NORTH ZONE OUTBREAK MANAGEMENT FAQs

(Questions and answers may not apply to all outbreak settings)

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Patient/Resident/Client Restrictions

Q1: Why is it okay for well patients/residents/clients to gather together for meals but not for social activities; are meals in a common room considered a social activity?

A1: Meals are a required dietary service for patients/residents/clients and are not considered to be a social activity. Infection control measures are in place to reduce the potential for transmission during meal times (i.e. patients/residents/clients are gathered for meal time only, common touch items have been removed from tables, hand sanitizer is available prior to eating, etc.). Patients/residents/clients on precautions are to be fed in their rooms and are not to eat in the dining room with well patients/residents/clients.

Q2: Can shared/communal resident self-serve nutritional areas/kitchenettes remain open during an outbreak?

A2: No, as commonly touched items may pose an infection risk.

Q3: Some facilities have public laundry rooms for patient/client/resident use. Can patients/residents/clients use these facilities if they are symptomatic?

A3: If possible, only well patients/residents/clients are to use public laundry rooms during an outbreak. This eliminates cross-contamination issues between clean and dirty laundry.

If it is necessary for symptomatic/isolated residents to do laundry, the facility should contact the outbreak lead for guidance. Options may include:

- If they have more than one separate public laundry area, may designate one laundry area for use by symptomatic residents
- If they have only one public laundry area, may designate a day per week for symptomatic/isolated resident use, or may allow symptomatic/isolated resident use at end of day. Either of these options require a thorough cleaning of the area prior to allowing regular resident use to resume.

Q4: Can patients/residents/clients leave the facility during an outbreak?

A4: Yes, provided the patient/resident/client is asymptomatic, they are able to come and go from the site, including attending their own medical appointments. Visiting other persons at acute care sites, congregate living sites and child care facilities is discouraged.

Q5: Can family members take patients/residents/clients home during an outbreak?

A5: Yes. However, family members are to be informed about the potential for spread of illness throughout the household. If the patient is symptomatic when they return to the facility, the patient will be isolated for 48 hours after their last symptom.

Q6: Are volunteer activities/group recreation therapy cancelled during an outbreak?

A6: Yes

Q7: Which facility activities are cancelled during an outbreak?

A7: All group activities and events are cancelled when an outbreak is declared. In some facilities, complete cohorting of staff and patients/residents/clients is possible and the affected wing or pod can be completely separated from the other areas of the facility. In this case, activities may be permitted on the unaffected wing or pod, as per your Outbreak Response Lead's discretion. If cases of illness are observed on the unaffected area, all activities are cancelled throughout the site until the outbreak is declared over. All volunteer activities such as clergy, recreational therapy, and hair dressing are also to be cancelled.

Q8: Can the facility host meetings, learning fairs, open houses for visitors during an outbreak?

A8: Consult with your outbreak response lead to determine if these activities will present a risk based on your physical environment.

Q9: Are essential services restricted during an outbreak?

A9: No. Direct 1 on 1 delivery of care is permitted (i.e. community care coordinators, respiratory technicians, physicians, food delivery, etc.).

Q10: Are resident transfers permitted to a higher level of care (e.g. Emergency Department) during an outbreak?

A10: Yes. It is the responsibility of the outbreak facility to notify BOTH the EMS transfer team and the receiving facility of the outbreak.

Q11: Are new resident admissions or hospital discharges back to the facility permitted during an outbreak?

A11: No. In general, new resident admissions, or resident discharges from hospital if the hospital admission date was prior to the start date of the outbreak are not permitted. In extenuating circumstances, the case may be reviewed by the Medical Officer of Health (MOH). If the hospital admission was initiated during the outbreak, for symptoms consistent with the outbreak, readmission to the outbreak facility may occur.

Q12: What is cohorting?

