Management of Infections and Outbreaks due to Viral Respiratory Illnesses in Adult Residential Facilities

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Developed in partnership with the Department of Social Development and the Department of Health

New Nouveau Brunswick

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ACRONYMS

AGMP	Aerosol Generating Medical Procedure
ARF	Adult Residential Facility
EMP	Extra Mural Program
PCR	Polymerase Chain Reaction
PCRA	Point of Care Risk Assessment
PH	Public Health
POCT	Point of Care Test
PPE	Personal Protective Equipment
RHA	Regional Health Authority
RMOH	Regional Medical Officer of Health
RSV	Respiratory Syncytial Virus
SD	Social Development

1.0 RESOURCES AND CONTACT DETAILS

Public Health may be contacted to provide support and guidance.

PUBLIC HEALTH COMMUNICABLE DISEASE TEAM				
Regions 1-7 Public Health Notifiable Disease Reportable Events Posters. Pdf(gnb.ca)				
Region		**During Business Hours (8:15*am-4:30pm Mon-Fri)**	**After Business Hours (Emergency Only)**	**Fax Numbers**
Central	Zone 3 (Fredericton)	CDFredVal@gnb.ca (506) 444-5905	(506) 453-8128	(506) 444-4877
South	Zone 2 (Saint John)	ComDisjPH@gnb.ca (506) 658-5188	(506) 658-2764	(506) 643-7894 or (506) 658-3067
East	Zone 1 (Moncton)	(506) 856-3220	(506) 856-2004	(506) 856-3544
	Zone 7 (Miramichi)	(506) 778-6104/ 778-6102		(506) 778-6756
North	Zone 4 (Edmundston)	(506) 735-2626	(506) 789-2428	(506) 735-2340
	Zone 5(Campbellton)	(506) 790-4769		(506) 789-2349
	Zone 6 (Bathurst)	(506) 547-2062		(506) 547-2208
**Zone 2 business hours start at 0830.*				

WEBSITES & RESOURCES	
General GNB COVID-19 Testing	COVID-19 Testing (gnb.ca)
General GNB COVID-19 Resources	Guidance and Support (gnb.ca)
Seasonal Influenza Resources	Influenza in New Brunswick (gnb.ca) Flu (influenza): Symptoms and treatment - Canada.ca
Respiratory Syncytial Virus (RSV) Resources	Respiratory syncytial virus (RSV): For health professionals - Canada.ca Respiratory syncytial virus (RSV): Symptoms and treatment - Canada.ca

EMAILS AND PHONE NUMBERS	
SD PPE Team	PPETeam/EquipeEPI@GNB.CA
SD COVID Response Team (SD CRT)	SD_CRT@gnb.ca
COVID-19 Vaccine Orders (for ARFs)	Special Care Home Unit, Extra Mural Program (EMP)
Extra Mural Program- EMP Care Coordination Centre	1-844-982-7367

2.0 PURPOSE OF RESPIRATORY ILLNESS GUIDANCE

This document provides guidance for Adult Residential Facilities (ARF) to prevent and manage respiratory or influenza-like illness within their facility. It is intended to be used year-round. While some respiratory illnesses are more likely to be present over the fall and winter months of "flu season", other germs are present all year.

Many different germs can cause respiratory illness. It is often difficult to tell which germ is causing the illness because the symptoms are similar. In addition, a person may be infected with more than one germ at the same time. This document will focus on viral respiratory illnesses of **COVID-19, Influenza, and Respiratory Syncytial Virus (RSV)** that can spread easily to others in a facility.

Respiratory illness is a leading cause of hospitalization and death among seniors and other vulnerable individuals. Residents may also experience worsening of chronic conditions and loss of independence due to respiratory illness. For these reasons, it is essential that facilities take steps to prevent the spread of respiratory illness, and that residents are provided access to vaccination and therapeutic treatments, such as antiviral mediations, if eligible.

NOTE: An ARF with 10 or fewer residents is often structured and functions similar to a household. They will continue to self-manage individual cases of respiratory illness within their facility, or situations involving 2 or more positive individuals. Best practice recommendations for case and situation management in this setting still apply and are listed in Section 6.1 Outbreak Management in an ARF with 10 or fewer residents.

This guide also explains the utilisation of antiviral medications for treatment or prophylaxis in an ARF to reduce the likelihood of severe illness or hospitalization for residents in an influenza outbreak. It also provides information and tools necessary to support an ARF resident's access to influenza antiviral medications.

The information provided in this document should be used to guide the development of policies and plans **BEFORE** respiratory illness happens in the facility. A Quick Reference Check List is provided with links to additional information.

