



Health and
Wellness

Prince Edward Island Guidelines for Viral Respiratory Infections and Outbreak Management in Long-Term Care and Community Care Facilities

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Department of Health and Wellness
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Viral Respiratory Infections

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1.0 Introduction

In May 2023, the World Health Organization (WHO) determined that COVID-19 was now considered to be an established and ongoing health issue and no longer constituted a public health emergency of international concern (PHEIC). WHO recommended integrating the COVID-19 pandemic response into broader infectious disease prevention and control programs that maintain operational readiness for surges of COVID-19 cases and other emerging and re-emerging respiratory pathogens. ⁽¹⁾

Many lessons, particularly with regards to infection prevention and control, have been learned throughout the COVID-19 pandemic. These lessons have provided us with increased knowledge and tools when dealing with known and emerging pathogens. So, while we continue to learn to live with SARS-CoV-2 (the virus that causes COVID-19) and its new variants, it is important to extend this knowledge to encompass the same infection prevention and control (IPAC) strategies when dealing with any viral respiratory pathogen given the transmission and prevention of many respiratory infections are similar. ^(1,2)

Following comparable approaches to the updated guidance documents in many jurisdictions across the country, and with a focus on balancing IPAC practices along with the physical, psychological, emotional, and spiritual needs of residents in these facilities, this guidance document provides current best practices and evidence-based guidance for control of respiratory outbreaks in long-term care facilities (LTCFs) and community care facilities (CCFs).

2.0 Background

Respiratory viruses, such as SARS-CoV-2, influenza, and respiratory syncytial virus (RSV) will continue to circulate and are easily transmitted between people who reside in LTCFs and CCFs due to communal living arrangements and proximity between residents. In addition, residents in these settings often have underlying risk factors (e.g., advanced age) and health conditions that contribute to their vulnerability to severe forms of these infections causing a deterioration in overall health status, which in turn can be a significant cause of hospitalization and death.

It is important to consider that while influenza is typically a seasonal infection commonly occurring from fall to early spring, other viral respiratory infections, like COVID-19, may occur year-round. **LTCFs and CCFs should routinely monitor for early signs and symptoms of viral respiratory infections in residents and staff particularly during the respiratory season but also when there is increased respiratory virus circulating within the community. IPAC measures initiated by staff at a facility experiencing an increase in viral respiratory infections may help to prevent further spread of infections and decrease the amount of time the facility must maintain precautions.**

The recommendations outlined in this document are aimed at protecting the health of residents, staff, visitors, and volunteers. The intent of this document is to provide information and guidance to facilities that are experiencing an increased number of viral respiratory infections where the infectious agent may or may not have been identified. The information contained in this document should be used by administrators and staff in these facilities to develop their own policies, procedures, and plans to prevent and manage viral respiratory infections and outbreaks.

3.0 Reporting Requirements

Influenza, COVID-19, respiratory syncytial virus (RSV), and outbreaks of influenza-like illness (ILI) in health facilities and institutions are notifiable events under the Prince Edward Island Public Health Act ⁽³⁾ and Notifiable Diseases and Conditions and Communicable Diseases Regulations. ⁽⁴⁾

3.1 Facility Operators/Staff

Health practitioners or facility administrators shall, in accordance with the Notifiable Diseases and Conditions and Communicable Diseases Regulations, as part of the Prince Edward Island (PEI) Public Health Act, report all confirmed and probable cases by phone and/or electronic transfer, as soon as suspected to the Chief Public Health Officer (CPHO) (or designate) as per PEI Reporting Notifiable Diseases, Conditions, and Events Regulations. ⁽³⁾⁽⁴⁾

3.2 Laboratory

The Provincial Laboratory, in accordance with the PEI Public Health Act, report all positive laboratory results by phone and mail, fax or electronic transfer, as soon as the result is known, to the CPHO (or designate), as per the PEI Reporting Notifiable Diseases, Conditions, and Events Regulations. ⁽³⁾

4.0 Summary of Viral Respiratory Infections

Viral respiratory infections can be caused by a variety of pathogens that can co-circulate. These pathogens have similar symptoms and can pose clinical diagnosis and management challenges. Viral respiratory pathogens are transmitted by droplets or small particle aerosols spread through coughing, sneezing, talking, and breathing. They may also be transmitted through direct or indirect contact with infected respiratory secretions on surfaces and objects. LTCF and CCF staff must be vigilant to prevent the spread of viral respiratory pathogens such as influenza, COVID-19, and RSV within their facility. ⁽⁵⁾

Especially during respiratory season, a high index of clinical suspicion is required by staff as older residents may not present with symptoms that are typical of a viral respiratory infection. If staff notice a change in a resident's baseline condition (including confusion/delirium) that could be due to a respiratory infection, testing should be conducted. It is also important to be aware of additional residents who experience symptoms within the same area of the LTCF or CCF over a short period of time. ⁽⁵⁾

LTCF and CCF staff may not immediately know which viral respiratory pathogen is causing illness but initiating Droplet and Contact Precautions when a respiratory infection is suspected in a resident is critical in slowing the spread of a virus since these precautions are effective against all viral respiratory pathogens. These precautions should remain in place while the clinical suspicion of the virus remains. ⁽⁵⁾

NOTE:

The use of enhanced public health measures (masking, physical distancing) particularly during respiratory season may be different in LTCF and CCF than in the general population due to the vulnerability of this population. ⁽⁵⁾

COVID-19, influenza, and RSV immunization offer a safe and effective way to decrease illness and limit severity of disease and death. However, outbreaks of these viruses can still occur among vaccinated residents. ⁽⁵⁾

4.1 Influenza

Influenza is an acute viral respiratory disease caused by the influenza A and B viruses. Generally, seasonal influenza occurs every year beginning in late fall and extending into the spring. It is characterized by fever AND cough, as well as other symptoms such as sore throat, arthralgia (joint pain), myalgia (muscle pain) and prostration (extreme weakness). The elderly may present without fever and simply have a cough, fatigue, and/or confusion. Most people recover from influenza within 3-7 days, but some, like the elderly, are at greater risk of hospitalization and complications, such as pneumonia and worsening of underlying medical conditions. ^(6,7)

Annual influenza vaccination of both residents and staff within LTCFs and CCFs is the most effective means of preventing influenza illness and decrease the risk of influenza-related complications. Antiviral medications are available for LTCF residents who are diagnosed with influenza to prevent progression to severe disease, to prevent infection in exposed residents (post-exposure prophylaxis {PEP}) and to prevent outbreaks in LTCFs. (See Appendix A)

4.2 COVID-19

COVID-19 is an illness caused by the SARS-CoV-2 virus. SARS-CoV-2 can infect anyone but populations such as the LTCF and CCF population are at higher risk from exposure to the virus due to their advanced age, chronic health conditions and the ease of transmission within the facilities. Symptoms can include runny nose, headache, sneezing, sore throat, cough, and fever. These symptoms are like those of influenza. Those infected with COVID-19 may be extremely ill or have little to no symptoms. New variants of the virus have evolved throughout the pandemic that have altered the incubation period, communicability, and pattern of symptoms that individuals experience. It is expected this trend will continue as new variants emerge in the future. ⁽⁸⁾

COVID-19 vaccination is recommended for all residents and staff in LTCFs and CCFs. If it has been 3- 6 months since the last dose of vaccine or COVID-19 infection (whichever is later), it is recommended that residents and staff receive a dose of COVID-19 vaccine in the fall. ⁽⁹⁾⁽¹⁰⁾ The antiviral drug Paxlovid™ (nirmatrelvir and ritonavir) is available to treat eligible residents symptomatic with mild to moderate COVID-19. The information regarding the use of Paxlovid™ and its eligibility can be obtained through the following link:

<https://www.princeedwardisland.ca/en/information/health-and-wellness/paxlovid-antiviral-for-treating-covid-19> .