A12: Cohorting is a technique used to limit the spread of infection. Staff cohorting is achieved by assigning certain staff member(s) to only patients/residents/clients that are symptomatic, with other staff member(s) taking care of the asymptomatic patients/residents/clients. In smaller units, partial/modified staff cohorting can be done by assigning the single caregiver to provide care to all asymptomatic

patients/residents/clients first, followed then by care to symptomatic patients/residents/clients. All usual PPE requirements would still need to be followed.

Patient/resident/client cohorting is not always possible in the physical environment, but may be used to group symptomatic individuals with the same lab-confirmed illness for purposes of care.

Q13: When is tray service required for patients/residents/clients?

A13: Tray service is required for symptomatic patients/residents/clients and those who are on additional precautions (isolation).

General Site Restrictions

Q14: Can the facility continue to serve guest meals during an outbreak?

A14: No, guest meals are to be cancelled during an outbreak.

Visitor Restrictions

Q15: Are visitors restricted during an outbreak?

A15: Visitors are to be informed that an outbreak is occurring and to visit one patient only and not go from room to room. Visitors of symptomatic patients/residents/clients are to be instructed in the use of PPE, and should wear appropriate PPE.

Duration of Restrictions

Q16: How long do infection control measures have to remain in place?

A16: Infection control measures remain in place until the outbreak is declared over by the Medical Officer of Health (MOH).

Handwashing

Q17: Does the use of hand sanitizer eliminate the requirement for proper hand washing?

A17: No. Alcohol-based hand rubs containing a minimum of 70% alcohol are as effective as soap and water **when hands are not visibly soiled**. Wash hands with soap and water if visibly soiled, or they feel dirty.

Disinfection

Q18: Is a quaternary ammonium compound (Quat) acceptable for disinfecting contact surfaces during an outbreak?

A18:

(i) Gastrointestinal Outbreaks: No. The following disinfectant categories/concentrations are recommended for disinfecting surfaces and equipment during GI illness outbreaks (follow manufacturer's directions for use):

1. Hypochlorite at a concentration of 1000 parts-per-million. Commercially available hypochlorite-containing solutions are recommended.

   Note: Freshly (i.e. daily) prepared, properly diluted household bleach solutions (e.g. 20ml of 5.25% sodium hypochlorite in 1 litre of water) can also achieve this concentration; however, these may not be effective for all GI outbreaks, or appropriate in all situations (e.g. may damage some surfaces or equipment). Diluted household bleach is a disinfectant only, not a cleaner, so surfaces must be cleaned first with a detergent before disinfection can take place. There are no manufacturer's directions for use available, and so the needed contact time is not known.

2. A surface disinfectant with a Drug Identification Number (DIN) issued by Health Canada with a specific label claim against norovirus, feline calicivirus or murine norovirus. An example of a product with this label claim currently in wide use in AHS facilities is 0.5% accelerated hydrogen peroxide. There are other products available with this label claim.

Notes:

1. Equipment should be cleaned and disinfected only with a product listed in and following the procedures outlined in the manufacturer's directions for that equipment.
2. Surfaces must first be cleaned prior to disinfection (2 step process). If the surface disinfectant product used has cleaning properties (detergent/disinfectant) it may be used for both steps. Follow manufacturer's directions for use.

(ii) Influenza-like-illness Outbreaks: Always follow the disinfectant's manufacturer's directions including contact-time requirements. The thoroughness of cleaning is more important than the choice of disinfectant used. Influenza is inactivated by low level disinfectants. These have a DIN (Drug Identification Number) and a general "DISINFECTANT" claim. Examples include: 3% hydrogen peroxide; 0.5% accelerated hydrogen peroxide; quaternary ammonia products; phenolics; and bleach dilutions (1000 ppm strength i.e. 1:50 dilution of household bleach).

Personal Protective Equipment (PPE)

(E.g. gloves, gowns, masks, protective eyewear/ face shields)

Q19: When is PPE required?