3.0 QUICK REFERENCE ARF CHECK LIST FOR VIRAL RESPIRATORY ILLNESS

Is your facility prepared to respond to respiratory illness?	Refer To:	✓
Prevent and Prepare for Respiratory Illness		
Offer and support access to vaccinations for residents and staff.	Appendix A: Illness Prevention Strategies	
Create a MyHealthNB account for each resident to access to their test results.		
Obtain informed consent for vaccinations and antiviral therapy. Update yearly.	Appendix C: Informed Consent Form	
Ensure recommended amount of PPE is available.	Table 1.0	
Update facility's Infection Prevention and Control Plan annually	Section 6.0	
Educate staff: cleaning and disinfection, hand hygiene, and staff health. Review yearly.	Appendix A: Illness Prevention Strategies	
The operator should consider approaching the ERA's pharmacy to plan for the upcoming respiratory illness season.		
Level 3 Generalist (3G) and Memory Care (3B) Homes: Obtain ***Influenza Antiviral Eligibility and Standing Orders*** from primary care providers on admission; renew yearly. Complete prescribed lab work on admission, and as ordered.	Appendix B: Influenza Antiviral Eligibility and Standing Orders Form	
1 Person with Symptoms of Respiratory Illness		
Symptomatic resident- Fever OR new or worsening cough, OR 2 other symptoms • Isolate with Contact and Droplet Precautions. • Test with POCT. If negative, test with PCR if ordered or influenza suspected.	Table 2.0 Appendix E: PCRA Section 5.31	
Symptomatic Staff: Work modification, test with POCT.	Section 5.32	
Contact EMP if concerned about resident's wellbeing; or if PCR ordered for non-mobile resident.		
Support resident's access to antiviral treatment, if eligible.	Appendix H: Influenza Antiviral & Appendix I: Paxlovid Antiviral	
Review with staff: isolation protocol, enhanced hand hygiene, PCRA, and environmental cleaning and disinfection. Post signage for isolation and hand hygiene.	Appendix A: Illness Prevention Strategies	
Passive Screening. Determine who has symptoms. Test promptly.	Appendix F POCT Swab	

2 or More People with Symptoms of Respiratory Illness:		
Continue with isolation and work modification guidance for the specific illness.	Section 5.0	
ARF with 10 or fewer residents: continue to self-manage, using measures	Table 6.0	
ARFs with more than 10 residents should consider consulting Public Health if 2 or more individuals test positive (POCT or PCR) for respiratory illness (COVID-19, Influenza, or RSV) in facility within 7-10 days respective of the virus. • Consider tracking symptom onset, testing, and new cases on a line list. • Public Health will declare and end outbreaks. • PH informs operator and pharmacy if influenza antiviral prophylaxis advised. • ARF contacts pharmacy to confirm number of standing prescription orders.	Sec 5.3	
Consider additional measures in affected area to manage transmission: • Active screening, continuous masking, and eye protection, as well as physical distancing for residents and visitors. • Enhance hand hygiene and environmental cleaning and disinfection, particularly for high touch areas. • Small group activities may continue, if able to manage the outbreak. Consistent membership. Must be symptom free. Use masking and physical distancing, as able. • Inform visitors and residents, post signage. Discourage social visits if unable to manage outbreak. DSP and Palliative Visitation may continue, with protective measures in place.	Section 6.0	

4.0 VIRAL RESPIRATORY ILLNESS

4.1 HOW DO VIRAL RESPIRATORY ILLNESSES SPREAD?

Respiratory illnesses are easily spread. When a person who has the virus coughs, sneezes, talks, or sings, they share the virus in tiny droplets or aerosol in the air. Tiny viral particles may also settle on nearby items. When a person touches the contaminated surface, and then touches their nose, mouth, or eyes without cleaning their hands, they may infect themselves with the virus.

4.2 WHO IS AT RISK FOR MORE SEVERE ILLNESS?

Individuals who live together in an adult residential facility often have many features that make them more likely to experience severe illness from a respiratory virus.

- Living together makes germs spread more easily from person to person.

- The immune system of elderly individuals and those who are immunocompromised may not respond as well as it used to.
- Chronic illnesses like heart disease, diabetes, chronic obstructive lung disease (COPD), may worsen when a person is ill with a respiratory virus.
- Pre-existing conditions such as obesity may also lead to more severe respiratory illness.
- Individuals whose memory or cognitive abilities have been impacted may struggle to use prevention measures to reduce their risk of illness.

4.3 WHAT MEASURES HELP TO PREVENT SPREAD?

Measures like vaccination, hand hygiene, cough and sneeze etiquette, cleaning high touch surfaces, and masking and distancing from others when ill can help prevent viral respiratory illnesses and many other illnesses from spreading. (Appendix A: Illness Prevention Strategies). Having facility-wide measures in place **before** someone receives a positive test result will support prevention and control. It is equally important to have an outbreak management plan ready if an outbreak is declared.

5.0 STRATEGIES TO PREVENT & CONTROL VIRAL RESPIRATORY INFECTIONS

ARF can implement measures to prevent and control the spread of respiratory infections.

- Be prepared - make plans to prevent and respond to respiratory illness.
- Screen for symptoms of respiratory infections.
- Perform Screening Tests
- Implement a Case and Outbreak Management Plan

5.1 BE PREPARED

Encourage and support residents and staff to get up to date with Influenza, COVID-19, and pneumococcal vaccinations. RSV vaccines will not be available in the 2023-2024 season.

