Interim Guidance for Respiratory Outbreak Management during Pandemic Transition

(Acute Care and Residential Care)

Provincial Infection Control-Newfoundland Labrador

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Revised: March 18th, 2022
Revised: March 29th, 2022
Revised: November 4th, 2022
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Summary of Revisions

Page	Revision	Date Revised
Page 5	Revision to swab collection requirement during an outbreak	November 29th, 2022
Page 11	Added patient or staff to transportation PPE recommendations	November 4th, 2022
Page 8	Updated testing requirement for asymptomatic individual from an outbreak site/facility/unit	November 4th. 2022
Page 6	Clarification of duration of precautions between acute care and residential care	November 4th, 2022
Page 12	New insert: Environmental Cleaning	November 1st, 2022
Page 11	New insert: PPE	November 1st, 2022
Page 10	New insert: AGMPs	November 1st, 2022
Page 8	Updated testing requirements	November 1st, 2022
Page 5	Updated Case and Contact Management	November 1st, 2022
Page 4	Updated outbreak definitions	November 1st, 2022
	Document title change	November 1st, 2022
Page 7	New insert: Testing Requirements under Admission/Transfers	March 29th, 2022
Page 7	New insert: Sentence under Leave of Absence clarifying testing requirement	March 29th, 2022
Page 4	Clarity of “Confirmed Outbreak” definition	March 18th, 2022

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Purpose

This document provides an interim guidance for decision making on IPAC measures during an outbreak of Respiratory Illness as we navigate through the pandemic transition phase.

Globally, there is evidence of increasing circulating respiratory viral transmission, including Influenza, COVID-19 and other respiratory viruses. In preparation for the upcoming cold and flu season, IPAC has reviewed and revised its outbreak management guidance for healthcare facilities and residential care to align with current epidemiology of circulating respiratory viruses, population vaccination status and new Public Health Case and Contact Management of COVID-19. (Link to new Case and Contact Management)

This document replaces the following archived IPAC COVID-19 documents:

Aerosol Generated Medical Procedures (AGMPs) for COVID-19 Patients
NL Guideline for Prioritization and Use of Personal Protective Equipment (PPE)
Long Term Care IPAC COVID-19 Management

Definitions

Acute Care and Residential Care facilities/homes:

Suspect Outbreak: One individual (resident/patient) with a laboratory confirmed organism who may have acquired or transmitted in the facility would trigger an Infection Prevention & Control (IPAC) investigation to determine whether an outbreak exists.

Confirmed Outbreak: Two or more individuals (resident/patient) with a laboratory confirmed organism in the facility for whom IPAC (In consultation with ID/RMOH as needed) has determined that healthcare acquired transmission likely occurred, with or without a known source.

Close Contact: A close contact of a positive case is anyone living in the same patient/resident environment (Roommate/s). It is at the discretion of Regional IPAC and the outbreak management team to determine if anyone outside the roommate would need to be considered for testing and/or isolation.

Patient/Resident Care Area: An area within a healthcare facility, hallway or lobby, which is accessible to patients, residents or clients who are there to access care or services. This includes home and community care settings.

Laboratory Confirmed: A laboratory confirmed test is a PCR (Polymer Chain Reaction) test for full respiratory panel (including COVID-19, Influenza A/B and other respiratory viruses) or a test completed for COVID-19 only by the Abbott ID Now or GeneXpert. A Rapid Antigen Test (RAT) is not considered a laboratory confirmed test.

Case and Contact Management of Respiratory Illness:

Residential Care Homes:

If a laboratory confirmed case of a respiratory virus is identified and it is a multi-bed room, the room is to be placed on precautions as per Table 1. If close contacts (roommates) develop symptoms, manage as per positive case. All other residents (outside room) to be monitored for signs and symptoms. Monitoring time dependent on laboratory confirmed organism (Table 1). It is at the discretion of Regional IPAC and the outbreak management team to determine if anyone outside the roommate would need to be considered for testing and/or isolation.

