MEDFORD LEAS

POLICY: RESPIRATORY OUTBREAK RESPONSE PLAN **APPROVAL: _____**
MANUAL(S): INFECTION PREVENTION AND CONTROL
EFFECTIVE DATE: 9/9/2020 **SUPERSEDES: 9/3/2020**

POLICY STATEMENT: It is the policy of Medford Leas to prevent the spread of respiratory illness and actively perform surveillance to identify a residents and staff infected with viral respiratory illness. It is the health care team's goal to prevent and control the spread of the highly contagious illness to residents, staff or visitors. Staff, residents (and/or responsible parties), county, state and federal officials will be informed about the existence of and infection control and preventative measures to reduce the spread of a viral respiratory illnesses, as required by current laws, rules and regulations.

PURPOSE OF POLICY: It is the purpose of the policy to facilitate early detection of respiratory outbreaks, stopping transmission through control measures, identification of agent responsible for outbreak and using appropriate treatments and infection control practices to minimize the spread of illness to residents and staff. An outbreak may be occurring if:

1. Several residents exhibit similar respiratory symptoms and are in the same room, the same wing of a floor or attended a common activity
2. Two or more residents develop respiratory illness within 72 hours of one another
3. There is an increase in employee absences with many staff reporting similar respiratory symptoms.

1. PROCEDURE:

If respiratory illness is suspected, droplet precautions should be immediately implemented. If suspected tuberculosis infection, airborne precautions are to be implemented at once. If Influenza infection is suspected, droplet precautions should be implemented at once. If COVID-19 or other novel coronavirus is suspected, contract, droplet, and airborne precautions are to be implemented at once.

- Post signs to reinforce infection control measures including the need to adhere to isolations precautions and perform strict hand hygiene before entering and leaving resident rooms
- Notify other departments, such as Environmental Services, Therapy etc. (as appropriate)
- Notify Dining Services:
  - Notify by calling x 3003 and ask for the supervisor on duty
  - Notify supervisor of the type of isolation precautions
  - Dining Services will prepare and deliver tray to the unit as normal. Nursing staff will deliver trays to resident room
  - After meal is completed, nursing staff will place the tray from isolation room in a plastic trash bag and will then place the tray in the cart

A. Droplet Precautions are used for residents with known or suspected diagnosis of an infection spread through droplets in the air.

1. In addition to Standard Precautions, Droplet Precautions include:
   a. Private room, if possible
      i. Cohort with a resident who is not a high risk for infection
      ii. Cohort with a resident who is compliant and cooperative with directions
   b. Personal Protective Equipment (PPE) are made available
      i. All personnel and visitors are to make use of the PPE necessary upon entering the room. PPE shall be stored at the entrance of the room

ii. Hand Hygiene: Staff and visitors should clean their hands before and after leaving the room
    1. This also applies to the resident
    2. Soap and alcohol-based hand rub (ABHR) will be available
iii. Gloves must be worn by staff upon entering the room and removed after leaving
iv. Gowns should be worn when providing direct care, anytime there is a possibility of contamination, and if a resident has a productive cough and unable to perform "cough etiquette"
v. Masks: Staff and visitors should wear a mask upon entering the room and remove after leaving. ***The resident should wear a mask when out of his or her room.***

c. Environmental Services Staff along with Nursing Staff are responsible for setting up the isolation rooms.
    i. Notify Central Supply to obtain appropriate isolation trash and linen bins and necessary PPE
    ii. Set up carts with necessary PPE
    iii. Provide hand soap and/or alcohol-based hand rub (ABHR) in bathroom
    iv. Set up Linen containers (with blue/green bags). *See Linen Management Policy.*
    v. Set up Trash containers
d. Avoid common use of equipment when possible. If equipment is brought into the room, it must be wiped down and dried with appropriate germicidal before taken out of the room.
e. Any linen, trash or specimens must be double bagged with appropriate bags will be picked up twice a day by Environmental Service Staff. Do not shake out/agitate linens. *See Linen Management Policy.*
f. The resident may shower, but it must be the last shower of the day, when scheduled in shower room on the unit or a shower in a semi-private room, so Housekeeping Staff can decontaminate the area.
g. The Physical Therapy appointment must be the last appointment of the day when scheduled in the community therapy area so the room can be disinfected directly after therapy. Treatment may also occur at the resident's bedside.