Antiviral medications can be more effective if given within 48 hours of symptom onset or exposure. By obtaining a standing order and consent in advance, antiviral medications can be taken promptly if needed.

ARFs should have an immunization policy for vaccine-preventable diseases. These policies should address residents, staff, and visitors within the home. They should be updated and communicated to all concerned each year.

- Policies and/or procedures addressing immunization as well as antiviral treatment and/or prophylaxis in the event of an outbreak should be available.
- Upon admission and annually before respiratory illness season, Level 3 Generalist and Memory Care Homes will ask a resident's primary care provider (doctor or nurse practitioner) to complete an *Influenza Antiviral Eligibility and Standing Order Form***.** This form gives direction for PCR testing if symptoms of respiratory illness are present, eligibility for antiviral therapy, and bloodwork for serum creatinine. (Appendix B)
- Primary care providers of residents in other ARF may provide advanced standing orders for early access to influenza antiviral treatment if the resident is clinically eligible according to the Association of Medical Microbiologists and Infectious Disease Canada (AMMI).
- It is more efficient if the primary care provider sends the advance standing order prescriptions directly to the resident's pharmacy; and provides the ARF with requisitions for lab testing.
- Operators can ensure that each resident's laboratory tests have been carried out resident on admission and as prescribed.
- Each ARF should have a communication plan to share information with residents, staff, and visitors about illness prevention strategies and outbreak protocols.
- Each facility should have a visitation policy that includes the following points; as well as a visitation policy to address when the facility is experiencing an outbreak of illness.
    - No visiting when ill, signage at door stating not to enter if unwell.

  - Visitors should be provided information outlining safe visiting practices, including frequent hand hygiene and respiratory etiquette with each visit, and postponing a visit when ill.
  - Mask use is optional for a visitor; however, a resident may request a visitor to wear a mask. Visitors may expect enhanced masking guidance if the risk of respiratory illness activity increases.
  - No age restriction related to visitation within a facility.
  - No restriction on visitation capacity at one time.
  - No requirement for visitors to provide proof of vaccination or medical exemption.
- ARFs should have ongoing Hand Hygiene and PPE education for staff, residents, and visitors.
- Continually evaluate and update the facility's response plan for respiratory illness.
- It is recommended that ARF have a minimum amount of PPE on hand. Refer to Table 1.0 for the recommended amount for a 72-hour period where outbreak measures would be in place.

Table 1.0 Emergency PPE Recommended for 72-hour Period

Number of Beds	Face Masks	Isolation Gowns	Face Shields	Gloves
10	300	300	300	1,050
30	900	900	900	3,150
60	1,800	1,800	1,800	6,300
100	3,000	3,000	3,000	10,500
Contact: PPETeam/EquipeEPI@GNB.CA if additional PPE is required.				

It is imperative that PPE be used correctly to protect staff and residents. Public Health may advise additional PPE use for certain situations or based on a point of care risk assessment (PCRA).

5.2 Screen for Symptoms of Respiratory Illness

The symptoms of a respiratory infection are similar for many viruses, including COVID-19, influenza, and RSV. It is often difficult to tell which one is causing the illness because the symptoms are similar.

All residents **with fever OR new or worsening onset of fever OR cough OR 2 or more other symptoms of respiratory illness** listed below in Table 2.0 should isolate with Contact and Droplet Precautions. (Appendix G: Contact and Droplet Precautions).

Even though an operator may not know what virus is causing the illness, Contact and Droplet Precautions work well to slow all respiratory viruses from spreading in their facility until test results are available.

Table 2.0 Symptoms of Respiratory Illness		
Fever*	Sneezing	Severe Fatigue
Cough	Wheezing	Loss of appetite
Runny/stuffy nose	Headache	Muscle aches/pain
Shortness of breath	Chills	Nausea and vomiting
Sore throat	Weakness/Dizziness	Diarrhea
Loss of taste	Loss of smell	

***NOTE:** Fever is defined as:

a) a single oral temperature of more than 37.8°C OR
b) repeated oral temperature of more than 37.2° C OR
c) repeated rectal temperatures of more than 37.5 ° C OR
d) a single temperature of more than 1.1° C over baseline from any site.

In residents 65 and over fever may not be very high. They may experience loss of appetite, weakness, confusion, vomiting, or diarrhea.

5.3 TESTING

Early diagnosis through testing helps eligible residents who have tested positive for Covid-19 or Influenza to begin antiviral therapy as soon as possible.

Early detection also allows facility-wide measures to be enhanced to reduce the spread to other residents. In addition, prompt testing helps to support access influenza antiviral medication for prophylaxis for eligible facilities.

5.3.1 Testing and Isolation of Symptomatic Residents

If at least one resident or staff member has developed symptoms, implement additional precautions as you investigate further.