4.3 Respiratory Syncytial Virus

RSV is a common seasonal respiratory illness that generally takes place from late fall to early spring. RSV is a common childhood illness but since infection produces partial and temporary immunity, reinfection with RSV can occur in all ages. Individuals usually have mild cold-like symptoms such as a runny nose, coughing, sneezing, fatigue, headache, and fever. As with other viral respiratory infections, the elderly may not present with the typical symptoms. Mostly healthy adults will recover on their own in 1 to 2 weeks however, older adults (≥ 65 years) and immune compromised individuals are more susceptible to developing severe disease such as bronchiolitis and pneumonia. Additionally, RSV can make chronic health conditions like heart disease

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and lung disease worse and cause death in elderly populations. Currently, antiviral medications are not available to prevent or treat RSV infections in this population. ⁽¹¹⁾

An RSV vaccine is currently available in Canada and aims to help prevent RSV disease in older adults. RSV vaccination is expected to be available this fall for residents of LTCFs and CCFs who are 60 years of age and older.

4.4 Other Respiratory Viruses

Other respiratory viruses including Human metapneumovirus (HMPV), Human rhinovirus (HRV), and Human parainfluenza virus (HPIV) can also affect the elderly, particularly those living in LTCFs and CCFs. While the LTCF or CCF are unlikely to have lab confirmation of these other viruses in their facility, the same IPAC measures will be effective and should be initiated. ⁽⁵⁾

4.5 Stages of Viral Respiratory Infections

Following sufficient exposure to a respiratory virus, individuals proceed through a series of stages: incubation, infectious, and symptomatic periods. See Table 1 for an outline of these stages for each respiratory viral pathogen. ⁽⁵⁾

4.5.1 Incubation Period

During this stage the virus is replicating (copying) itself in the individual. During the early stages of the incubation period, the viral load within the body is not sufficient for the individual to be infectious. However, by the end of this period, the viral load has increased, and the individual then becomes infectious.

4.5.2 Infectious Period

An individual in the infectious period can spread the viral infection to others, even if they have not yet developed symptoms.

4.5.3 Symptomatic Period

At the beginning of the symptomatic period, the individual continues to shed the virus and can spread it to others. As they progress to recovery, less virus is shed and the risk of spreading to others is lessened.

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TABLE 1. Comparison of key features of respiratory viral pathogens				
	Influenza	COVID-19	RSV	Other
Viral etiology	Influenza A & B	SARS-CoV-2	Respiratory syncytial virus	Adenovirus, human metapneumovirus, parainfluenza virus, rhinovirus
Laboratory/point of care molecular testing for LTCF and CCF	Both available	Both available	Laboratory testing done as part of respiratory panel during influenza season	Laboratory testing only done as part of an extended respiratory panel during influenza season for specific cases
Incubation Period	1-4 days median 2 days	2-14 days median 2-4 days	2-8 days median 5 days	2-10 days
Communicable Period	1 day before symptom onset to 5 days after symptom onset	2-3 days prior to symptoms to about 7-10 days after symptom onset; if asymptomatic date of positive test	1-21 days median 8 days	May be communicable a few days before and while symptomatic
Vaccine Available	Yes, publicly funded	Yes, publicly funded	Yes, publicly funded	No
Antiviral Prophylaxis or Treatment/Therapeutics	Prophylaxis and treatment are recommended in LTCF	Treatment available for eligible residents	No antiviral or treatment available in this age group	No
Actions when resident has symptoms of a Viral Respiratory Infection	<ul style="list-style-type: none"> • Isolate and immediately initiate Droplet and Contact Precautions for symptomatic resident(s) • Collect viral swab for symptomatic resident and test for COVID-19, Influenza, and RSV using laboratory-based PCR or COVID-19 and Influenza using Abbott ID Now NAAT <p>Suspect viral respiratory infection outbreak if: there are 2 symptomatic residents within 72 hours with an epidemiologic link</p> <ul style="list-style-type: none"> • Notify the lab that the facility might be in an outbreak situation if sending for laboratory-based PCR • Notify CPHO 902-368-4996 during government business hours or by the on-call number after hours • Begin resident and staff line list (Appendix G) and fax <u>daily</u> to CPHO at 902-620-3354 with subsequent cases <p>See section 7.2 Screening and Management of Symptomatic Residents</p>			

5.0 Infection Prevention and Control (IPAC) for Viral Respiratory Illnesses

5.1 Facility Planning

Viral respiratory infections can occur in LTCFs and CCFs throughout the year. Outbreaks of viral respiratory illnesses in these facilities can result in high morbidity and place considerable strain on operations. Planning for their prevention and control should engage all staff. **This document is intended to assist facilities in developing policies and procedures specific for their facilities and ensure these are communicated to all staff, physicians, family, visitors, and volunteers in advance of an outbreak.** See Table 2 for steps in preparing for the viral respiratory season.

TABLE 2.	Steps in Preparing for Viral Respiratory Season
	<ul style="list-style-type: none"> • Ensure there are facility specific policies and procedures that include IPAC measures and education for influenza, COVID-19 and RSV, the associated clinical presentations, environmental management, and communication plan for all staff
	<ul style="list-style-type: none"> • Ensure sufficient Personal Protective Equipment (PPE) supply for routine operations and initial outbreak response and clear process to order more when needed
	<ul style="list-style-type: none"> • Ensure a process is available for regular N95 fit testing for staff
	<ul style="list-style-type: none"> • Ensure an adequate supply of nasopharyngeal (NP) swabs for PCR lab testing of COVID-19, influenza, and RSV and Abbott ID Now testing kits (check expiry dates) are available and provide education for staff on collection techniques. NP swabs can be obtained from the Microbiology Lab and should be stored appropriately for maximum effectiveness
	<ul style="list-style-type: none"> • LTCFs – Ensure to calculate and record the creatinine clearance on all residents yearly in the fall
	<ul style="list-style-type: none"> • LTCFs – Obtain a signed Physician/Nurse Practitioner standing order yearly by early fall for the administration of influenza antiviral treatment and/or prophylaxis (Appendix A)
	<ul style="list-style-type: none"> • Prepare a process to access Paxlovid™ treatment for COVID-19 positive <u>symptomatic</u> residents who are eligible
	<ul style="list-style-type: none"> • Obtain resident or substitute decision maker consent for COVID-19, influenza, and RSV vaccines and treatments
	<ul style="list-style-type: none"> • Plan for influenza, COVID-19, and RSV immunization of residents annually and influenza and COVID-19 immunization of staff annually.
	<ul style="list-style-type: none"> • Ensure Goals of Care/Advanced Directives are reviewed and updated for all residents

5.2 Immunization of Staff and Residents

5.2.1 Influenza Immunization

Staff Influenza Immunization

The National Advisory Committee on Immunization (NACI) continues to recommend immunization for health care providers and other care providers in facilities who, through their activities, can transmit viral infections to those at elevated risk of complications from these viruses. Therefore, all staff should receive an annual influenza vaccine for their own protection, as well as the protection of residents, available in early fall. ⁽¹²⁾

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Resident Influenza Immunization

Immunization of residents in LTCFs and CCFs against influenza continues to be an important way to prevent viral respiratory infections and their severe outcomes. For residents 65 years of age and older NACI preferentially recommends High Dose QIV. Residents under 65 years of age are eligible to receive the QIV vaccine. Both are available in early fall. ⁽¹²⁾

5.2.2 COVID-19 Immunization

Staff COVID-19 Immunization

Facility operators of LTCFs and CCFs are responsible for policies about COVID-19 vaccination for their employees, outside service providers and volunteers. Vaccination remains one of the best ways for people to protect themselves, their co-workers, and vulnerable residents from severe disease, hospitalization, and death. COVID-19 vaccination will be available in the fall for those not previously vaccinated and those previously vaccinated. For those previously vaccinated it can be given if it has been 3-6 months since their last COVID-19 vaccine or COVID-19 infection (whichever is later). ⁽¹⁰⁾

Resident COVID-19 Immunization

NACI recommends that COVID-19 immunization is particularly important for those at increased risk of severe disease from a COVID-19 infection. Residents in LTCFs and CCFs fall in this category. As mentioned above, residents can receive their primary series of COVID-19 vaccine or subsequent dose of vaccine in the fall. ⁽¹⁰⁾

5.2.3 RSV Immunization

Resident RSV Immunization

Beginning in the fall of 2024, it is expected that RSV vaccine for older adults will be available for the first time through public programming for residents of LTCFs and CCFs who are 60 years and older.

