks (e.g. Influenza) can be declared over if no new cases have occurred in 8 days from the onset of symptoms of the last resident case.

Note: For other respiratory organisms that may be isolated during the outbreak, discussion should be held with Lambton Public Health to determine when outbreak will be declared over.

The rationale for this definition is, if the outbreak were continuing, given active surveillance, new cases would have been identified within 8 days since 8 days is the outer limit of the period of communicability of influenza (5 days) plus one incubation period (3 days). Note: if symptoms in the last resident case resolve sooner than 5 days, or if the last case is a staff member who should stay at home during the period of communicability, the time until the outbreak is declared over can be shortened accordingly. Since large Long-Term Care Homes tend to have some sporadic influenza or respiratory infection cases in non-outbreak situations, the OMT may need to attempt to differentiate between these sporadic cases and outbreak-associated cases in identifying the last outbreak related resident case.

Complete the Outbreak Investigation File

Complete “Outbreak Closure/Wrap up Checklist” as per Addendum # 9-6-2-2

Completion of the Final Report of Institutional Respiratory Outbreak is to be done jointly by the Home and Lambton Public Health.

For a confirmed influenza outbreak Lambton Public Health will submit the completed report to the Ministry of Health and Long-Term Care within three weeks after the outbreak has been declared over. Copies of all documents related to the outbreak are to be kept on file by the Infection Control staff at the Home.

Review the Outbreak

Arrange a meeting with Lambton Public Health staff to review the course and management of the outbreak.

The purpose of this meeting is to review what was handled well and what could be improved for future outbreaks. Provide the report to the Infection Control Committee and a copy to be kept by the Home administration.

INFLUENZA OUTBREAKS

(i) PREVENTION – INFLUENZA IMMUNIZATION

- Vaccination is recognized as the cornerstone for preventing or attenuating influenza for those at high risk of serious illness or death from influenza infection and related complications.
- Health care workers and their employers have a duty to actively promote, implement and comply with influenza immunization recommendations in order to decrease the risk of infection and complications in the vulnerable populations for which they care. Educational efforts aimed at health care workers and the public should address common doubts about disease risk for health care workers, their families and patients, vaccine effectiveness and adverse reactions.
- The provision of influenza vaccination for health care workers who have direct resident contact is an essential component of the standard of care for the protection of their residents. Health care workers who have direct resident contact should consider it their responsibility to provide the highest standard of care, which includes annual influenza vaccination. In the absence of contraindications, refusal of health care workers who have direct resident contact to be immunized against influenza implies failure in their duty of care to residents (Source: CCDR http://www.phac-aspc.gc.ca/naci-ccni/).
- LTCHs should:
  - Ensure that all staff are provided with information annually regarding the influenza vaccine and exclusion policy
  - Promote and implement accessible influenza vaccination clinics
  - Keep an updated record of all resident and staff influenza immunizations and update list throughout the influenza season.
  - Report immunization status among residents, staff, and volunteers to the local medical officer of health by the outlined date provided by the MOHLTC.
  - Advise outside agencies that provide staff to the LTCH of the Home's immunization/exclusion policy
  - Develop a staffing contingency plan based on immunization rates in their Home

(ii) RECOMMENDED POLICY STATEMENT – Influenza Outbreaks

- In order to protect vulnerable residents during an outbreak, it is reasonable to exclude from direct resident contact, those health care workers with confirmed or presumed influenza, and unvaccinated health care workers who are not receiving antiviral prophylaxis.

- Homes should have an Exclusion Policy for use for staff and volunteers who choose not to be immunized and/or take antiviral drugs.

Things to consider or include in the development of Exclusion policy:

- How and when the exclusion policy comes into effect
- Who falls under the definition of staff
- Hierarchy of immunization status, and what to do at each step
- Consequences of failure to comply
- Managing shared staff working in a Home with a declared outbreak
- Length of exclusion time clearly defined when staff is on an antiviral drug
- How to verify staff is taking the antiviral
- How staff will be educated and updated re: policy
- Obtaining antiviral prescription pre-season
- Define HR issues, e.g., time off designation, cost of anti-virals.

Residents

Prior to, or upon admission, each resident should be assessed regarding vaccination and medical status. Based on this assessment, informed consent from the resident or substitute decision-maker should be obtained for influenza and pneumococcal vaccines, and antiviral drugs for influenza prophylaxis in the event of an outbreak.

Immunity after influenza vaccination usually lasts less than 1 year. However, in the elderly, antibody levels may fall below protective levels in 4 to 6 months.

To ensure that protection lasts throughout the influenza season, the recommended time for influenza immunization is from October to mid-November unless otherwise advised by Lambton Public Health. If the resident is admitted after the Home’s fall vaccination program and before the influenza season is over (usually late March), vaccination must be offered unless the person has already received the current season’s influenza vaccine.

If the influenza immunization status of a resident is not available or unknown, the resident should be considered unvaccinated, and vaccination should be given.

The immunization record of the resident should be retained in a readily accessible part of their health record. Upon transfer, the resident’s recent immunization status should be shared with the receiving Health Care Home.

Staff

Annual immunization against influenza is recommended for all persons carrying on activities in the LTCH unless medically contraindicated. Influenza immunization may be received at the annual influenza clinic or from any other private health care provider.

All staff who receives the influenza vaccine from a source other than the LTCH must provide proof of influenza immunization.