- Passively screen for symptoms.
- Identify the number of residents and staff who have symptoms of respiratory illness.
- Determine if those affected are limited to one unit/floor.
- Staff will use a Point of Care Risk Assessment (PCRA) before every resident interaction.

Isolate any symptomatic resident with Contact and Droplet Precautions.

If available, rapid antigen (POCT) testing should be the first choice when testing symptomatic residents of an ARF for COVID-19. Refer to Appendix F: Point of Care Testing for COVID-19.

- If results are positive, maintain isolation according to Table 3.0 below.
- If results are negative and symptoms persist, maintain isolation. Retest with POCT in 24 hrs, and again in 48 hrs.
- If symptoms persist, and individual continues to test negative on POCT, maintain isolation until resident starts to improve, and:
    - fever free for 24 hours without fever reducing medication, and
    - free of vomiting and diarrhea for 48 hours.

It is important to notify your local laboratory at the time of sample collection that you are investigating a potential outbreak, and that influenza test results should therefore be reported to both the nursing home and the RHA Public Health office as soon as they become available, whether positive or negative.

Table 3.0 Length of Resident Isolation Based on Type of Respiratory Illness*

		COVID-19	Influenza	Other Respiratory Illness (i.e., RSV)
Length of Isolation (Contact and Droplet Precautions)	Isolation (Without antiviral)	Isolate 5 days from earliest positive test result (POCT or PCR). Cease after day 5, if they have been 24h fever-free without fever reducing medication, and 48 h free of vomiting and diarrhea, and improving. Use Enhanced Precautions** for an additional 5 days.	Isolate for 7 days after symptom onset. Cease after day 7, if they have been 24 h fever free without fever reducing medication, 48 h free of vomiting and diarrhea, and symptoms improving.	Isolate until 24 h fever free without fever reducing medication, 48 h free of vomiting and diarrhea, and symptoms improving.
	Isolation (With antiviral)	Same as above	Cease following 72 hours of antiviral treatment and no symptoms for 24 hours	Same as above; no antivirals available
	Immunocompromised	Consult local Public Health unit	Consult local Public Health unit	Consult local Public Health unit

*In outbreak units, individuals may not be PCR confirmed, but can be presumed to have a certain illness. This should be documented, and these individuals should be managed based on the presumed illness.

*****Enhanced Precautions for Residents:**

- Wear a well fitted medical grade mask when awake; if possible.
- Perform hand hygiene frequently.
- Maintain physical distancing and limit non-essential contact with other residents (as able).
- Avoid gatherings or activities with others.
- Eating/drinking must be performed in resident's room or a private area. If unable to find a place to eat or drink alone, ensure there is two metre distancing from others while mask is off or consider staggering lunch hour for residents who are positive and negative etc.
- Use private or designated washroom; if possible.
- Staff to clean high touch areas after use.

If a resident is suspected or confirmed positive for COVID-19, Influenza, and/or RSV and is receiving an Aerosol Generating Medical Procedure (AGMP), the resident should be in a private room with the door closed. Staff entering the room are to

wear appropriate PPE which includes an N95 mask. Examples of an AGMP include (but are not limited to) CPAP/BIPAP, High flow oxygen &/or humidity, nebulizer therapy, CPR, and intubation. See Table 4.0 Low flow Oxygen Delivery for examples of low flow oxygen therapy (These examples would NOT require the use of N95 mask).

Table 4.0 Low Flow Oxygen Delivery	
Device	**Low Flow Rate**
Nasal Prongs	1-6 L/Minute
Simple O2 mask	6-10 L/Minute
Non-Rebreather mask	10-15 L/Minute
Oxymask	1-15 L/Minute

5.3.2 When to Request a PCR Test for COVID-19, Influenza, and RSV

If initial POCT results for COVID-19 are negative, a PCR test for COVID-19, influenza, and respiratory syncytial virus (RSV) may be ordered by the primary care provider, eVisitNB, or after-hours ambulatory services if required for treatment or care.

- If the resident does not have a primary care provider, or if one is not available, the operator can contact the EMP care coordination center for an on-site assessment and possibly a PCR test.

An ARF operator of a Level 3G or 3B facility may seek PCR testing for a resident for the purpose of obtaining early access to influenza antiviral medications. Check resident's care plan for a standing order and corresponding lab requisitions from their primary care provider (doctor or nurse practitioner) for PCR testing.

- If resident is housebound or already a patient of Extra-Mural Program (EMP), contact EMP Care Coordination Center at 1-844-982-7367 for PCR on-site testing.
- If resident is mobile and not an EMP client; go to testing site identified by their Regional Health Authority.
- If no standing order is in place, contact resident's primary care provider to order the PCR test for COVID, Influenza, and/or RSV. However, if resident does not have/or is unable to reach their primary care provider, contact eVisitNB.

Individuals will continue to have access to their test results on *MyHealthNB* and through health care providers who have requested them.

5.3.3 Testing and Work Modification of Symptomatic Staff

Any symptomatic staff member should stay home and test for COVID-19 with POCT.