5.3 Routine Practices

Routine practices apply **to all staff, residents, and visitors, at all times, in all LTCFs and CCFs** and include but are not limited to:

- ◆ Conducting a point of care risk assessment (PCRA)
- ◆ Hand hygiene
- ◆ Appropriate use of PPE
- ◆ Adhering to respiratory hygiene (i.e., turning away from others when coughing or sneezing, covering a cough/sneeze with a tissue or cough/sneeze into sleeve, dispose of tissues, follow with hand hygiene)

5.4 Point-of-Care Risk Assessment (PCRA) (Appendix B)

Prior to any resident interaction, all staff have the responsibility to assess the infectious risks posed to themselves, other staff, other residents, and visitors from a resident, situation, or procedure.

- ◆ The PCRA helps staff to select the appropriate actions and/or PPE to minimize risk or exposure to known and unknown infections.
- ◆ Performing a PCRA helps with the appropriate use of PPE.
- ◆ Resident factors to consider while conducting a PCRA are:
 - Signs, symptoms, or clinical syndromes that require the use of Additional Precautions.

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- The resident's volume of respiratory secretions, and ability to control behaviors (e.g., shouting), secretions and cough.
- The resident's ability to comply with IPAC practices (e.g., hand hygiene, medical mask use, respiratory hygiene, or other IPAC practices).
- Requirement of extensive or prolonged direct care.

5.5 Hand Hygiene (Appendix C)

5.5.1 Staff are required to perform hand hygiene

- ◆ On entry to and exit from the LTCF or CCF
- ◆ Before and after contact with a resident, regardless of whether gloves are worn
- ◆ Before preparing or administering all medications or food (handwashing with soap and water required for food handling)
- ◆ Before performing aseptic procedures
- ◆ Before putting on PPE and during removal of PPE according to facility procedure for putting on or removing PPE
- ◆ Before putting gloves on
- ◆ After removing gloves
- ◆ Before and after contact with the resident's environment (e.g., medical equipment, bed, table, door handle) regardless of whether gloves are worn
- ◆ Any other time hands are potentially contaminated (e.g., after handling blood, body fluids, bedpans, urinals, or wound dressings)
- ◆ After other personal hygiene practices (e.g., blowing nose, touching face, using toilet facilities, etc.)

5.5.2 Residents should perform hand hygiene:

- ◆ Upon entering or leaving their room
- ◆ Prior to eating, oral care, or managing oral medications
- ◆ After using toileting facilities
- ◆ Any time hands are potentially contaminated (e.g., after handling blood, body fluids, bedpans, urinals, or wound dressings)

5.6 Droplet and Contact Precautions (Appendix D)

- ◆ Droplet and Contact Precautions must be implemented for all residents who are diagnosed with or presenting with signs and symptoms of a viral respiratory illness.
 - Gloves and a long-sleeved cuffed gown (covering front of body from neck to mid-thigh) must be worn upon entering a resident's room, along with a well-fitting medical grade mask and face or eye protection.
 - Facial protection includes eye protection that is either a full-face shield that covers the front and sides of the face or well-fitting goggles.
(*regular eyeglasses or safety glasses with gaps between glasses and the face are not sufficient protection*)
- ◆ The area where PPE is donned should be separated as much as possible from the area where it is removed and discarded.
- ◆ Hand hygiene must be performed prior to putting on and after removing PPE.

NOTE:

For interactions with residents who are suspected or confirmed to have a viral respiratory illness, PPE consistent with a minimum of Droplet and Contact Precautions (e.g., gloves, a gown, a well-fitting medical grade mask and eye protection) should be worn. An N95 or equivalent respirator should be worn in place of a mask when performing or exposed to an AGMP. Use of an N95 or equivalent respirator may be considered in other circumstances under which risk of exposure to aerosolized virus may occur.

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6.0 Case Definitions of Respiratory Viral Infections

It is important in LTCFs and CCFs, when staff notice a change in the baseline of a resident which could be related to a respiratory virus, that active daily screening and documentation is initiated. The goal of active screening is to pick up viral respiratory illness early by being aware of symptoms such as confusion, which are more common in the elderly. Widespread asymptomatic testing is not recommended but testing a resident where respiratory symptoms are absent may be appropriate based on clinical judgement and staff knowledge of the resident's baseline. ⁽⁵⁾

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6.1 Influenza-Like Illness (ILI)

ILI Case Definition	ILI Outbreak Definition
<p>Acute onset of respiratory illness with fever* and cough and with one or more of the following:</p> <ul style="list-style-type: none"> • sore throat • arthralgia • myalgia • prostration that could be due to influenza virus <p>In persons <u>>65 years</u>, fever may not be prominent.</p>	<p>Two or more cases of ILI within a seven-day period with a common epidemiological (epi) link</p>

*Fever is as follows:

- o Single oral temp >37.8C OR
- o Repeated oral temps >37.2C or rectal temps >37.5 OR
- o Single temp >1.1C over the individual's baseline (oral or rectal)

6.2 Influenza Illness

Influenza Case Definition	Influenza Illness Outbreak Definition
<p>A person with ILI symptoms as outlined above <u>and</u> *test-confirmed infection with influenza</p>	<p>Two or more cases of ILI within a seven-day period with an epi link, including at least one *test-confirmed case of influenza within the surveillance setting</p> <p>Or</p> <p>Two or more *test-confirmed cases of influenza which are epi linked to a specific setting or location</p>

***Test-confirmed influenza case:** case with a positive result on lab-based PCR or Abbott ID Now NAAT.

6.3 COVID-19 Illness

COVID-19 Case Definition	COVID-19 Outbreak Definition
<p>A person with *test-confirmed infection with SARS-CoV-2</p>	<p>Two or more *test-confirmed cases of COVID-19 which are epi linked to a specific setting or location</p>

***Test-confirmed COVID-19 case:** case with a positive result on lab-based PCR or Abbott ID Now NAAT. A case with a positive result on a rapid antigen test may be considered to be a test-confirmed case of COVID-19 upon review by the Chief Public Health Officer or designate.

6.4 RSV Illness

RSV Case Definition	RSV Outbreak Definition
<p>A person with laboratory confirmation testing of RSV</p>	<p>Two or more cases of ILI within a seven-day period with an epi link, including at least one laboratory confirmed case of RSV within a surveillance setting</p>

7.0 Outbreak Management for Viral Respiratory Illnesses

Despite stringent IPAC measures, outbreak control can be difficult. Therefore, to prevent spread of infection in LTCFs and CCFs, staff must initiate IPAC measures promptly, without waiting for laboratory confirmation of the viral respiratory pathogen. IPAC measures include Routine Practices, Hand Hygiene, and implementation of Droplet and Contact Precautions.