B. <u>Airborne Precautions</u>

- Medford Leas does not have negative air pressure rooms available on campus and, therefore, does not have the capability to properly care for a resident requiring isolation due to airborne pathogens.
- If it is determined/ordered that a resident needs this type of isolation precaution, a nurse who is fitted for an N-95 mask will care for the resident until the resident is transferred to the hospital. If a fit-tested N-95 mask is not available, the best available mask shall be utilized. The nurse will also utilize other precautions per procedures and protocols (gown, gloves, etc.).
- Residents are not required to be transferred to hospital assuming: 1) the resident does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19 or other novel coronaviruses . Residents infected with COVID-19 may vary in severity from lack of symptoms to mild or severe symptoms or fatality. Initially, symptoms may be mild and not require transfer to a hospital as long as the facility can follow the infection prevention and control practices recommended by CDC.

- The resident may develop more severe symptoms and require transfer to a hospital for a higher level of care. Prior to transfer, emergency medical services and the receiving facility should be alerted to

the resident's diagnosis, and precautions to be taken including placing a facemask on the resident during transfer.

Please refer to "Isolation Precautions Quick Reference Guide" for detailed guidance.

2. Reporting

Reporting of suspected or confirmed outbreak to Burlington County Health Department or NJ Department of Health. Upon notification, NJDOH will assign an "E" number to the outbreak, which should be used for all outbreak correspondence and any laboratory samples.

The LHD, in consultation with the NJDOH epidemiologist, shall lead the investigation by providing the facility with guidance, support and assistance. The LHD should consider making an on-site visit for initial evaluation and ongoing assessment. The facility shall follow the basic steps listed below.

Note: Steps may or may not occur simultaneously during the course of the investigation.

A. Confirm that an outbreak exists
B. Verify the diagnosis using clinical, epidemiological and lab test information, considering seasonal disease occurrence
C. Develop a case definition based on clinical and laboratory criteria
D. Perform active surveillance
E. Document cases in a line list
F. **Co**ntact tracing investigation
G. Identify and eliminate transmission sources when possible
H. Institute control measures, balancing infection control concerns with disruption of residents' quality of life routines
I. Evaluate effectiveness of control measures and modify as needed
J. Summarize the investigation in a written report to communicate findings

3. Confirm that an outbreak exists

Gather information to confirm an outbreak is occurring within the facility; this would include initial information on the number of ill and well residents and staff.

Definition of a Respiratory Virus Outbreak in LTC Settings:

One laboratory-confirmed positive case (e.g., influenza, RSV, adenovirus, Covid-19) in a resident along with other cases of respiratory illnesses on the unit;

OR

A sudden increase over the normal background rate of acute respiratory illness (ARI)* cases, with or without documented fever (temperature ≥ 100°F OR 2° above the established baseline for that resident).

**ARI includes any two of the following symptoms: fever, sore throat, cough, rhinorrhea, and nasal congestion in the absence of a known cause (e.g., seasonal allergies, COPD).*

Note: Elderly or medically fragile persons may manifest atypical signs of respiratory virus infection and may not present with fever.

4. Verify the diagnosis

A. Determine the cause of acute respiratory illness based on the history, physical exam and/or laboratory findings of the resident or staff member. Diagnostic testing can aid clinical judgment and guide outbreak control decisions**.** Be alert for noninfectious causes of symptoms such as COPD exacerbations. Influenza infections are seasonal, with higher incidence from December

through April. During these months, when signs and symptoms are clinically compatible, strongly consider influenza.

B. Regardless of laboratory findings, public health control measures still need to be implemented.

C. Obtain laboratory confirmation of the infecting organism by testing specimens from several residents or staff within 48-72 hours of illness onset. Rapid antigen viral testing, PCR and viral culture should be done by collecting two simultaneous swabs. Use one swab for on-site rapid testing (if available), and send the second swab to the laboratory for PCR or virus culture. Some laboratories perform a respiratory virus panel, which would also include results for influenza. Bacterial culture should be considered as well, particularly during an outbreak of pneumonia. Strictly follow the protocol entitled "Instructions for Collection, Testing, and Shipping of Respiratory Virus Specimens" since the techniques used for the collection and submission of specimens can influence the outcome of test results.