A19: Before starting any task, assess the risk of acquiring/spreading infection:

- Note any potential contact you may have with body fluids, stool or contaminated clothing/equipment/environment during patient/resident/client care (symptomatic or asymptomatic), patient transport or environmental cleaning/contact.
- Put on appropriate PPE to prevent acquiring/spreading infection.

Further information on PPE is available at: http://www.albertahealthservices.ca/6854.asp

Q20: During an outbreak should staff have to wear PPE at all times when on an affected unit/ward/floor or only when entering a patient/resident/client's room or transporting a patient?

A20: Only when entering the patient/resident/client's room or transporting the patient/resident/client. Note: tasks that require only a brief entry and exit from the room may not require the use of PPE. These special situations must be discussed with Infection Prevention and Control (IPC) or the Outbreak Response Lead.

Q21: During a confirmed influenza outbreak, does personal protective equipment have to be used by staff who are immunized or taking prophylactic antivirals?

A21: Yes. There is the possibility of vaccine or antiviral failure that could result in staff infection. If PPE is not used, there is also a risk of indirect transmission from health care worker clothes and skin.

Q22: Does PPE have to be changed when staff move from one ill patient to another ill patient even within the same room?

A22: Gloves, gowns, masks and protective eyewear should be changed. If there are questions, check with IPC or the Outbreak Response Lead.

Q23: If personal protective equipment is effective in preventing transmission, why is it important to be immunized or take prophylactic antivirals during a confirmed influenza outbreak?

A23: Use of PPE alone might lead to the occasional human error which could lead to transmission. Immunization will also protect workers against sources of infection outside the workplace.

Q24: When should N95 respirators be worn?

A24: An N95 respirator is breathing protection that is individually fitted to a user. It is used by clinical staff during specific procedures only - staff should check with their Workplace Health and Safety for recommendations prior to use. Visitors do not require masks to visit residents during outbreaks. Hand hygiene and routine precaution protocols should be followed at all times.

Influenza and Influenza-Like Illness Outbreaks

Q25: Does annual influenza immunization help prevent influenza outbreaks?

A25: Yes. Influenza immunization significantly reduces the risk of becoming ill with influenza, as well as reduces the chance of spreading influenza to others. It is important to get immunized for influenza annually, as circulating strains do change, and the vaccine is updated accordingly.

Q26: If an outbreak is caused by lab-confirmed influenza, who is eligible for antiviral prophylaxis?

A26: With authorization from the Medical Officer of Health (MOH), all asymptomatic residents who reside in the declared outbreak wing/area of the Congregate Living Settings (CLS) facility are eligible for antiviral prophylaxis.

- Funding is provided through the Alberta Blue Cross program for patients/residents/clients
- CLS is defined as a facility in which the Supportive Living Licensing Act applies, or a homeless shelter or a group home are eligible for funded antivirals.

Further information for pharmacies is available at:
https://www.ab.bluecross.ca/pdfs/pharmacy-benefacts/pharmacy-benefact-757.pdf

Those **not eligible** for publicly-funded antivirals:

- Residents of long term care (LTC) facilities or nursing homes (as per the Nursing Homes Act) and patients in a hospital (as per the Hospitals Act).
- Healthcare workers (employees or volunteers) in CLS.
- Health care workers (employees or volunteers) at LTC facilities, nursing homes or hospital. The employer (e.g. AHS) is responsible for providing information regarding your eligibility for coverage.

Q27: If residents are immunized with the current year's influenza vaccine, why is antiviral prophylaxis being offered?

A27: Antiviral prophylaxis for residents provides additional protection against influenza during an outbreak in the facility.

Q28: In a lab-confirmed influenza outbreak, is antiviral prophylaxis required for staff immunized with the current year's influenza vaccine?

Q28: No. Current year's influenza vaccine is sufficient. However, in year(s) that there is a significant mismatch between vaccine and circulating strain(s), the Chief Medical Officer of Health may expand the antiviral prophylaxis eligibility to include immunized staff (e.g. 2014-15 influenza season).