7.1 General Outbreak Management Principles

- ◆ Prompt isolation of symptomatic resident and initiation of droplet and contact precautions (See Appendix D and E for posters)
- ◆ Testing of symptomatic residents to determine viral pathogen
- ◆ Notify CPHO who will declare the start and end of outbreaks
- ◆ Reporting guidance: once outbreak is confirmed by CPHO report subsequent cases daily to CPHO by using the line list in Appendix G
- ◆ Resident assessment: daily active monitoring of residents
- ◆ Staff screening: passively screen before every shift and self-monitor throughout shift
- ◆ Work exclusion for staff who meet symptom checker criteria
- ◆ Enhanced cleaning and disinfection of resident and staff areas
- ◆ Stringent adherence to masking and eye protection for staff working on affected household/unit/area
- ◆ Post Outbreak Signage in appropriate units/areas (Appendix H)

7.2 Screening and Management of Symptomatic Residents

Active screening of residents should be carried out at least once a day when LTCF and CCF staff notice a change in baseline of a resident(s), including new confusion/delirium that may be the result of a viral respiratory infection. See section 4.0 for a summary of viral respiratory illness and section 6.0 for case definitions and outbreak definitions for each. The following steps should be followed for any symptomatic residents and their close contacts.

Step 1: Immediately isolate symptomatic resident and place on droplet and contact precautions. A resident who is suspected or confirmed to have viral respiratory illness should be cared for, if possible, in a single room with a toilet and sink designated for their use. Roommates of symptomatic residents should not be moved to a new shared room but, if possible, should be placed in a single room and monitored for signs and symptoms.

Step 2: Swab symptomatic resident for point of care testing (POCT) for COVID-19 (if POCT is not available for use, send swab for lab-based PCR). If POCT is negative for COVID-19, test for influenza. When respiratory season is underway, a lab-based PCR test may be required if the POCT is negative for both COVID-19 and influenza in symptomatic residents because POCT for COVID-19 and influenza is less sensitive than lab-based PCR and can take longer to become positive in early stages of infection or RSV may be circulating. See Appendix G for nasopharyngeal (NP) process on obtaining a swab.

Step 3: If a viral respiratory outbreak is suspected, report this to CPHO. (See section 6.0 for outbreak definitions)

7.3 Managing Testing and Testing Results of Residents

7.3.1 Symptomatic Residents with COVID-19

- ◆ Residents with COVID-19 symptoms are to be placed on droplet and contact precautions.
- ◆ Symptomatic residents can be tested for COVID-19 using a laboratory-based PCR or Abbott ID Now NAAT.
- ◆ It is important when sending specimens for laboratory-based PCR to notify them that the facility may be in an outbreak situation. The lab will advise how many specimens to send but usually 2 specimens are sufficient.
- ◆ A newly symptomatic resident who tested positive for COVID-19 infection in the **previous 60 days** generally should not be retested for COVID-19, but the house physician or nurse practitioner should be alerted for testing orders for FLUVID/RSV PCR.
- ◆ Symptomatic and positive COVID-19 residents tested as above, can initiate access to Paxlovid™ treatment if eligible.
- ◆ Once a COVID-19 outbreak has been confirmed (2 epi-linked positive residents), testing additional symptomatic residents for COVID-19 during this time is generally not necessary unless directed by CPHO. Testing additional symptomatic residents may be recommended when:
 - A resident will require access to Paxlovid™
 - A resident develops new or worsening symptoms while on treatment
 - A resident with no epidemiological link to the outbreak presents with symptoms
- ◆ If doing PCR laboratory testing, the lab should be notified by CPHO/IPAC when additional testing is being requested.
- ◆ Regular contact with CPHO/IPAC is recommended if the outbreak spreads to other units/areas of the facility and to determine when to declare the outbreak over.
- ◆ Symptomatic residents diagnosed with COVID-19 should remain on droplet and contact precautions for **5 days** following date of symptom onset or the positive test date (regardless of vaccination status) **and** until resolution of fever for 24 hours (without fever reducing medication) and symptoms have improved.
***NOTE: Residents who are moderately or severely immunocompromised may require an extension of droplet and contact precautions. This can be discussed with IPAC or CPHO.**

Close Contacts of Cases with COVID-19

- ◆ Residents considered to be close contacts may be roommates, dining table mates and other residents with significant contact with the symptomatic resident.
- ◆ Close contacts are to be monitored for symptoms at least twice daily for **4 days** following the last exposure to the case. Day 0 is the day of last exposure to the case.
- ◆ There is no need to test or restrict asymptomatic roommates or close contacts from activities within the facility.

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- ◆ If close contacts become symptomatic and an outbreak has been declared, no testing is required. They are to be placed on droplet and contact precautions for the duration as mentioned above.

7.3.2 Symptomatic Residents with ILI/Influenza

- ◆ Symptomatic residents with ILI symptoms are to be placed on droplet and contact precautions.
- ◆ Testing should be done as soon as possible (but within 24 hours of symptom onset) using a laboratory-based PCR or Abbott ID Now NAAT.
- ◆ It is important when sending specimens for laboratory-based PCR to notify them that the facility may be in an outbreak situation. The lab will advise how many specimens to send but usually 2 specimens are sufficient.
- ◆ Once an influenza outbreak has been confirmed, (2 epi-linked positive residents) testing additional symptomatic residents for influenza during this time is generally not necessary unless directed by CPHO. Testing additional symptomatic residents may be recommended when:
 - A resident develops new or worsening symptoms while on treatment/prophylaxis
 - A resident with no epidemiological link to the outbreak presents with symptoms.
- ◆ If doing PCR laboratory testing, the lab should be notified by IPAC/CPHO when additional testing is being requested.
- ◆ Regular contact with CPHO/IPAC is recommended if the outbreak spreads to other units/areas of the facility and to determine when to declare the outbreak over.
- ◆ Residents with symptoms of ILI or confirmed influenza should remain on droplet and contact precautions for at least **5 days** following date of symptom onset **and** clinically improving with resolution of fever for 24 hours (without fever reducing medication) and is not moderately or severely immunocompromised.
***NOTE: Residents who are moderately or severely immunocompromised may require an extension of droplet and contact precautions. This can be discussed with IPAC or CPHO.**
- ◆ **LTCF Residents Only:**
 - Once the antiviral prophylaxis is started, a daily line list is no longer required by the CPHO, however it might be useful for the facility in managing the outbreak.
 - If influenza is already known to be in the community, the CPHO will help determine if testing of residents is needed and if/when prophylaxis should be started.

Close Contacts of Cases with ILI/Influenza

- ◆ Roommates and close contacts should be considered exposed to influenza and be monitored for symptoms at least twice per day following the day of exposure for **2 days**.
- ◆ There is no need to restrict asymptomatic roommates or close contacts from activities within the facility.

7.3.3 Symptomatic Residents with RSV

- ◆ Symptomatic residents with RSV symptoms are to be placed on droplet and contact precautions.
 - ◆ Testing should be done as soon as possible (but within 24 hours of symptom onset) and sent to the lab for FLUVID/RSV PCR if the POCT for COVID-19 and influenza were negative.
 - ◆ It is important when sending specimens for laboratory-based PCR to notify them that the facility may be in an outbreak situation. The lab will advise how many specimens to send but usually 2 specimens are sufficient.
 - ◆ Once an RSV outbreak has been confirmed, (2 epi-linked positive residents) testing additional symptomatic residents for RSV during this time is generally not necessary unless directed by CPHO. Testing additional symptomatic residents may be recommended when:
 - A resident develops new or worsening symptoms
 - A resident with no epidemiological link to the outbreak presents with symptoms.
 - ◆ The lab should be notified by CPHO/IPAC when additional testing is being requested.
 - ◆ Regular contact with CPHO/IPAC is recommended if the outbreak spreads to other units/areas of the facility and to determine when to declare the outbreak over.
 - ◆ Residents with confirmed RSV should remain on droplet and contact precautions for at least **8 days** following date of symptom onset **and** clinically improving with resolution of fever for 24 hours (without fever reducing medication) and is not moderately or severely immunocompromised
- *NOTE: Residents who are moderately or severely immunocompromised may require an extension of droplet and contact precautions. This can be discussed with IPAC or CPHO.**

Close Contacts of Cases with RSV

- ◆ Roommates and close contacts should be considered exposed to RSV and be monitored for symptoms at least twice per day following the day of exposure for **5 days**.
- ◆ There is no need to restrict asymptomatic roommates or close contacts from activities within the facility.