- If initial POCT result is negative and symptoms persist or worsen, retest with POCT in 24 hours and again in 48 hours.
- If at any time symptoms have resolved, further testing is not required, and staff may return to work.
- If third POCT remains negative, staff may return to work when the individual is fever free for 24hrs without using fever reducing medications, free of vomiting and diarrhea for 48 hours, and symptoms are improving.
- If clinically indicated, staff members in ARFs can access PCR testing through consultation with their medical care provider. Those who do not have or are unable to contact their medical care provider may access testing through eVisitNB, Telecare 811, or other outpatient services. PCR testing will be done at the location indicated by the Regional Health Authority (RHA).
- **If POCT result is positive** for a viral respiratory illness, follow guidance provided in Table 5.0.

Table 5.0 Work Modification for Symptomatic Staff

Staff with Respiratory Illness- confirmed by POCT/PCR	• Recommend staff refrain from reporting to work for 5 days (day of symptom onset is day 0) and until symptoms are improving and fever free x 24hrs without using fever reducing medication, and free of vomiting/diarrhea for 48 hours. • Required to use Enhanced Work Precautions* until day 10 from onset of symptoms. When possible, assign employee to positive or recently recovered residents during the period of enhanced work precautions.
Staff with Respiratory Illness of Unknown cause OR Critical Staffing Capacity	• Staff are able to work when symptoms are improving and fever free for 24hrs without using fever reducing medication, and free of vomiting/diarrhea for 48 hours. • Required to use Enhanced Work Precautions* until day 10 from onset of symptoms. When possible, assign employee to positive or recently recovered residents during the period of enhanced work precautions.
***Enhanced Work Precautions** • Wear a well fitted medical grade mask. • Perform hand hygiene frequently. • Maintain physical distancing and limit non-essential contact with other staff, and residents (as able). • Avoid meeting spaces and lunchrooms.	

• Eating/drinking must be performed in a private area. If you cannot find a place to eat or drink alone, ensure there is two metre distancing from others while your mask is off or consider staggering lunch hour for staff who are positive and negative etc.
• Use washrooms within the organization which are the most frequently cleaned if a designated washroom is not possible.
• Employees should also clean high touch areas after use.

5.3.4 Retesting- recommendations for those who have previously tested positive for COVID -19

When clinically indicated, POCT testing is recommended for individuals previously infected with COVID-19 presenting with new or worsening respiratory symptoms. If POCT test is negative, further testing may be indicated (at the discretion of the primary care provider or the MOH) based on symptoms and presence/ circulation of other viruses in the community.

5.4 WHEN TO NOTIFY REGIONAL PUBLIC HEALTH

To be assessed for influenza antiviral prophylaxis, operators of Level 3 generalist care or memory care facilities should **inform Public Health if two or more cases of influenza are confirmed in their facility within 7 days.**

ARFs with more than 10 Residents should consider contacting Public Health as soon as possible, between the hours of 8am to 4:30 pm (including weekends and holidays) **if two or more individuals test positive (POCT or PCR) for respiratory illness in facility.**

- 2 or more cases of COVID-19 within 10 days
- 2 or more cases of Influenza or RSV within 7 days
- Subsequent individuals who test positive may be reported using a daily line list or per Public Health direction.

Other ARFs with 10 or fewer residents will self-manage individual cases of respiratory illness, and situations involving 2 or more positive individuals. Refer to Section 6.1 Outbreak Management in an ARF with 10 or fewer residents.

OUTBREAK MANAGEMENT RESPONSE

This section of the document is intended for use by operators and managers of ARFs with more than 10 residents to guide their decision-making related to outbreak response. Consider incorporating these elements into your facility's Outbreak Management Plan and update the plan each year before respiratory illness season.

6.0 SUSPECTED OR CONFIRMED CASE AND OUTBREAK MANAGEMENT

COVID-19 outbreak: An outbreak in a vulnerable setting may be declared by the MOH, typically when there are two or more positive cases among residents or staff within 10 days and transmission within the facility cannot be ruled out.

Influenza or RSV outbreak: An outbreak in a vulnerable setting may be declared by the MOH, typically when there are two or more positive cases among residents or staff within 7 days, and transmission within the facility cannot be ruled out.

Public Health remains committed to supporting ARFs in managing outbreaks.

- Public Health will lead and manage outbreaks within ARFs with more than 10 residents if the outbreak includes at least 1 resident.
- For ARFs that have outbreaks that do not include any residents, the home will self- manage using general outbreak management principles unless directed by Public Health.

It is important for ARFs to note that not all outbreaks are the same. Therefore, guidance may vary depending on each situation and circumstance. Direction may be adjusted by Public Health /MOH as needed based on the result of their risk assessment and applicable factors. If homes are unsure why certain directives might be given to them, they should seek to have their questions clarified.

6.1 OUTBREAK MANAGEMENT IN AN ARF WITH 10 OR FEWER RESIDENTS

An ARF with 10 or fewer residents will self-manage 2 or more cases of respiratory illness.

