RESPIRATORY ILLNESS AND GASTROINTESTINAL ILLNESS OUTBREAK MANAGEMENT: ACUTE AND LONG-TERM CARE FACILITIES

Note: *where the term patient is used, it shall be interpreted as referring to patient, resident, or client*

IDENTIFICATION AND CONFIRMATION OF OUTBREAK

IDENTIFICATION OF OUTBREAK

Report suspect outbreak to IP&C/designate.

IMPORTANT info to report

- ☐ Total number of symptomatic patients
- ☐ Onset date of initial cases
- ☐ Laboratory or diagnostics completed as ordered by site primary care provider
- ☐ Location of outbreak in facility (I.e., unit, area)
- ☐ IP&C measures implemented

Case definition for cases and outbreak definition must be met prior to declaring outbreak.

Regional IP&C/designate will review definitions and will advise whether outbreak declared or to continue monitoring.

INITIAL IP&C MEASURES

Implement Additional Precautions for confirmed/suspect cases

Respiratory/Influenza-like Illness

- Implement **Droplet/Contact Precautions**
- If cohorting required, consult Regional IP&C/designate

NOTE: Until COVID-19 is ruled out, all patients who meet respiratory/ILI case definition to initially be placed on Droplet/Contact Precautions with Airborne for AGMPs.

COVID-19

- Implement **Droplet/Contact Precautions with Airborne for AGMPs**
- Refer to COVID-19 Cohorting Guidelines. If cohorting is necessary, consult Regional IP&C/designate
- For more information, see COVID-19 Resources - Shared Health (sharedhealthmb.ca)

Gastrointestinal Illness

- Implement **Contact Precautions**
  - Dedicate a toilet/commode for patients experiencing GI symptoms
- ABHR is appropriate to use when caring for patients with *C. difficile*, except in outbreak or hyperendemic (sustained high rates) settings, when handwashing with soap and water is recommended.
- If cohorting required, consult Regional IP&C/designate

NOTE: Until COVID-19 is ruled out, all patients who meet COVID-19 suspect criteria (i.e., >24 hours vomiting or diarrhea) to initially be placed on Droplet/Contact Precautions with Airborne for AGMPs.

RESPIRATORY ILLNESS AND GASTROINTESTINAL ILLNESS OUTBREAK MANAGEMENT: ACUTE AND LONG-TERM CARE FACILITIES

cont'd **INITIAL IP&C MEASURES**	**Implement the following measures:** • Promote and reinforce hand hygiene • Promote and reinforce cough/respiratory etiquette • Heighten surveillance to identify symptomatic patients • Review availability of supplies (i.e., PPE) • Increase requirement for equipment and environmental cleaning and disinfection
SPECIMEN COLLECTION	Collect specimens to identify a causative organism(s), as recommended by IP&C/designate. These must be submitted with the appropriate Cadham outbreak code noted on them. If possible, collect specimens early in the outbreak. **Specimen Collection Resources** ▪ Respiratory Specimen Collection ▪ GI Illness Specimen Collection ▪ Outbreak Sample Cadham Lab Req

RESPIRATORY ILLNESS AND GASTROINTESTINAL ILLNESS OUTBREAK MANAGEMENT: ACUTE AND LONG-TERM CARE FACILITIES

OUTBREAK DECLARED

OUTBREAK CONFIRMATION	Regional IP&C/designate will communicate to site/facility that outbreak declared (if not already provided, will provide CPL Outbreak Code) IP&C/designate to establish working case/outbreak definition. Site to maintain/implement Additional Precautions for confirmed/suspect cases as per initial IP&C measures above.
NOTIFICATION	Facility staff to submit outbreak line list as per site specific process to IP&C/designate upon initial identification of outbreak, followed by once daily until outbreak declared over. Line lists examples can be found here.
SIGNAGE	Post at entrance to facility/unit where outbreak is occurring: Outbreak Signage  All patients on Additional Precautions shall have signage posted prior to entry into their room/area:   Shared Health Additional Precaution Signage