D. Lab testing in an outbreak setting may be done through the facility's standard procedures or at the state Public Health and Environmental Laboratory (PHEL). The LHD or NJDOH epidemiologist can assist with facilitating laboratory testing and/or specimen transport. All specimens sent to PHEL must be pre-approved by NJDOH and properly labeled and packaged.

E. After a single laboratory-confirmed case of influenza, Covid-19, or other respiratory virus among residents has been identified, it is likely that subsequent cases of associated respiratory illness are also caused by the same organism; mixed outbreaks due to other respiratory pathogens may sometimes occur. Persons developing compatible symptoms should be tested for respiratory pathogens. Ideally, at least two laboratory-confirmed cases within an incubation period are needed to confirm an outbreak's etiology. When necessary, collect additional specimens from newly ill cases. When fewer than two laboratory-confirmed cases are found, a probable infectious agent can be inferred through clinical signs and symptoms.

5. Develop a case definition

An outbreak case definition describes the criteria that an individual must meet to be counted as an outbreak case. This includes clinical signs & symptoms, physical location and specific time period. Every outbreak will have a unique outbreak case definition. The outbreak case definition will be developed by the local health department or NJ department of health epidemiologist with cooperation from the facility based on the current situation. The NJ department of health epidemiologist is available for consultation as needed. Two examples of case definitions for acute respiratory illness associated with a long-term care setting are shown below:

A. Residents or staff on XYZ Unit experiencing an illness that is characterized by fever and at least two of the following, on or after mm/dd/yy: rhinorrhea (runny nose), nasal congestion, sore throat, cough (productive or non-productive), change in appetite, change in mental status, headache, lethargy, myalgia, respiratory distress, dyspnea, shortness of breath, pleuritic chest pain, or radiographic evidence of a pulmonary infiltrate.

B. Laboratory evidence of a respiratory pathogen such as influenza in a resident or staff member of Unit XYZ on or after mm/dd/yy **AND** at least one symptom or sign compatible with respiratory infection (e.g., rhinitis, pharyngitis, laryngitis, cough or pneumonia).

6. Perform active surveillance

A. Seek out additional cases of respiratory illness among residents and staff. Be alert for new-onset illness among exposed persons, and review resident and staff histories to identify previous onsets of illness that may not have been correctly recognized as being part of the outbreak.

B. Use influenza, Covid-19, and other respiratory viral testing promptly in newly identified cases of respiratory illness so that infection control measures specific to respiratory outbreaks can be initiated to prevent spread (e.g., antiviral prophylaxis.)
C. Testing Procedures
    1. Any resident with suspected signs or symptoms of respiratory disease shall, as soon as feasible, be tested for influenza and/or Covid-19 as applicable. The resident will remain on transmission-based precautions outlined in Section 1. Procedure of this plan while awaiting test results.
    2. Testing for Covid-19 will be part of the contact tracing program. Any resident who is identified during a contact tracing investigation to have a risk for exposure will be tested as soon as feasible. Staff testing may also occur at the Medical Directors (or designee) discretion when staff are identified during contact tracing investigations to have had a possible exposure.
    3. Residents who have tested positive will remain on transmission-based precautions for a minimum of 14 days from the date of their initial test collection. After 14 days a second test will be performed. The resident will remain on transmission-based precautions while test results are pending. If the test results are negative the transmission-based precautions may be discontinued. If the test remains positive the retesting procedure will repeat in another 7 days for a total of 21 days past the date of initial test collection.
    4. Any staff members who have tested positive for Covid-19 either at Medford Leas or any other outside laboratory or testing center will be excluded from work for a minimum of 14 days from the date their positive test collection occurred. The employee may return to work once 14 days from the date of the positive test has passed as long as they have been free of any symptoms of respiratory illness for at least 72 hours.
    5. Facility wide routine testing of staff and residents may be conducted as directed from the NJ DOH, CMS, or other governing agencies. When facility wide testing is instituted the testing is mandatory for all staff. Any staff member not tested may be excluded from work for until testing is completed. Staff members will be required to give authorization for release of their laboratory testing results to the Medical Director with the intent of informing the facility of need to institute infection control measures and/or contact tracing investigations. Facility wide routine testing will follow the schedule as listed below:

        Active Monitoring

        During an outbreak or when otherwise directed by the NJ DOH, CDC, or othering governing agency, active monitoring shall occur.