7.4 New Admissions, Re-Admissions, and Transfers During Viral Respiratory Outbreaks

- ◆ Admissions, readmissions, and transfers to a facility experiencing an outbreak may be allowed to the affected areas in certain circumstances.
- ◆ Considerations include:
 - Is the outbreak limited to one household/unit/section of the facility or the entire facility?
 - What is the status of outbreak and management (length of time since last case, attack rate, severity of illness)?
 - Is there adequate staff available to provide care?
 - Is the area of the facility that the resident is returning to experiencing the outbreak or have cases of viral respiratory illness in the resident population?
 - What is the resident's past viral respiratory pathogen exposure?
 - What is the resident's co-morbidities?

Viral Respiratory Infections

- Is the resident immunized or on antiviral prophylaxis?
- Have the resident /substitute decision maker and most responsible provider/physician been informed of the outbreak and consented to the move?
- What is the overall benefit vs. risk to the health of the transferring resident of immediate vs. delayed placement in the facility?
- ◆ Where transfers are medically necessary (hospital admission) or for urgent/medically necessary appointments (dialysis), the receiving facility/unit and transporting personnel must be notified of the outbreak and of any additional precautions the resident requires. Notify the receiving hospital or clinic to ensure that care can be provided safely.
- ◆ Notify any facility that you transferred a resident to within the past 10 days, that your facility has a viral respiratory outbreak.
- ◆ Residents should **only be tested on admission if symptoms are present** initially using point-of-care molecular testing (POCT), if available, or by collecting a viral swab.
- ◆ Place on droplet and contact precautions **only** if they are symptomatic.
- ◆ If the POCT is negative, continue precautions and alert house physician or nurse practitioner for testing orders to send a specimen for FLUVID/RSV PCR.

7.5 Screening and Management of Symptomatic Staff

- ◆ Staff are **not routinely tested** for viral respiratory illnesses unless ordered by a physician or nurse practitioner for other purposes outside concerns occurring in the facility.
- ◆ Staff will self-monitor for signs and symptoms of viral respiratory illnesses daily and immediately report any new symptoms to facility management.
- ◆ Staff will refrain from working when they have signs or symptoms of any viral respiratory illness.
- ◆ Staff who become symptomatic at work, should immediately perform hand hygiene, ensure they are wearing a well-fitting medical mask, inform their supervisor, avoid further resident and staff contact and leave the workplace.
- ◆ Symptomatic staff with a viral respiratory illness should not return to work until fever free for 24 hours (without taking fever reducing medication) and symptoms have improved.

7.6 Screening and Management of Symptomatic Visitors and Volunteers

- ◆ Visitors and volunteers are to monitor themselves for signs and symptoms of viral respiratory illnesses prior to entering the LTCF or CCF.
- ◆ Visitors and volunteers are not to enter the facility when they are ill and should not enter until they have been fever free for 24 hours and symptoms have improved.

7.7 Aerosol-Generating Medical Procedures (AGMPs)

An AGMP is any procedure conducted that can induce production of aerosols of various sizes, including droplet nuclei. Consider discontinuing CPAP/BiPAP during an outbreak in consultation with the physician/NP. AGMPs on a resident suspected or confirmed to have a viral respiratory infection should be avoided if possible and only be performed if:

- ◆ The AGMP is medically necessary and performed by the most experienced person.
- ◆ The minimum number of persons required to safely perform the procedure are present.
- ◆ All persons in the room are wearing a fit-tested and/or fit-checked (Appendix F), N95 respirator, gloves, gown and face or eye protection.
- ◆ The door of the room is closed.

7.8 Specimen Collection

Nasopharyngeal (NP) or nasal and throat swabs should be collected by qualified staff who are knowledgeable about proper collection methods.

- ◆ During sample collection, staff should be limited to those necessary for resident care during the procedures.
- ◆ All staff in the room during collection should wear PPE in accordance with contact and droplet precautions.

Handling Lab Specimens

All specimens collected for laboratory investigations must be regarded as potentially infectious and placed in biohazard bags. Handle as per Routine Practices.

7.9 Environmental Cleaning and Disinfection

Cleaning and Disinfection

- ◆ Cleaning and disinfection of high-touch surfaces is important for controlling the spread of microorganisms.
- ◆ Environmental disinfectants must be classed as a hospital grade disinfectant **registered in Canada with a Drug Identification Number (DIN) or medical device license (MDL) and labelled as effective for both enveloped and nonenveloped viruses.**
- ◆ If commercially prepared hospital disinfectants are not available, diluted bleach solution may be used to disinfect the environment.
 - The minimum concentration of chlorine must be 5000 ppm or 0.5% (equivalent to a 1:9 dilution of 5% concentrated liquid bleach).
 - When using bleach, cleaning must precede disinfection.
- ◆ All surfaces, that are considered “frequently touched” (e.g., telephone, bedside table, overbed table, chair arms, call bell cords or buttons, door handles, light switches, bedrails, handwashing sink, bathroom sink, toilet and toilet handles, shower handles, faucets or shower chairs, grab bars, outside of paper towel dispenser, dining tables, etc.) must be cleaned and disinfected at a minimum of twice daily and when soiled.

Viral Respiratory Infections

- ◆ Resident care equipment (e.g., BP cuffs, electronic thermometers, oximeters, stethoscope) must be cleaned and disinfected after each use and between residents with hospital-grade disinfectant following the recommended contact time.
- ◆ **Room cleaning and disinfection** must be performed at least **once per day on all low touch surfaces** (e.g., shelves, bedside chairs, windowsills, overbed light fixtures, etc.). Floors and walls must be kept visibly clean and free of spills, dust, and debris.
- ◆ All surfaces or items, **outside of the resident room, that are touched by or in contact with staff** (e.g., computer carts and/or screens, medication carts, charting desks or tables, computer screens, telephones, touch screens, chair arms) must be cleaned and **disinfected at least daily and when soiled**. Staff should ensure that hands are cleaned before touching shared equipment.
- ◆ **Environmental services staff must wear the same PPE as other staff when cleaning and disinfecting the resident's room.**
- ◆ Never vacuum carpeted areas during an outbreak as viruses may become airborne. If carpet becomes contaminated use paper towel to clean up the material and then use a disinfectant designed for use on carpets and thoroughly steam clean the area if possible.
- ◆ Facility protocol for cleaning of the resident's room after discharge, transfer, or discontinuation of Droplet and Contact Precautions must be followed. Toilet brushes, unused toilet paper and other disposable supplies should be discarded, and all bedside privacy curtains removed and laundered at the time of resident discharge or transfer.

Resident Care Equipment

- ◆ All reusable equipment and supplies, electronics, personal belongings, etc., should be dedicated to the use of the resident with suspect or confirmed viral respiratory infection. If use with other residents is necessary, the equipment and supplies must be cleaned and disinfected with a hospital-grade disinfectant, ensuring adequate contact time before reuse. Items that cannot be appropriately cleaned and disinfected should be discarded.

Linen, Dishes and Cutlery

- ◆ No special precautions are recommended; routine practices are used.

Waste Management

- ◆ No special precautions are recommended; routine practices are used.

7.10 Group Activities

Includes communal dining, recreational activities, and group entertainment.