- An influenza outbreak may be called in a Memory Care or Generalist Care Home to provide access to antiviral prophylaxis, on a case-by-case basis.

Best practice recommendations for case and situation management in this setting still apply and are listed below. However, it is recognized that ability to implement may be limited by staffing levels, facility size, or capacity of residents.

Table 6.0 Best Practice Recommendations for Respiratory Illness Management in ARF with 10 or Fewer Residents:	
Testing	• When available, rapid antigen (POCT) testing should be the first choice when testing symptomatic residents of an (ARF). Refer to Section 5.31 Testing and Isolation of Symptomatic Residents, and Appendix F Throat Nasal Swab for Point of Care Testing for COVID-19. • Only test symptomatic residents and staff. • Once two cases of a respiratory illness (COVID-19, influenza, or RSV) are identified, others who become symptomatic will be considered to have the same virus and there will be no need to test them unless eligible for Paxlovid treatment. • If POCT negative for COVID-19, PCR testing may be advised by primary care provider if clinically indicated, or resident is eligible for influenza antiviral treatment. • If more than one virus has been detected in the facility at the same time, contact Public Health for further testing guidance.
Case and Symptomatic Resident Isolation	• Cases and symptomatic residents isolate separately, and apart from other residents, as best as possible. • A symptomatic person or positive case can eat in their room; or consider having different dining shifts to increase separation between residents at table. • Isolate per Table 3.0 length of resident isolation based on type of illness.
Daily Care	• Monitor resident's symptoms and ability to cope with illness daily. i.e., Fever, cough, or difficulty breathing, diarrhea, fatigue; and stability, alertness, intake. • Refer to Caring for Someone with Covid-19. • If there are concerns related to the health of the resident, contact their primary care provider. If resident does not have a primary care provider, or they are unavailable, contact EMP, EMP Care Coordination Center 1-844-982-7367. • Watch for signs that indicate immediate help is needed. Call 911* if you notice: o significant difficulty breathing. o chest pain or pressure. Or o new onset of confusion; or o difficulty waking up. • Make sure you let 911 and the hospital know that the resident has respiratory illness symptoms or has tested positive for COVID-19.
Washroom	• Designate separate washroom for case if possible. • If shared with others, try to clean between users or as often as possible each day.
Cleaning	• Per Appendix A, Table 8.0 Cleaning and Disinfection Guidance, as able.
Staff PPE	• Resources permitting, and where possible, contact/droplet precautions are recommended with cases for isolation period as well as with any other symptomatic residents. (Appendix D Personal Protective Equipment.)

	• Wearing a mask is also recommended during and after isolation, until 10th day after symptom onset.
Antiviral treatment	• Support residents to access antiviral treatment, if eligible. Appendix H: How to Access Influenza Antiviral Medication or Appendix I: How to Access Paxlovid Toolkit
Group activities	• Active daily monitoring. Only asymptomatic participate. • On site, with masking and distancing in place as much as possible. Provide hand sanitizer and encourage cough/sneeze etiquette.
Visitors	• General visitation may continue for those who are symptom free, with measures like masking and hand hygiene in place to prevent transmission if facility is able to manage the outbreak. • If not, DSP only, or palliative visitation permitted. Discourage social visits.
End of additional precautions	• 5 days after last case identified for COVID-19 or influenza.
Reporting	• Complete the form *New Brunswick Long-Term Care Facility Respiratory Surveillance Form* for all respiratory illness outbreaks declared in an ARF. Submit the completed form by fax or email to your Regional Public Health office when an outbreak is first declared as well as at the end of the outbreak.

6.2 GENERAL OUTBREAK MANAGEMENT PRINCIPLES

- Public Health will declare the start and end to outbreaks.
- Resident assessment: daily active monitoring of residents.
- Staff screening: passively screen before every shift and self-monitor throughout shift.
- Work modification for staff with **fever OR new or worsening onset of cough OR 2 or more other symptoms of respiratory illness listed in Table 2.0.**
- Enhance cleaning and disinfection of staff areas (break/lunchrooms, workstations etc.).
- Stringent adherence to masking and eye protection for staff working on affected unit/area.
- Ensure staff break/lunch areas do not promote transmission – limit capacity, ensure adequate distancing and barriers, if possible, between staff, wipes for disinfection etc.
- On any unaffected unit(s), until the outbreak is declared over, all staff, volunteers, visitors and Designated Support Persons (DSPs) are required to wear a medical-grade face mask in all resident-facing areas. Medical grade face masks shall remain available for anybody wishing to wear one at any time.

- Please refer to the 2023-2024 New-Brunswick Respiratory Season Vaccine Guide for resident vaccination during an outbreak **OR** reach out to the MOH who is directing your outbreak for guidance.

Reporting Guidance: if an outbreak is confirmed, Public Health will communicate this to the home.