        1. Active monitoring of residents should include at a minimum once per 12-hour nursing shift full set of vital signs and evaluation for presence of signs of symptoms of active respiratory illness.
        2. Employees are instructed to perform self-monitoring for any signs and symptoms of respiratory illness and to report any noted signs symptoms to their supervisor and not report to work when ill.
        3. Any employee on work exclusion due to testing positive for Covid-19 will be given a self-monitoring form to complete which includes self-evaluation of symptoms and twice per day body temperature readings.
        4. Entrance screening is enacted during an outbreak of Covid-19 or when otherwise directed by the NJ DOH, CDC or other governing agency. This may include answering questions about sign or symptoms, exposure and taking of body temperatures. Any employee or visitor who has a temperature of greater than 99.9 F or answers in the positive to the presence of any signs or symptoms or exposure to

Covid-19 or other respiratory illness infected persons will not be allowed entry to the facility. If the person is an employee their supervisor and the infection preventionist shall be notified and the employee is encouraged to contact their primary care practitioner and/or local testing center to be tested for Covid-19 or other respiratory illness as appliable. If the person is a visitor, they will be encouraged to contact their primary care practitioner. Any Medford Leas residents who present with positive signs or symptoms and/or a body temperature over 99.9 F will be asked to self-isolate as soon as possible and the Wellness Center/OAC will be notified immediately.

7. Document and count cases

A. The facility shall develop and maintain a line list. Starting and maintaining a line list helps track the progress of an outbreak. A sample line list for residents with acute respiratory illness may be found at http://nj.gov/health/forms/cds-11.dot. A separate line list for employee illness should also be maintained.

B. The local health department investigator shall review the line list frequently with the facility and the NJ department of health epidemiologist to assess the status of the outbreak, and make recommendations regarding control measures.

8. Identify and eliminate possible transmission sources

A. A floor plan may be used in conjunction with the line list to document the physical locations of case-patients and ill staff to identify possible transmission routes.

B. Exclude sick staff. Staff members who become sick with a fever and/or respiratory symptoms during their shift shall be sent home immediately.

C. Monitor personnel absenteeism. Monitor personnel absenteeism due to respiratory symptoms and exclude those with influenza-like symptoms from work until at least 24 hours after they no longer have a fever.4

D. Inform receiving facilities of the outbreak when transferring residents. Transfer notification applies to both ill residents and exposed well residents. If at all possible, limit transfers to medical necessity.

E. The facility, local health department and NJ DOH epidemiologist should collaborate to determine the outbreak source. Occasionally, even with thorough investigation, the source might not be identified.

9. Institute control measures

Control measures are the tools that can end the outbreak by halting transmission. The local health department, in consultation with the NJ DOH epidemiologist, shall provide recommendations and guidance to the facility regarding control measures. Control measures can negatively impact residents' quality of life by restricting their lifestyle, and staffing limitations are difficult to implement. Nevertheless, the facility should make every effort to institute and maintain adequate control measures until the outbreak is declared over.
Basic control measures are listed below.

Cohort residents, staff, equipment and supplies according to the living/work area

- Identify three cohort groups: 1.) "Ill" 2.) "Exposed" (not ill, but potentially incubating) and 3.) "Not ill/not exposed" (new admissions/staff.)
- Restrict use of equipment and supplies to use within a specific area, and do not allow residents/staff from one cohort to mix with other cohorts. (For example, suspend community dining or recreational activities where ill and well would otherwise intermingle.)

- Close the facility to new admissions if the physical set-up does not allow for complete segregation between "not ill/not exposed" and "ill/exposed" cohorts.
- Symptomatic residents should remain in their assigned room as much as possible, including having their meals served in their rooms, until 24 hours after their fever and respiratory signs and symptoms have resolved.
- If resident movement or transport is necessary, have the resident wear a facemask (e.g., surgical or procedure mask), if possible.
- Staff assigned to affected unit(s) should not rotate to unaffected units until the LHD and regional epidemiologist have determined that the outbreak is under control. This restriction includes prohibiting staff from working on unaffected units after completing their usual shift on the affected unit(s).
- In the instances of staffing shortages staff may be pulled or shared between areas that do not have any Covid-19 positive or presumed positive residents. In addition, licensed nursing managerial staff and leadership staff are available to for relief as needed.