- ◆ Modify activities on affected units as appropriate.
- ◆ Consider limiting activities to those that are low risk during an outbreak (e.g., arts and crafts, bingo, card games, other small group activities). Remove shared food containers from dining areas (e.g., shared water/juice pitchers, salt and pepper shakers, butter etc.).
- ◆ Dispense food and snacks directly to residents.
- ◆ If using single serve packets of condiments, provide packet directly to each resident.
- ◆ Cease activities that involve resident participation in food preparation.
- ◆ Use of disposable plates and cutlery by symptomatic residents is not required.
- ◆ Close kitchen/nourishment areas accessed by residents/visitors.

7.11 Resident Passes

- ◆ Minimize the frequency of passes during an outbreak, particularly by residents that are impacted by outbreak units.
- ◆ Case or symptomatic resident should not go out on a pass except for essential medical or emergency care.

7.12 Outbreak Visitation

- ◆ Facility decisions around visitation can be determined based on their operational capacity.
- ◆ During an outbreak, visitation aims to balance the physical, psychological, emotional, and spiritual needs of residents.
- ◆ Visitors are to limit their movement within the facility to directly visiting the resident and exiting the facility after their visit.
- ◆ During an outbreak family or visitors may visit the resident at any time, provided this visit does not have a negative impact on the care of any other resident in the facility.
- ◆ Visitors must follow all IPAC protocols in place, including wearing appropriate PPE.
- ◆ Visitors shall maintain physical distancing from other residents and staff.

8.0 Declaring the Outbreak Over

- ◆ The facility Outbreak Management Team should have a plan in place to discontinue additional precautions for individual residents, rooms, units, and the full facility.
- ◆ IPAC control measures will be continued until the outbreak is declared over.
- ◆ An outbreak may be considered over when **no new cases of viral respiratory illness in residents or staff in the facility with an epidemiological link are identified for the duration of days as listed in the table 3 below depending on the pathogen** and in consultation with the CPHO.
- ◆ Factors to assess when making decisions include:
 - Are the residents in the room/unit/facility still symptomatic?
 - Have the precautions been effective in controlling the spread of the outbreak?
 - Is the number of new symptomatic patients decreasing and for how many days?
 - Is the staffing available to adequately care for the residents?

Respiratory Virus	Declaring the Outbreak Over*
Confirmed Influenza	4 days
Confirmed COVID-19	10 days
Confirmed RSV	10 days
Outbreak: Unidentified/Other Respiratory Pathogen	5 days

*Two incubation periods following the last known exposure to an infectious person in the affect unit/area.

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Appendix A – Influenza Antiviral Guidelines and Post-Exposure Prophylaxis (PEP) LTCF Only

Antiviral Treatment – Specific to LTCFs Only

Treatment with antiviral medication is recommended for influenza when it is diagnosed early in the illness (usually within 48 hours of symptom onset). The Association of Medical Microbiology and Infectious Diseases Canada (AMMI) recommends that antiviral medication should still be used even if it has been more than 48 hours since the onset of symptoms when the individual belongs to a group at high risk for complications of influenza.

Prescribing antiviral medication to individuals who have been exposed to influenza but who have not yet developed symptoms is known as post-exposure prophylaxis (PEP). PEP is recommended for residents in long term care facilities to reduce the risk of transmission to other residents and to minimize the impacts of an influenza outbreak in this vulnerable population. The Chief Public Health Office provides antiviral medication (oseltamivir) for post-exposure prophylaxis of residents in both public and private long-term care facilities (LTCF) in PEI.

1. The decision on the use of antiviral medications to control the outbreak will be made in consultation with the CPHO after reviewing the information collected.
2. The CPHO may recommend antiviral medication after consultation with the attending physician.
3. Table 1 outlines the AMMI recommendations for antiviral treatment and prophylaxis.
4. Antiviral medication (Oseltamivir®75mg and 30mg doses) are now pre-positioned within each facility for all residents (long term care and dual long-term care/community care facilities). Table 2 can be used to determine if additional antiviral doses are required over and above what is pre-positioned in the facility. The CPHO will arrange for further doses as required.
5. If a resident develops influenza-like illness while on the prophylaxis dose, the resident should be switched to the treatment dose as per Table 1 and start as if on day one.

Viral Respiratory Infections

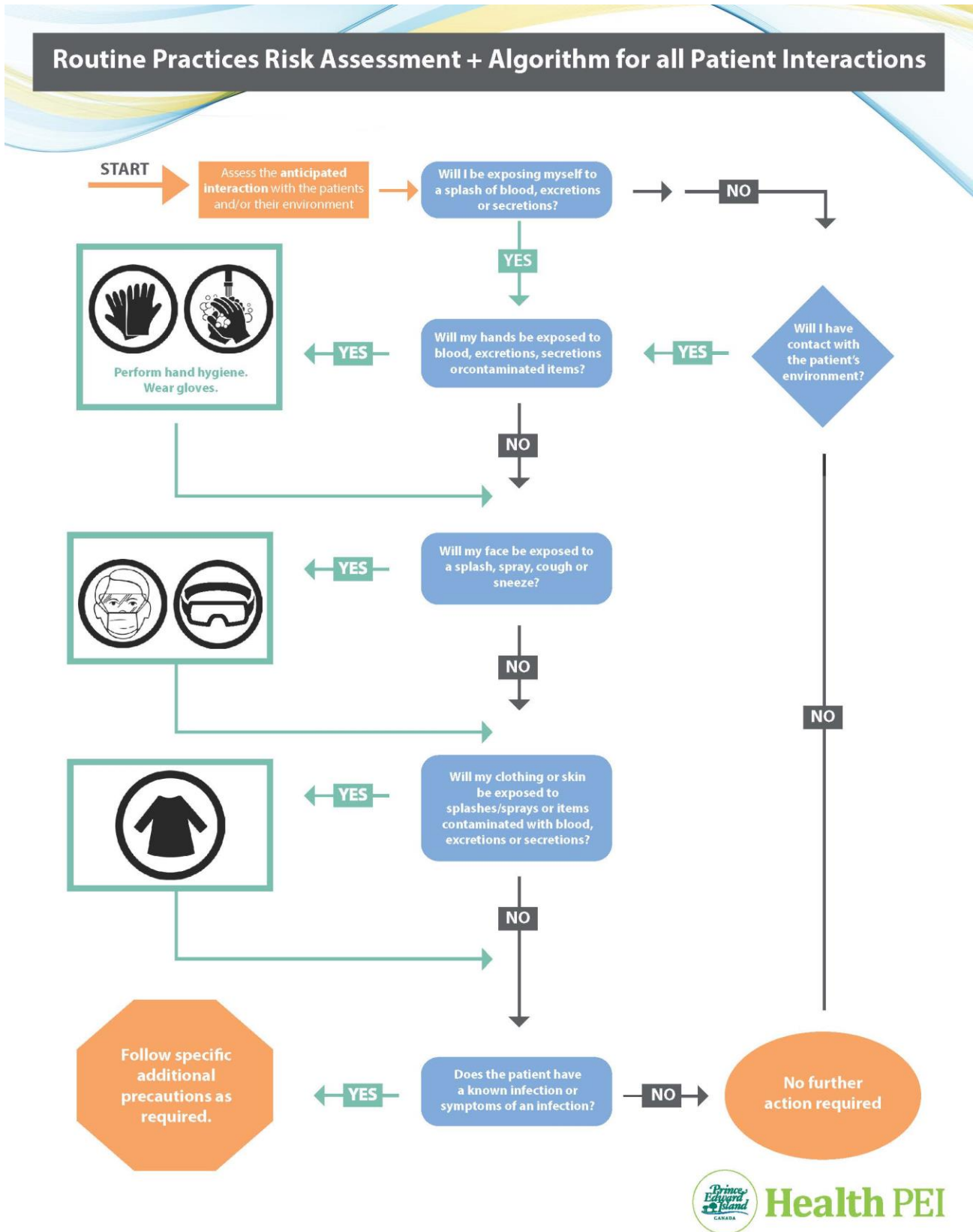
Table 1: Influenza Treatment and Post-Exposure Prophylaxis Dosages LTCF Only