Only the following should be accepted as proof of influenza immunization:

- A personal immunization record documenting receipt of the current season's influenza vaccine signed by a health care professional
- A signed physician's note indicating immunization
- Documented immunization from another Home or institution

If this documentation is not available, the LTCH should not consider the staff member immunized, and the employer must offer influenza immunization to the person.

RECOMMENDED POLICY STATEMENT FOR INFLUENZA OUTBREAKS

Policy

Lambton County Homes has an established protocol for staff during a confirmed influenza outbreak that complies with the recommendations of Lambton Public Health.

Purpose

To ensure the residents and workers are protected from possible exposure to and transmission of influenza during an influenza outbreak.

(iii) INFLUENZA OUTBREAK MANAGEMENT

When a positive isolate of Influenza A or B is received, an outbreak of influenza will be confirmed and the following recommendations will be reviewed with your Home by Lambton Public Health staff. To reduce the impact of influenza and ensure that residents and staff are protected from possible exposure to and transmission of influenza during an outbreak, the following actions are recommended:

a) **Antiviral Prophylaxis (Prevention)**

- Antiviral medication for prevention (prophylaxis) shall be given to all residents, whether vaccinated or unvaccinated, and to all unvaccinated staff members. Currently recommended medications for prophylaxis are neuraminidase inhibitors–oseltamivir (Tamiflu ^{TM}) and zanamivir (Relenza^{TM}). Oseltamivir (Tamiflu ^{TM}) is the recommended drug of choice for both prophylaxis and

treatment in influenza outbreaks. Consult with pharmacy for prophylactic dosage recommendations for residents (ideally, this is done pre-influenza season).

- Prophylaxis should be given until the outbreak is declared over. Antiviral medication may be ordered for 14 days initially and repeated if the outbreak lasts longer than 14 days. Homes may wish to consult with their pharmacy representatives.
- Prescriptions of neuraminidase inhibitors, as for all other medications for residents are the responsibility of the medical directors or attending physicians of the residents.
- For staff, prescriptions of neuraminidase inhibitors are the responsibility of the staff member's family physician.

b) **Antiviral Treatment**

- For residents who have been ill for <48 hours, antiviral medication for treatment should be given. Consult with pharmacy regarding treatment dose recommendations for residents.
- Treatment decisions are the responsibility of the attending physicians. Oseltamivir (Tamiflu ™) is the recommended drug of choice for both prophylaxis and treatment in influenza outbreaks.
- Treatment must be started within 48 hours of onset of symptoms to be effective and may decrease the rate of complications.
- For residents who have been ill >48 hours, treatment will not provide benefit.

c) Staff Recommendations

- Staff immunized with influenza vaccine at least 2 weeks prior to the outbreak may continue to work as long as they are not symptomatic with flu-like symptoms; immunized staff may also continue to work between Homes
- Unimmunized staff have 3 options:

1) Take antivirals AND receive flu vaccine and return to work; antiviral medications need to be taken for 2 weeks minimum or until outbreak is declared over, whichever comes first
2) Take flu vaccine only and return to work in 2 weeks or when outbreak is declared over
3) If influenza vaccine is medically contraindicated or refused, take antivirals only and return to work; antiviral medication must be taken for the duration of the outbreak
    - If options 1, 2 and 3 are refused, then staff must remain off work until the outbreak is declared over. Note: If unimmunized asymptomatic staff chooses to work at another Home, they must wait one incubation period (72 hours) after working the last shift at the outbreak Home.
    - Note: It is reasonable to allow staff to work with residents as soon as they start antiviral prophylaxis.

WEBSITES WITH INFORMATION ABOUT INFLUENZA

1) www.health.gov.on.ca - Ministry of Health and Long-Term Care Current health issues. Updated regularly.

2) https://www.publichealthontario.ca/en/data-and-analysis/infectious-disease/respiratory-pathogens-weekly
The Ontario Influenza Bulletin – the most useful site for Ontario specific data on influenza. The Ontario Ministry of Health Web page for influenza bulletins. These are published weekly for the province and have region specific data for nursing home outbreaks, sentinel physician activity and laboratory testing. You can move to a publication on immunization for public information on influenza and vaccine.

3) http://www.phac-aspc.gc.ca/fluwatch/index-eng.php
Public Health Agency of Canada web page on influenza surveillance. Updated every two weeks, with data on laboratory results for respiratory virus identification, and influenza activity across Canada

4) www.oma.org/
Up to date information on influenza

5) http://www.phac-aspc.gc.ca/naci-ccni/
Current Canada Communicable Disease Reports (CCDR)

6) http://www.sanofipasteur.ca
Sanofi Pasteur web page for flu product monograph

7) http://www.gsk.ca
GlaxoSmithKline web page for flu product monograph

Refer to Outbreak Management Guidelines - Yellow Binder provided by Lambton Public Health

Refer to policy #9-3-3 NP Swab Collection

References/resources:

County Of Lambton Long-Term Care Division Pandemic Plan

Infectious Diseases Protocol Appendix B: Provincial Case Definitions for Reportable Diseases

MOHLTC Public Health Division Long-Term Care Homes Branch. *A Guide to the Control of Respiratory Outbreaks in Long-Term Care Homes.* November 2018
Public Health Ontario: Best Practices for Prevention, Surveillance and Infection Control Management of Novel Respiratory Infections in all Health Care Settings: https://www.publichealthontario.ca/-/media/documents/B/2020/bp-novel-respiratory-infections.pdf?la=en

Infection prevention and control for COVID-19: Interim guidance for long term care homes" https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevent-control-covid-19-long-term-care-homes.html#a14