- Operators are strongly encouraged to report additional cases in a daily line list that will be sent to Regional Public Health at an agreed upon time in the day. PH may provide the home with a line list template to use to report the cases.
- Please complete the *New Brunswick Long-Term Care Facility Respiratory Surveillance Form* for any respiratory outbreak occurring in your facility and submit the completed form by fax or email to your Regional Public Health office when an outbreak is first declared as well as at the end of the outbreak.
- if Public Health declares an outbreak, please send an email to the centralized team at SD_CRT@gnb.ca as soon as possible with the following details: Name of home, date your outbreak was declared, and any questions you may have.
- Report incidents as per the standards. In addition to reporting to PH and to the SD COVID Response Team, ARFs are to continue reporting incidents as per the process and requirements from their respective standards.

6.3 ANTIVIRAL TREATMENT AND PROPHYLAXIS

Antiviral treatments may be used in an ARF to treat those who have tested positive for COVID-19 or Influenza.

- Eligibility assessment for Paxlovid antiviral treatment for COVID-19 may be obtained through the primary care provider or participating pharmacist.
    - The primary care provider may prescribe nirmatrelvir/ritonavir (Paxlovid) for eligible residents with a positive COVID-19 test result. The eligibility form may be found here: PaxlovidEligibilityForm.pdf (gnb.ca)
    - Refer to Appendix I Paxlovid Toolkit, in this document for information regarding benefits of Paxlovid medication.
- Eligibility assessment for influenza antiviral treatment (Oseltamivir), may be obtained through the primary care provider or eVisitNB. This drug can help to reduce the severity of influenza symptoms and how long they last.
- As well, influenza antiviral prophylaxis (Oseltamivir), may be recommended by the RMOH to prevent the spread of influenza once an outbreak has been declared in a facility. Symptom-free residents who are at risk for more severe illness may be prescribed influenza antiviral prophylaxis to help prevent infection if taken shortly after exposure.
    - Once prophylaxis has been recommended by a MOH, residents may access influenza antiviral medication through a prescription from their primary care provider, pharmacist, or eVisitNB.
    - Currently, eligibility for influenza antiviral prophylaxis is limited to Level 3 Memory Care and Generalist Care facilities and must be recommended by the MOH.

Antiviral Treatment
medication that is given to a person who has tested positive or is presumed to be positive for a specific illness (i.e., Influenza or Covid-19).

Antiviral Prophylaxis
Antiviral medication that is given to more vulnerable residents in an area where an outbreak has been declared, and prophylaxis has been recommended by Public Health, whether vaccinated previously or not (i.e., Influenza).

The antiviral prophylaxis should be continued until the outbreak is over. If residents develop influenza-like symptoms while on prophylaxis, they should be switched to the antiviral treatment dosing schedule.

Please refer to:

- Appendix H: Influenza Antiviral Medication
- Appendix I: How to Access Paxlovid Toolkit

6.4. OUTBREAK THAT INCLUDES AT LEAST ONE RESIDENT

6.4.1. Public Health - plays active role in outbreak management.

- Initial touchpoint with facility to review the situation, declare the outbreak and adjust/clarify the above guidance as well as any additional guidance required.
- Answer questions from facility.
- Involved in determining risk level of exposures.
- MOH will determine if prophylaxis is recommended for a Memory Care Home or Generalist Care Home in outbreak.
    - If yes, Public Health will notify the pharmacy that the home is in outbreak and prophylaxis has been recommended.
- Receive daily line lists to maintain situational awareness.
- Declare outbreak over.

6.4.2. Resident Testing during an outbreak that includes at least one resident.

- Once an outbreak has been declared, testing of all symptomatic residents may not be required.
- The purpose of testing is to identify the most likely circulating virus. While there is no testing limit for POCT, facilities should perform no more than 6 PCR tests per outbreak investigation within 10 days, unless otherwise directed by the Medical Officer of Health.
- If the facility feels more tests are necessary, contact public health for advice on how to proceed.
- If several residents have symptoms at the same time, collect only from residents whose symptoms have started less than 48 hours ago, preferably those with the most prominent symptoms.
- Cases (probable) may be identified and managed based on presence (one or more) of new or worsening symptoms.
- The MOH will determine the timing of testing if required.
- Testing may be prescribed for the purpose of determining eligibility to treatment
- Refer to 5.34 Retesting- recommendations for residents/staff who have previously tested positive for COVID -19
- Additional testing may be required to rule out co-infections with other respiratory illnesses.