Creatinine Clearance	Tamiflu Treatment	Tamiflu Prophylaxis
greater than 60 ml/min	75 mg capsule twice daily for 5 days	75 mg capsule once daily until outbreak is over
30 ml/min-60 ml/min	75 mg capsule once daily or 30 mg twice daily x 5 days	30mg capsule once daily until outbreak is over
10 - 30 ml/min	30 mg once daily for 5 days	30 mg capsule on alternate days until outbreak is over
Less than 10 ml/min (renal failure)	1 single 75 mg dose for the duration of illness	No data available Consult with primary physician or specialist
Residents on Dialysis	Low-flux HD: 30 mg at onset of influenza symptoms, then 30mg after each dialysis session	30 mg before dialysis, then 30 mg after alternate dialysis sessions
	High-flux HD: 75 mg after each dialysis session	No data available Consult with primary physician or specialist
	CAPD dialysis: 30 mg once before the start of dialysis CRRT high-flux dialysis: 30 mg daily or 75 mg every second day	30 mg before dialysis, then 30 mg once weekly No data available Consult with primary physician or specialist

Table 2: Facility Specific Information for Influenza Antiviral Medication Replacement for LTCF Only

Number of doses pre-positioned in the facility	75 mg:	30 mg:
Total # of residents at the facility:		
# Of residents who are symptomatic		
• # with CC greater than 60 ml/min:		
• # with CC 30 ml/min-60 ml/min:		
• # with CC < 10ml/min		
• # with CC 10 - 30 ml/min		
• # on dialysis		
# Of residents needing PEP:		
• # with CC greater than 60 ml/min:		
• # with CC 30 ml/min-60 ml/min:		
• #with CC < 10ml/min		
• # with CC 10 - 30 ml/min		
• # on dialysis		

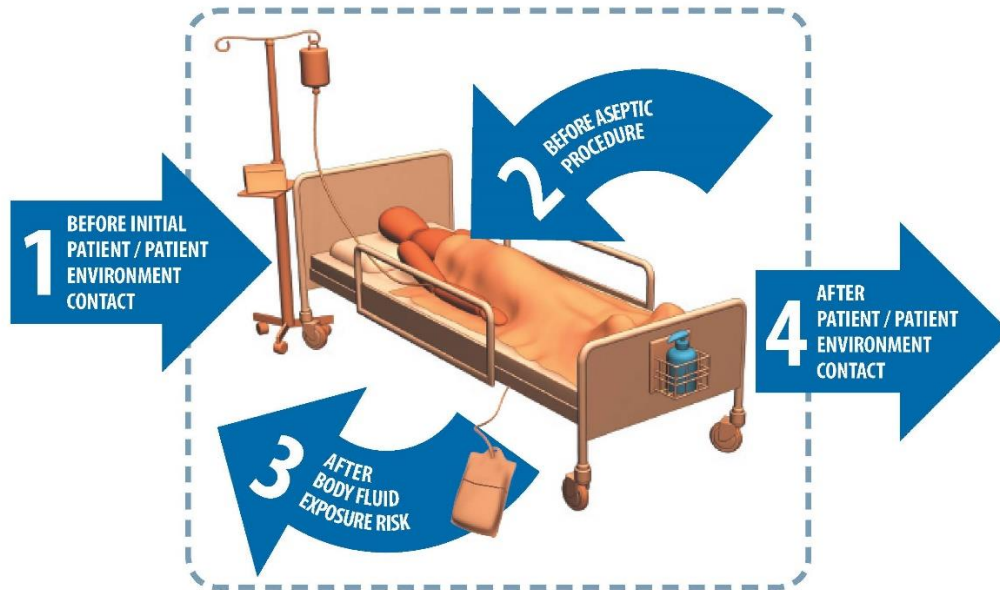
Appendix B – Point-of-Care Risk Assessment (PCRA)



Appendix C – Hand Hygiene



Your 4 Moments for Hand Hygiene



1 BEFORE initial patient / patient environment contact	WHEN? Clean your hands when entering: • before touching patient or • before touching any object or furniture in the patient's environment WHY? To protect the patient/patient environment from harmful germs carried on your hands
2 BEFORE aseptic procedure	WHEN? Clean your hands immediately before any aseptic procedure WHY? To protect the patient against harmful germs, including the patient's own germs, entering his or her body
3 AFTER body fluid exposure risk	WHEN? Clean your hands immediately after an exposure risk to body fluids (and after glove removal) WHY? To protect yourself and the health care environment from harmful patient germs
4 AFTER patient / patient environment contact	WHEN? Clean your hands when leaving: • after touching patient or • after touching any object or furniture in the patient's environment WHY? To protect yourself and the health care environment from harmful patient germs



Health PEI



Appendix D – Droplet and Contact Precautions



All Visitors and Staff Entering Room:

1



Wash hands with soap and water

or use

alcohol hand rinse.



2

Put on gown – fasten all ties.



3

Put on mask with visor – adjust top of mask to fit snugly over nose.



4

If no visor attached to mask put on goggles or face shield.



5

Put on gloves – extend gloves over gown cuffs.



Droplet/Contact Precautions

Health PEI

ONE ISLAND FUTURE



ONE ISLAND HEALTH SYSTEM

Contributors:

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All Visitors and Staff Leaving Room:

- 1 Remove gloves – grasp outside edge of glove near wrist and peel away from your body. DO NOT touch outside of glove. Place fingers inside second glove to remove.**



- 2 Remove gown – unfasten ties. Remove gown pulling away from body. DO NOT touch outside of gown.**



- 3 Exiting patient's room:**



Wash hands with soap and water or use alcohol hand rinse.



- 4 Remove goggles or face shield if worn. Remove mask – pull away from face using ear loops/ties. DO NOT touch outside of mask/visor.**



- 5 Wash hands with soap and water or use alcohol hand rinse.**



Wash hands with soap and water or use alcohol hand rinse.



Droplet/Contact Precautions

Health PEI

ONE ISLAND FUTURE

ONE ISLAND HEALTH SYSTEM

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Appendix E – How to Fit Check and Wear a N95 Respirator

Fit checking involves a quick check - each time the mask is put on - to ensure that the respirator is properly applied, that a good seal is achieved over the bridge of the nose and mouth and there are no gaps between the respirator and face. Fit checking is the appropriate minimum standard at the point of use for healthcare workers using N95 respirators. No clinical activity should be undertaken until a satisfactory fit has been achieved.

Instructions to fit check a N95 mask:

1. Place the respirator on your face.
2. Place the headband or ties over your head and at the base of your neck.
3. Compress the respirator to ensure a seal across your face, cheeks, and the bridge of your nose.
4. Check the positive pressure seal of the respirator by gently exhaling. If air escapes, the respirator needs to be adjusted.
5. Check the negative pressure seal of the respirator by gently inhaling. If the respirator is not drawn in towards your face, or air leaks around the face seal, readjust the respirator and repeat process, or check for defects in the respirator.

How to Wear a N95 Respirator

Donning the respirator



Cup the respirator in your hand with nosepiece at your fingertips. Allow the head straps to hang freely below your hand.



Put respirator up to your face. Take top strap to the crown of your head.



Take bottom strap up and over to the back of your neck below your ears.



Take both hands and shape the nosepiece firmly into the face by pushing inward and down.