RESPIRATORY ILLNESS AND GASTROINTESTINAL ILLNESS OUTBREAK MANAGEMENT: ACUTE AND LONG-TERM CARE FACILITIES

OUTBREAK MANAGEMENT TEAM	For small unit or area specific outbreak, form an outbreak management team – team members should represent those disciplines that may have an impact on the outcome (e.g., senior leadership, nursing, infection prevention and control, housekeeping, physicians, allied health, manager, epidemiologist, director, pharmacy, communications). For large or significant epidemics, incident command structure may be used (or already exist) with site leadership and alternative communication/management processes in place.
REPORTING AND COMMUNICATION	In Manitoba, outbreaks are reported by IP&C/designate through the CNPHI Online Outbreak Reporting System. Additional notification regarding an outbreak must follow SDO requirements: • Staff to notify patients and substitute decision makers, as directed by site leadership. • IP&C/designate to provide verbal and/or written reports to appropriate stakeholders within the unit/facility and/or SDO (e.g., Senior Leadership) • Managers of the specific areas of care to provide verbal and/or written information to their staff regarding outbreak • Following communication from IP&C/designate, Chief Medical Officer (CMO) or Medical Director to notify physician(s) of outbreak and associated control measures If Outbreak Management Team (OMT) meetings take place, may refer to Outbreak Management Team Meeting Template. If GI outbreak, refer to Manitoba Enteric Illness Protocol regarding public health inspector notification.
IMMUNIZATION	Depending on causative organism, review vaccination status of patients and offer as needed according to guidelines.
ANTIVIRAL PROPHYLAXIS	In the event of a confirmed influenza outbreak, oseltamivir (Tamiflu®) is an antiviral medication recommended for treatment and prophylaxis against seasonal influenza. Facility Medical Director/MOH consultation and orders are required. Refer to Manitoba Health Seasonal Influenza Protocol.
OCCUPATIONAL HEALTH	During each outbreak, Occupational Health will provide direction for absenteeism, staff testing (if applicable) and staff vaccination (if applicable) according to the recommendations of OMT/established OESH policies/current Communicable Disease Guidelines. Ideally, it is recommended staff work only in one facility during an outbreak. If staff are permitted to work between facilities, they should ensure they self-screen for symptoms and change their uniform before commencing work at another facility.
COHORTING STAFF	Restrict or minimize movement of staff, students, and volunteers between units/floors and common areas as possible. Cohort staff assignments as much as possible. Where possible, staff should work only with symptomatic or well patients, but not both. Refer to COVID-19 Cohorting Guidelines (sharedhealthmb.ca).

RESPIRATORY ILLNESS AND GASTROINTESTINAL ILLNESS OUTBREAK MANAGEMENT: ACUTE AND LONG-TERM CARE FACILITIES

DISCONTINUATION OF PRECAUTIONS

Consult IP&C designate prior to discontinuation of precautions

ILI/Respiratory (non-COVID)

- Discontinue precautions for suspected or confirmed non-ventilated patients based on resolution of symptoms
- Discontinue precautions for suspected or confirmed ventilated patients based on clinical improvement for 48 hours

COVID-19 (confirmed case)

See Quick Reference Guide Testing and Clearance – Acute, Long Term, and Home Care

GI (non-COVID)

Discontinue precautions based on symptom resolution 48-72 hours after the last episode of vomiting or diarrhea. If causative organism known, refer to Manitoba Health and Seniors Care Routine Practices and Additional Precautions Part C, Table 6 for further guidance for duration of precautions

ENVIRONMENTAL/ EQUIPMENT CLEANING AND DISINFECTING

EQUIPMENT

- Facilities in declared outbreak or any room where Additional Precautions are in place SHALL NOT use open windows, portable fans or window/portable air conditioners
- Dedicate equipment if able. If not, all shared equipment must be cleaned and disinfected prior to use on the next patient
- Slings and sliders should be dedicated to the person receiving care or cleaned & disinfected, laundered prior to use on another patient
- Ensure wipeable materials used for any activities (e.g., electronic tablets or other devices, craft supplies, bingo cards, cooking utensils, linens, tools, etc.) are not shared unless appropriately cleaned and disinfected between each use
- Do not share items that cannot be easily cleaned and disinfected, discard instead

ENVIRONMENT

- Clean and disinfect patient room and dining room, as well as high-touch surface areas (e.g., doorknobs, telephone, call bells, bedrails, hallway handrails, light switches) at least twice daily and when visibly soiled. Resource: WRHA Isolation Occupied Patient Room
- A facility-approved disinfectant must be used to disinfect all surfaces, achieving the manufacturer's recommended wet contact time to ensure appropriate disinfection. Wet contact time is the time the surface must remain wet with disinfectant. Where there is ongoing transmission, Regional IP&C/designate may recommend a different disinfectant (e.g., sporicidal).
- After a case is determined to be recovered or is discharged, isolation room discharge cleaning/disinfection (i.e., terminal cleaning/disinfection) is performed. Resource: WRHA Standard Operating Procedure Isolation Discharge Patient Room
- Clean shared areas e.g., lounge areas more frequently
- Dedicate housekeeping cart to the outbreak unit/area. If not possible, clean/disinfect the housekeeping cart before using in another area
- For rooms/bed spaces housing patients with vomiting or diarrhea, vomit and feces must be cleaned promptly, including items in immediate vicinity, followed by disinfection
- Dedicate bathroom to patient. If not possible, use dedicated commode and/or consider use of disposable absorbent waste management system in commodes so waste is not dumped into the toilet contaminating the bathroom.