Acute Care:

If a laboratory confirmed case of a respiratory virus is identified and it is a multi-bed room, the room is to be placed on precautions as per Table 1. If close contacts (roommates) develop symptoms, manage as per positive case. All other patients (outside room) to be monitored for signs and symptoms. Monitoring time dependent on laboratory confirmed organism (Table 1). It is at the discretion of Regional IPAC and the outbreak management team to determine if anyone outside the roommate would need to be considered for testing and/or isolation.

Recommendation for Swab Collection during an outbreak:

In a suspect respiratory outbreak (including COVID), collect a minimum of 3 nasopharyngeal swabs on initial cases (to a maximum of 10, more if needed) until a result is confirmed (3 confirmed positive of same virus). Once the organism/s is confirmed, residents/patients who then present as symptomatic will be placed on Droplet-Contact Precautions as per protocol but further testing is not required for duration of outbreak. For the purpose of surveillance, continue with tracker submission of symptomatic residents/patients for confirmed COVID outbreaks, (only those with confirmed positives will be entered as confirmed cases, all others to be entered as probable). All other organisms are to be entered for data collection as per current protocol (e.g. CNPHI). It is at the discretion of IPAC (in consultation with ID and/or RMOH as needed) to determine if additional testing required. Considerations for additional testing may include changes in severity, new cases in a prophylaxed population during a confirmed flu outbreak, suspicion of a non-viral agent, new cases in other parts of a facility, ongoing cases after a substantial period of time, new cases after a long gap.

Note:

For full respiratory panel testing, specimens must be identified as one of the following (specimen labels and Meditech comments section):

IP: In-patient, ER-IN: ER in-patients, LTC: Long Term Care residents, RC: Residential care (including Personal Care Homes, Group Homes, Corrections, Shelters)

Table 1: Duration of Precautions for Respiratory Illnesses in any setting

Organism	Precautions /PPE	Duration of Precautions
SARS CoV 2 (COVID-19)	Droplet/Contact N95 for AGMPs Well fitted medical mask or N95 for routine care based on PCRA	**Residential Care:** Minimum of 5 days on precautions from symptom onset with 24hrs symptom improvement and no fever Then: 5 days of modified isolation (see below) **Acute Care:** Minimum of 5 days on precautions from symptom onset with 24hrs symptom improvement and no fever. Recommend masking (if tolerated) for the next 5 days post discontinuation of isolation. **IPAC must be consulted for appropriate patient placement if patient movement required within the 5 days post** Severe case or immunocompromised: minimum of 20 days or as per clinical judgement
Influenza (A/B)	Droplet/Contact N95 for AGMPs Well fitted medical mask or N95 for routine care based on PCRA	Minimum of 5 days on precautions if symptom improvement with no fever for 24hrs may discontinue
Other respiratory viruses (RSV, EV, hMPV, etc.)	Droplet/Contact N95 for AGMPs Well fitted medical mask or N95 for routine care based on PCRA	Duration of symptoms Symptom improvement with no fever for 24hrs
N95 worn for all patients/residents on some form of Droplet or Airborne Precautions undergoing an AGMP		
If co-infection (COVID and another respiratory virus) manage as per COVID protocol		
***Modified Isolation(Residential Care):** • Encourage mask wearing outside of room if tolerated • Remain in the affected area until modified isolation ends • May participate in social activities in the affected area as determined by the Outbreak Management Team (Residential Care)		

Admissions/Transfers

Outbreak Site:

Creating capacity in the acute and residential care system and ensuring access to service during this transition period requires deliberate decision-making. The ultimate goal is for residents and patients to be cared for safely in an environment that best meets their care needs.

IPAC and the Outbreak Management Team, in consultation with the ID/RMOH (as necessary) should consider the following prior to an admission/transfer to a suspect or confirmed outbreak site/facility/unit:

- Admissions/transfers may occur during a suspect or confirmed outbreak to an unaffected or non-outbreak area (i.e., unit/floor/wing). These areas should be clearly identified.
- Admissions/transfers to an affected or outbreak area may be considered only if necessary. Circumstances may include patient/residents' current level of safety and well-being, lack of beds (urgent).
- Patients/residents with laboratory confirmation of the same organism may be cohorted together.
- Any attempt to cohort must be approved by IPAC prior to occurring.
- If possible, HCWs should be cohorted to work in either the outbreak area or the non-outbreak area.
- If not possible due to staffing shortages, care should be provided to patients/residents in the non-outbreak area first.
- Consider patient/resident ability to follow IPAC measures, wandering patient/residents for example, may be at risk and require additional care during the outbreak period.
- To minimize risk of an immunocompromised or high-risk patient/resident, consider admitting under Droplet/Contact Precautions. The Outbreak Management Team to assess daily.