Place both hands completely over the respirator without disturbing the position and exhale sharply. If air leaks around your nose, adjust the nosepiece. If air leaks around respirator edges, adjust the straps. If you cannot achieve a proper seal do not enter the contaminated area and see your supervisor.

Doffing the respirator



Never touch the respirator as it is contaminated. Only handle the straps. With both hands, take bottom strap up and over head. Gently drop in front of the respirator.



Slightly lean forward and take the top strap up and over. Gently pull away from face by the strap.



Deposit respirator gently into waste. Wash hands.

Appendix F – Procedure for Obtaining a Nasopharyngeal (NP) Swab

1. Use the swab supplied with the viral transport media.
2. Explain the procedure to the patient.
3. When collecting the specimens, don and doff personal protective equipment (PPE) which includes eye protection, gloves, and a mask. (Appendix E & F) Change gloves and wash your hands between each patient.
4. If the patient has a lot of mucus in the nose, this can interfere with the collection of cells. Either ask the patient to use a tissue to gently clean out visible nasal mucus or clean the nostril yourself with a cotton swab (e.g., Q-Tip).
5. How to estimate the distance to the nasopharynx: prior to insertion, measure the distance from the corner of the nose to the front of the ear and insert the shaft approximately 2/3 of this length.
6. Seat the patient comfortably. Tilt the patient's head back slightly to straighten the passage from the front of the nose to the nasopharynx to make insertion of the swab easier.
7. Insert the swab along the medial part of the septum, along the floor of the nose, until it reaches the posterior nares; gentle rotation of the swab may be helpful. (If resistance is encountered, try the other nostril as the patient may have a deviated septum.)
8. Allow the swab to sit in place for 5-10 seconds.
9. Rotate the swab several times to dislodge the columnar epithelial cells. Note: Insertion of the swab usually induces a cough.
10. Withdraw the swab and place it in the collection tube.
11. Remove PPE as per doffing.
12. Attach completed requisition with two unique patient identifiers on the swab and the requisition.
13. Refrigerate specimen until ready for transport to the laboratory.

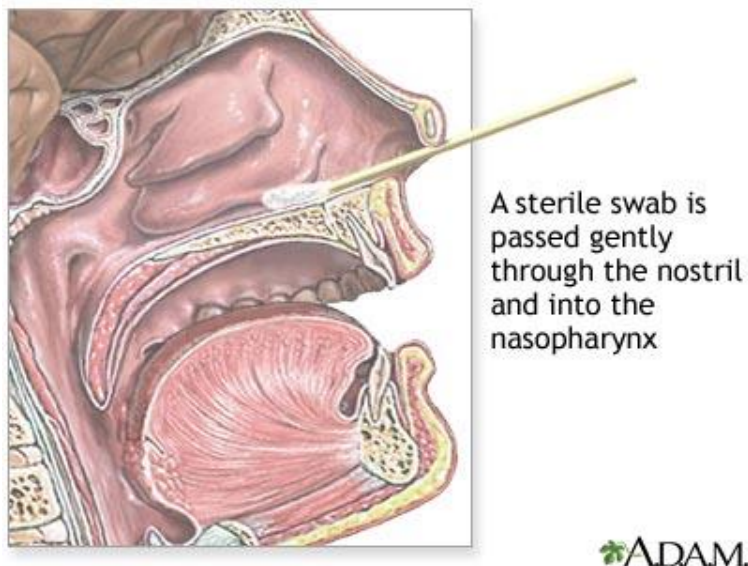


Image obtained from <https://medlineplus.gov/ency/imagepages/9687.htm>

Viral Respiratory Infections

Appendix G – Line List

Viral Respiratory illness- Surveillance Line List LTC and CCF									
Facility Name: _____					Date: _____				
RESIDENTS: Total Number of Residents _____					Number of Residents ill: _____				
Name, MRN, and DOB	Onset Date	Unit	Symptoms			Vaccine		Swabbed If Yes, Date	Comments
			<input type="checkbox"/> Fever	<input type="checkbox"/> Sudden onset cough	<input type="checkbox"/> Influenza Y or N	Date			
			<input type="checkbox"/> Muscle/body aches	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Covid Y or N	<input type="checkbox"/> Y or N			
			<input type="checkbox"/> Headache	<input type="checkbox"/> Other	<input type="checkbox"/> RSV Y or N				
			<input type="checkbox"/> Fever	<input type="checkbox"/> Sudden onset cough	<input type="checkbox"/> Influenza Y or N	<input type="checkbox"/> Date			
			<input type="checkbox"/> Muscle/body aches	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Covid Y or N	<input type="checkbox"/> Y or N			
			<input type="checkbox"/> Headache	<input type="checkbox"/> Other	<input type="checkbox"/> RSV Y or N				
			<input type="checkbox"/> Fever	<input type="checkbox"/> Sudden onset cough	<input type="checkbox"/> Influenza Y or N	<input type="checkbox"/> Date			
			<input type="checkbox"/> Muscle/body aches	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Covid Y or N	<input type="checkbox"/> Y or N			
			<input type="checkbox"/> Headache	<input type="checkbox"/> Other	<input type="checkbox"/> RSV Y or N				
			<input type="checkbox"/> Fever	<input type="checkbox"/> Sudden onset cough	<input type="checkbox"/> Influenza Y or N	<input type="checkbox"/> Date			
			<input type="checkbox"/> Muscle/body aches	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Covid Y or N	<input type="checkbox"/> Y or N			
			<input type="checkbox"/> Headache	<input type="checkbox"/> Other	<input type="checkbox"/> RSV Y or N				
STAFF: Total Number of Staff _____					Number of Staff ill: _____				
Name	Onset Date	Date Last Worked	Symptoms			Vaccine		Swabbed If Yes, Date	
			<input type="checkbox"/> Fever	<input type="checkbox"/> Sudden onset cough	<input type="checkbox"/> Influenza Y or N	Date			
			<input type="checkbox"/> Muscle/body aches	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Covid Y or N	<input type="checkbox"/> Y or N			
			<input type="checkbox"/> Headache	<input type="checkbox"/> Other					
			<input type="checkbox"/> Fever	<input type="checkbox"/> Sudden onset cough	<input type="checkbox"/> Influenza Y or N	<input type="checkbox"/> Date			
			<input type="checkbox"/> Muscle/body aches	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Covid Y or N	<input type="checkbox"/> Y or N			
			<input type="checkbox"/> Headache	<input type="checkbox"/> Other					
			<input type="checkbox"/> Fever	<input type="checkbox"/> Sudden onset cough	<input type="checkbox"/> Influenza Y or N	<input type="checkbox"/> Date			
			<input type="checkbox"/> Muscle/body aches	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Covid Y or N	<input type="checkbox"/> Y or N			
			<input type="checkbox"/> Headache	<input type="checkbox"/> Other					
			<input type="checkbox"/> Fever	<input type="checkbox"/> Sudden onset cough	<input type="checkbox"/> Influenza Y or N	<input type="checkbox"/> Date			
			<input type="checkbox"/> Muscle/body aches	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Covid Y or N	<input type="checkbox"/> Y or N			
			<input type="checkbox"/> Headache	<input type="checkbox"/> Other					

Fever = 1) single oral temp >37.8°C 2) Repeated oral temps >37.2°C or rectal temps >37.5° or 3) Single >1.1C over baseline from any site.

Any new or worsening respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat or difficulty swallowing), or

Any new onset non-respiratory symptoms including chills, muscle aches, diarrhea, malaise, headache, sudden loss of taste or smell or other unexplained symptoms or change in clinical s

Appendix H – Outbreak Signage



OUTBREAK!



Do not visit
if you are
sick

Visiting is
Restricted
Please check with
front desk
or staff

Clean Your
Hands
before entering
when leaving

In This Facility

**Protect Yourself
and Others**