RESPIRATORY ILLNESS AND GASTROINTESTINAL ILLNESS OUTBREAK MANAGEMENT: ACUTE AND LONG-TERM CARE FACILITIES

<table>
<tr><td>LAUNDRY / DISHES/ GARBAGE</td><td colspan="3">
<table>
<tr><th>Laundry</th><th>Dishes</th><th>Garbage</th></tr>
<tr>
<td>Continue to follow Routine Practices.
Staff should wear PPE if there is risk of contamination of employee clothing from bodily fluids or secretions. Ensure soiled linen is handled as little as possible, with minimum agitation, and transported in closed bags. Double bagging is not necessary unless the inner bag is leaking.</td>
<td>• Continue to follow Routine Practices
• Observe the requirements for PPE when Additional Precautions are in place (e.g., gloves for Contact Precautions)</td>
<td>• Continue to follow Routine Practices
• Place garbage in a leak-proof bag and close securely before removal from the patient’s room
• Double bagging is not necessary unless the bag is leaking</td>
</tr>
</table>
</td></tr>
<tr><td>NUTRITION SERVICES</td><td colspan="3">In the event of an outbreak, all kitchenettes, snack bars, snack trays, water coolers, ice machines, etc. should be closed to direct patient/visitor access. Staff will need to get patient’s snacks and drinks; sites are to come up with a unit process to meet this requirement.
Communal food for staff in lunch rooms, nursing stations, etc. is not recommended.
If GI outbreak and causative agent is foodborne – refer to Manitoba Enteric Illness Protocol.</td></tr>
<tr><td>ADMISSIONS</td><td colspan="3">When an outbreak is declared, admissions (including respite admissions) to outbreak unit/area are generally suspended unless the new admission is infected with the same outbreak organism.
If required, admissions (including respite admissions) will be assessed by the Care Team Manager/Supervisor on a case-by-case basis. Consult IP&C/designate as necessary. Consideration must be given to factors such as:
• Status of the outbreak, microorganism, severity of illness, and physical layout of the site
• Demand for capacity within the health system
• Patient factors (e.g., vaccination status, underlying medical conditions that increase risk of severe outcomes, signs and symptoms of infection)
  ○ Immunization should be offered to new admissions, as appropriate
• Risks and benefits of delayed admission (e.g., risks of exposure)
As part of the admission process, the patient/substitute decision maker must be advised of admission to a unit with an active outbreak. They shall receive information on measures that are/will be in place to prevent exposure.
If confirmed influenza outbreak, chemoprophylaxis should be offered as appropriate to the new admissions</td></tr>
</table>

RESPIRATORY ILLNESS AND GASTROINTESTINAL ILLNESS OUTBREAK MANAGEMENT: ACUTE AND LONG-TERM CARE FACILITIES

	Where the outbreak is COVID • New admissions may be considered if the patient is a recently recovered COVID-19 case within 120 days of positive test or if the patient is COVID-19 positive • **If Acute Care Facility** - Guidance for Admission To, Discharge and/or Transfer from Acute Care • **If LTC Facility** – for additional info regarding admissions, refer to COVID-19 Infection Prevention and Control Guidance for Personal Care Homes
TRANSFERS	**Intra-Facility Transfers** • The transfer of cases with suspected or confirmed illness within a health care facility should be restricted to medically necessary tests and procedures. Time spent outside of the room should be minimized. • Ensure advance notification of IP&C measures to receiving department (e.g., laboratory, diagnostic imaging). • Patients from outbreak units with known exposures must be managed as suspect cases and placed on additional precautions for duration of incubation period. Patients from outbreak units with no known exposures must have a risk assessment completed to determine if additional precautions are indicated. • When transfer is required, use appropriate PPE at all times. **Inter-Facility Transfers** **Notify the transport team staff and the receiving facility** in advance that there is an outbreak at the sending facility. This allows the transport team staff and the receiving site to prepare and ensure appropriate precautions are in place during transfer and upon arrival.
VISITATION	**Visitation will be restricted**. Designated caregivers can continue in order to meet care needs of the patient. **General visitors are not normally permitted** during an outbreak except in certain situations (e.g., end of life). Refer to: Visitor Access Acute and Long Term Care Advise those who visit during an outbreak to practice good hand hygiene, to wear appropriate personal protective equipment (PPE), and to not visit more than one patient within the facility. Offer Information for Families and Visitors During an Outbreak, Respiratory Hygiene (English) (French),and Clean Hands Saves Lives (English) (French).
ACTIVITIES/ THERAPIES	• **Cease large group activities**. Instead offer small group activities with those who are well and not symptomatic. For those symptomatic or recovering, 1:1 activity is appropriate. • **Cancel or postpone previously scheduled activities** (e.g. entertainers, school groups, community presentations and/or communal meals for special holidays) until the outbreak is declared over. • Continuation of hair dressing services is dependent on where the outbreak is occurring in the facility and may be cancelled/continued at the discretion of the facility or ICP/designate.