Q29: Are symptomatic residents eligible for antiviral prophylaxis in a lab-confirmed influenza outbreak?

A29: No. If the resident is symptomatic, s/he should be assessed by her/his regular physician as there may be various causes for the underlying illness (es) that require physician assessment and treatment. It is the responsibility of the facility to make the attending physician aware.

Q30: Do staff require current influenza immunization to work in a confirmed influenza outbreak area?

A30: Yes. Influenza immunization (received >14 days prior) provides the best protection to the staff member against developing influenza, as well as transmitting influenza to other vulnerable individuals in his/her care. Alternatively, if staff have been immunized <14 days ago, or unimmunized, then they can take antiviral prophylaxis until 14 days after the immunization,

Or for the duration of the outbreak if unimmunized.

Q30: How does a seniors' living facility arrange for antivirals during a confirmed influenza outbreak?

A30: Depending on the level of care provided by the facility, there are a variety of tools available on the NZ MOH website to help guide and organize antiviral access and preparedness prior to an outbreak:
http://www.albertahealthservices.ca/medstaff/Page14478.aspx

If not completed prior to an outbreak, these arrangements need to be made as soon as an influenza-like-illness (ILI) outbreak is identified.

Q31: What is a current serum creatinine level for antiviral dosing?

A31: In outbreak preparedness, we use the guideline of serum creatinine within 6 months to ensure the creatinine is current during an outbreak, which could occur several additional months later. Serum creatinine tests for residents/patients should be adequate if done within the past year, provided there has not been a sudden change in kidney function or change in weight. Facilities should prepare for respiratory virus outbreak season each year by ordering serum creatinine and recording resident weights. A baseline temperature should also be taken and recorded. Ultimately, prescribers are responsible for determining the appropriate antiviral dose for their patients.

Q32: When should antiviral prophylaxis be started during an influenza outbreak?

A32: In seniors' living facilities, best practice is to start antiviral prophylaxis within 24h of receipt of confirmation of influenza in the facility.

Q33: What are common side effects of antivirals?

A33: In general, Tamiflu (oseltamivir) prophylaxis is well-tolerated. If Tamiflu is taken with food, it helps reduce potential side effects that some individuals may experience including nausea, vomiting, abdominal pain or headache.

Q34: How is consent to administer antiviral medication obtained, for clients in facility (e.g. LTC) during an influenza outbreak?

A34: Consent forms can be found under Influenza Immunization Resources. Consent to Treatment Plan or Procedure form (09741)

Consent for the administration of Antiviral medication is obtained in alignment with Consent to Treatment/Procedure(s) - PRR-01 and the related procedures: Consent to Treatment/Procedure(s) Adults with Capacity - PRR-01-01 and Consent to Treatment/Procedure(s) Adults with Impaired Capacity and Adults who Lack Capacity - PRR-01-02

Consent must be informed and includes the discussion where patients or alternate decision makers are able to ask questions and have them answered appropriately

The patient or alternate decision makers must be provided with information about antiviral medication (Resident Letter). This may be written information and may be supplemented with discussion with members of the clinical team.

Documentation of consent will follow usual site processes, and may include (but not limited to) narrative notes, family conference notes or interdisciplinary team conference notes. The Consent to Treatment Plan or Procedure form (09741) may be used to document consent if circumstances require /suggest a specific written consent.

When Consent for administration of antivirals is obtained in advance of an active outbreak as part of outbreak planning, the clinical team should consider if the clients condition has changed significantly and a previously obtained consent is still applicable (see section 6 of Consent to Treatment/Procedure(s) Adults with Capacity - PRR-01-01 or section 8 of Consent to Treatment/Procedure(s) Adults with Impaired Capacity and Adults who Lack Capacity - PRR-01-02)

For further information, please contact your Outbreak Response Lead.

Adapted from Alberta Health Services, South Zone and Central Zone: Outbreak Management FAQs.