Prior to admission, the patient and/or substitute decision-maker should be notified of the plan. Safety measures in place to reduce the risk of exposure to respiratory viruses should be discussed.

Non-outbreak Site:

A non-outbreak site may accept an admission/transfer from an outbreak site/unit/facility (i.e., outbreak in acute care to LTC) based on recommendations of the Outbreak Management Team. The considerations listed in "Admissions/Transfers" may apply. A symptomatic admission or asymptomatic admission/transfer from an outbreak site/unit/facility should preferably be

admitted to a private room. If a private room is not available, consult with Regional IPAC for appropriate placement.

Screening Tool

All patients and residents will be screened for symptoms of respiratory viral illness as per the most recent updated screening tool.

Testing Requirements (outbreaks)

- Residents/patients admitted **from Community** will be screened upon admission and monitored for symptoms, testing will be based on screen results.
- Residents/patients admitted/transferred **from a non-outbreak** site/unit/facility:
  - ✓ Asymptomatic- screen and monitor for symptoms
  - ✓ Symptomatic or positive screen- test and isolate upon admission as per screening tool
- Residents/patients admitted/transferred **from an outbreak** site/unit/facility:
  - ✓ Asymptomatic- screen and isolate x5 days. Monitor for symptoms (If resources allow, may swab at 72hrs and if negative may discontinue precautions)
  - ✓ Symptomatic or positive screen- test and isolate upon admission as per screening tool
- Residents/patients admitted/transferred **to an outbreak** site/unit/facility:
  - ✓ Routine admissions/transfers may occur to **areas not affected** in a facility outbreak-notify IPAC of all admissions
  - ✓ Asymptomatic- screen and monitor for symptoms
  - ✓ Symptomatic or positive screen- test and isolate upon admission as per screening tool
  - ✓ Admissions/transfers may occur **to an outbreak affected** area in consultation with IPAC, Outbreak Management Team and ID/RMOH (as needed)

See section “Aerosol generating medical procedures” for guidance on testing requirements for AGMPs.

Declaring an Outbreak Over

An outbreak may be declared over 10 days from the last day of exposure(COVID and Influenza A/B outbreaks) or as determined by IPAC and the Outbreak Management Team (other respiratory viruses) in consultation with ID/RMOH as needed.

Visitation/Leave of Absence

Limited visitation will continue during an active confirmed outbreak and reassessed by the Outbreak Management Team. Increase or decrease of visitation will be dependent on epidemiology within the facility/home. As per existing outbreak guidance, visitation for end of life and extenuating circumstances will be permitted.

Routine visitation for non-outbreak sites may continue with all visitors required to wear a medical mask upon entry to facility. Visitation guidance (numbers, duration, etc.) may be determined by the Regional Health Authority in consultation with Regional IPAC.

Leave of absence (any duration of time) may be considered during a confirmed outbreak for a resident in an area not affected by the outbreak as recommended by the Outbreak Management Team. Residents who leave the facility/home are encouraged to wear a mask (if tolerated) and not visit with family members who are symptomatic of a respiratory illness. Residents/patients returning from a Leave of Absence/Pass >24hrs will be screened and monitored for symptoms.

Activities

Social interaction is essential to our residents' mental and physical well-being. During prolonged periods of isolation due to an active facility outbreak, social interaction among residents is limited. The Outbreak Management Team may consider low risk social activities for residents unaffected by a facility outbreak. The same consideration may be given to residents' not on isolation but are confined to a specific area that is affected by an active outbreak.

Planned events may continue in a non-outbreak site taking into consideration the facility layout and capacity. Masking and distancing to the greatest extent possible to continue. Planned facility events may be done so in consultation with Regional IPAC.