RESPIRATORY ILLNESS AND GASTROINTESTINAL ILLNESS OUTBREAK MANAGEMENT: ACUTE AND LONG-TERM CARE FACILITIES

	• Medically necessary activities such as foot care, physiotherapy, occupational therapy, rehab, etc. may continue. Organize workflow to minimize risk of transmission. • Requests for Leave of Absence or Day Pass should be reviewed by manager in consultation with IP&C/designate. If approved, patients should be advised that if they become symptomatic while away from their unit/facility, they should return to or contact their unit/facility, or seek medical attention. • **Previously booked non-patient events** (e.g., meetings, staff in-services) in an outbreak unit/facility **should be cancelled or postponed** to minimize risk of exposure to others. • If the outbreak facility operates a day program, discuss postponement of this program with Management. Usually programs may continue to operate in a facility with an ongoing outbreak if: 1. The day program is operating in an area separated from areas of the facility in which there have been symptomatic cases (may consider an alternate location for day program). 2. Patients attending the program do not socialize with patients from the outbreak facility. 3. Day Program staff do not provide care in areas of the facility in which there have been outbreak cases. • Community health-based programs based in a facility that is experiencing an outbreak (i.e., Meals on Wheels Programs) should be assessed on a case-by-case basis.
DISCHARGES	Cases who are to be discharged from hospital should be assessed for the stage of their exposure or disease. Additional measures may be put into place, such as self-monitoring. If the patient had been ill, but is well enough to go home and is still within the period of communicability, they will be instructed regarding appropriate precautions to avoid transmitting illness to others.
MONITORING / SURVEILLANCE	Ongoing surveillance is required during an outbreak to quickly detect new cases, in order to take necessary steps to prevent, and control further transmission. All health care settings must have a system in place to communicate cases of new/additional infections to appropriate stakeholders according to SDO policy. Patients must be monitored closely for signs and symptoms of illness. Staff working in healthcare settings must also self-monitor for symptoms. Staff members who are feeling unwell at work must report to their supervisor or manager and leave work immediately, remaining off work until they meet the criteria to return to work.

RESPIRATORY ILLNESS AND GASTROINTESTINAL ILLNESS OUTBREAK MANAGEMENT: ACUTE AND LONG-TERM CARE FACILITIES

OUTBREAK TERMINATION

OUTBREAK TERMINATION

Outbreaks are declared over by the ICP/designate; consult with IP&C physician, MOH, and/or LTC Medical Director as required. The guideline for declaring an outbreak over is the following

ILI / RESPIRATORY	COVID-19	GASTROINTESTINAL
▪ If the causative agent is known, an outbreak may be declared over when there are no new cases after 2 incubation periods following appropriate isolation of the last case. ▪ If the causative agent is unknown, an outbreak may be declared over after 8 days with no new cases following appropriate isolation of the last case.	▪ An outbreak may be declared over after 7 days with no new COVID-19 HAI cases starting after the last case was appropriately isolated and/or left the facility ▪ For Acute Care, see: https://sharedhealthmb.ca/files/IPC-acute-care-manual-provincial.pdf ▪ For Long Term Care, see: https://sharedhealthmb.ca/files/covid-19-ipc-guidance-for-pch.pdf	▪ If the causative agent is known, an outbreak may be declared over when there are no new cases after 2 incubation periods following appropriate isolation of the last case. ▪ If the causative agent is unknown, an outbreak may be declared over when there have been no new cases for 72 hours after the resolution of acute symptoms of the last identified case. It is important that vigilant observation for new cases continues even after the outbreak is declared over, especially when the causative agent has not yet been identified.

EVALUATION

Evaluate your facility's response to and management of the outbreak. Refer to Outbreak Management Evaluation Questionnaire.

A debriefing session can be used to learn from the outbreak within two weeks of declaring it over.

IP&C/designate will complete the final CNPHI report.