10. Provide in-service education to ALL staff on ALL shifts

- In addition to all direct caregivers employed by the facility, staff includes volunteers, private duty, contracted or agency personnel who perform housekeeping, recreational, laundry, dietary, social service, physical therapy and administrative activities.
- Education is mandatory for all shifts, even if a staff in-service program has been completed recently.
- Place major emphasis on meticulous hand hygiene since it is the most effective measure for preventing further spread. Provide information on the infecting organism and its transmission, standard and droplet precautions, and movement restriction.
- Contact the LHD for fact sheets or other pertinent educational materials.

11. Restrict visits from family, friends and volunteers as necessary

Visitors with respiratory symptoms should be encouraged to postpone their visit until their symptoms resolve. However, a family member determined to visit may do so under any circumstance. For such visitors, consider offering a surgical mask, and encourage them to limit their visit only to their respective family members and to minimize touching of residents and environmental surfaces.

12. Environmental Measures

- Use routine cleaning and disinfecting strategies during influenza season. Focus on cleaning frequently touched surfaces in common areas and resident rooms. Special handling of soiled linens and dietary trays is not necessary.
    - Use of disinfectants registered by the U.S. Environmental Protection Agency (EPA) is recommended whenever these are available. Lists of all registered disinfectants can be found at http://www.epa.gov/oppad001/chemregindex.htm. Many, if not all, of these products indicate potency for several target pathogens on the label. There are approximately 400 registered disinfectants with human influenza A and/or B listed on the product label, and all will inactivate respiratory viruses when used according to manufacturer instructions.10
    - Environmental Services staff should use appropriate personal protective equipment (PPE) (i.e., gloves) as needed when preparing disinfectant and cleaning solutions and when applying these solutions.
    - Clean and disinfect surfaces that are touched routinely by hand (e.g., doorknobs, bed rails, bedside and over-bed tables, bathroom surfaces, safety/pull-up bars, television controls, call buttons) on a more frequent schedule than that used for large housekeeping surfaces.

- Follow manufacturer instructions for proper use of disinfectants, especially with regards to the proper concentration of product and the time the product should be in contact with the surface being disinfected.
- Consult medical equipment instructions for appropriate methods of cleaning and disinfection for these items, and consider using barrier coverings for equipment that may be hard to clean or has accessible electronic components.
- Clean large housekeeping surfaces (e.g., floors) in resident -care areas with detergent/disinfectants in accordance with manufacturer instructions on a regular basis as per facility policy (i.e., at least daily and terminally cleaned at patient discharge).
- Avoid large-surface cleaning methods that produce mists or aerosols or disperse dust in resident -care areas (e.g., use wet dusting techniques, wipe application of cleaning and/or disinfectant solutions).
- Detergent and water are adequate for cleaning surfaces in nonresident -care areas (e.g., administrative offices).
- Follow facility procedures to ensure the cleanliness of cleaning and/or disinfectant solutions, rinse water, mop heads, and cloths (e.g., separate buckets for solutions and rinse water, frequent exchanges of solutions, replacing soiled mops heads and cloths with clean items, using microfiber mopping methods).
- Avoid placing influenza patients in rooms with carpeting if possible; use vacuums equipped with HEPA filtration when vacuuming carpets in resident -care areas.

13. Evaluate the effectiveness of control measures and modify as needed

Generally, the outbreak is considered to be over when two incubation periods have passed without a new case being identified. Waiting two incubation periods allows for recognition of potential secondary case-patients that are still asymptomatic but in whom the disease may be incubating. For influenza, two incubation period is approximately one week.

- • If new cases are identified after control measures have been instituted for one incubation period, continue outbreak control measures in consultation with the facility administration, LHD and the regional epidemiologist. Evaluate and enforce adherence to infection control precautions by all staff, residents and visitors. Continue control measures until no new cases are identified for two incubation periods.
- • When no new cases are identified after two incubation periods, control measures may be relaxed. Continue active surveillance for new cases according to LHD recommendations.