Aerosol Generating Medical Procedures (AGMPs)

AGMPs include procedures that mechanically create and disperse aerosols (e.g. bronchoscopy or tracheal intubation) and procedures that induce the patient to produce aerosols (e.g., the pressure on a patient's chest during chest compressions can induce a cough like force).

List of AGMPs
Autopsy involving respiratory tissue AND/OR the use of high-speed oscillatory tools
Bag-valve mask ventilation
Bronchoscopy
Chest compressions
Chest tube insertion under positive pressure ventilation
Intubation
Extubation
High flow oxygen/oxygen via nasal prongs > 5L/min **
High frequency oscillatory ventilation
Non-invasive positive pressure ventilation (CPAP, Bi-PAP)
Open airway suctioning (e.g. deep insertion for nasopharyngeal or tracheal suctioning, NOT inclusive of anterior oral suctioning)
Administration of nebulized medications (Note: Avoid if possible; use of alternatives such as meter-dose inhaler with spacer are preferred)
Sputum induction (i.e. inhalation of nebulized hypertonic saline solution to liquefy and produce secretions, NOT natural coughing to bring up sputum) includes cough assist devices
Tracheostomy insertion/care/tube change/decannulation. Note: Tracheostomy care does not include dressing changes or tie changes
Upper endoscopy

Testing prior to an AGMP will be based on clinical judgement. All symptomatic (including COVID-19, Influenza and other respiratory viruses) patients or residents requiring an AGMP will be managed with Droplet-Contact/Airborne (N95s). Asymptomatic patients and residents will

be managed as per PCRA. The use of an N95 is required when the infectious status of an individual is unknown.

Personal Protective Equipment (PPE)

List of PPE items required for Droplet Contact/Airborne Precautions:

Level 2 gown (long sleeve cuffed)
Nitrile gloves (12 inch)
Well fitted medical mask (Level 2 or 3 ASTM rated)
N95 respirator or equivalent (AGMPs)
Eye protection (full-face shield or goggles)

Table 2: PPE

Setting	PPE required or recommended	Staff	Visitors (including volunteers, contractors, etc.)
Patient/Resident care area (See definition)	Well fitted medical mask or PPE as per RPAP signage required	Yes	Yes
All remaining areas outside Patient/Resident care area	Well fitted medical mask strongly recommended	Yes	Yes
Entry to healthcare facilities	Well fitted medical mask required	Yes	Yes
Meeting rooms	Well fitted medical mask strongly recommended and distancing to the greatest extent possible if mask not worn	Yes	Yes
Gatherings	Well fitted medical mask strongly recommended and distancing to the greatest extent possible if mask not worn	Yes	Yes
Transportation (RHA vehicles)	Well fitted medical mask strongly recommended If patient transport, well fitted medical mask required	Yes	Yes
AGMPs	N95 for all symptomatic patients/residents Asymptomatic patients/residents well fitted mask or N95 based on PCRA	Yes	Yes

As per the Precautionary Principle it is the right of any Healthcare Worker to choose an item of PPE based on a PCRA (Point of Care Risk Assessment)

Environmental Cleaning

Isolation rooms will be cleaned twice a day as per Additional Precautions protocols. During a surge or increased activity of respiratory illness, increase routine cleaning of high touch surface areas to twice a day and as needed.

References

Aerosol Generating Medical Procedures for COVID-19 positive patients (2021). Provincial PPE Task Force.

Department of Health and Community Services (2022). Most prevalent Omicron symptoms in NL December 15th 2021-August 24th 2022.

Newfoundland Labrador Guideline for Prioritization and Use of PPE (2021). Provincial PPE Task Force.

https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_congregate_living_guidance.pdf

https://www.gov.nl.ca/covid-19/files/Covid-Exposure-Flowchart-2021-FINAL.pdf

https://www.gov.nl.ca/covid-19/files/LTC-Guidance-July-7-2021.pdf

https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/guidance-documents/signs-symptoms-severity.html

https://www.gov.nl.ca/covid-19/

http://www.bccdc.ca/Health-Professionals-Site/Documents/Mask_Use_Health_Care_Facilities.pdf