6.4.3. Control measures to be implemented during an outbreak that includes at least one resident.

- Restrict residents to affected wings/units.
- Group activities can continue provided small, consistent groups are maintained. Masking and physical distancing for residents as able. Individuals attending should be symptom free.
- General visitation may occur for asymptomatic residents during an outbreak if the facility is able to adequately function in outbreak management. Consider including the following measures to reduce transmission:
    - Visitors must be informed of outbreak.
    - Visitors are required to practice hand hygiene upon entering and leaving the facility.
    - Visitors are required to wear a mask for the entire visit. A resident would wear a mask, if able.
    - Visitors go directly to see resident; then exit facility. Do not visit multiple people.
    - Residents on affected wings may not be permitted to leave the facility during an outbreak, unless for medical or emergency purposes.
- There may be circumstances that require further restrictions for visitors, as recommended by the MOH. In such cases, DSPs and Palliative visitation may continue. See Table 7.0
- When residents are sharing a room, and one person is symptomatic, space beds a minimum of 2 meters apart, and privacy curtain must remain pulled. Consider masking residents in that room while awake, as able.
- Given that cohorting residents may not be practical, assigning staff members to care only for residents affected with the same signs and symptoms should be considered, where possible.
- Antiviral medications for COVID-19 or influenza can help to slow transmission in a facility. They reduce the duration and severity of symptoms in people who have tested positive for these illnesses. Antiviral medication for influenza can also help to prevent infection if taken shortly after exposure.

Table 7.0 In case of an outbreak where additional restrictions are needed:	
If the Medical Officer of Health has recommended restricting general visitation in a unit/ARF that is experiencing an outbreak, it is important to limit visitations to the following:	
Designated Support Persons (DSPs)	Permitted into **affected units/facilities**. These individuals are to be informed that an outbreak is occurring and to visit one resident within the facility only and not go from room to room. DSPs must follow the same infection control measures as staff, including the appropriate use of PPE during visits as indicated. If resident is not on isolation precautions DSP must wear medical grade mask and eye protection continuously as required as part of outbreak management.
Palliative[1] Visitation	In collaboration with the home, a physician or nurse practitioner determines if the resident's condition is considered end-of-life based on current clinical assessment findings. When death is anticipated as imminent, palliative visitation may occur, with a visitation plan developed in consultation with the care team of the home. Resident/POA/substitute decision maker may have a list of 10 visitors. Homes should develop a safe visitation plan for any palliative visitation which will occur. Safe visiting interventions may include: ○ Visitors understand the risk of exposure to the respiratory illness (for self and others). ○ Visitors follow all related home policies and public health measures in place within the home; and ○ Visitors remain vigilant in protecting themselves and others while on site, including continuous use of medical grade mask and eye protection, appropriate hand hygiene, following isolation precautions as required.
For the purposes of this document, palliative residents, are defined as individuals whose condition is considered end-of-life and death is anticipated as imminent.	

6.4.4 Admissions & Readmissions (return from hospital) During Outbreak

Patient transfers from a hospital outbreak unit to an ARF, or from a hospital to a facility experiencing an outbreak, will be made on a case-by-case basis involving the home, the primary care provider, in consultation with the Regional Medical Officer of Health and Social Development prior to discharge. The hospital physician should work with the receiving physician (if different) and the home is to arrange the appropriate transfer. Individuals should not be unreasonably denied admission or

[1] For the purposes of this document, palliative residents, are defined as individuals whose condition is considered end-of-life and death is anticipated as imminent.

readmission. When a risk of a respiratory illness has been identified, no admissions, readmission, or transfer will be considered if either of the following criteria are met:

- Inability to isolate the resident (either availability of private room and bathroom, cognitive impairments that would impede isolation or other operational considerations), applicable to situations where a resident requires isolation upon admission.
- Critical Staffing at the receiving ARF facility.

6.5 END OF OUTBREAK

Typically, an outbreak is declared over by MOH.

- **COVID-19:** absence of symptomatic or positive individuals for 10 days from last exposure
- **Influenza**: absence of symptomatic or positive individuals for 8 days.
- **RSV**: absence of symptomatic or positive individuals for 8 days.

APPENDIX A: ILLNESS PREVENTION STRATEGIES

IMMUNIZATION

- **Keep Immunizations Up to Date** Immunization helps to prevent infection and provides protection from severe illness and hospitalization for COVID-19, influenza, and other respiratory illnesses (i.e., pneumococcal). RoutineImmunizationSchedule.pdf (gnb.ca).
- New-Brunswick Public Health continues to recommend that all eligible ARF residents and staff should **stay up to date** with their COVID-19 vaccination. This means getting a dose with the updated mRNA vaccine. Individuals are eligible if it has been 6 months (minimum of 3 months) since your last dose or infection (whichever is most recent). Refer to COVID-19 vaccines (gnb.ca)
- A seasonal influenza vaccine is highly recommended for those persons at high risk of influenza-related complications, those capable of spreading influenza to individuals at high risk of complications, and those who provide essential community services. This includes:
    - People of any age who are residents of ARF or NH (Nursing Home) facilities.
    - People ≥. 65 years of age.
    - Health care and other care providers in facilities and community settings.
- RSV vaccines are not currently available. Once available, the resident or substitute decision maker should approach their primary care provider to discuss whether RSV vaccination is right for them.
- Document evidence of immunization for all residents. If immunization status of a resident is unknown or undocumented, they should be considered unvaccinated, and vaccination should be considered. If a resident is not immunized the reason should be recorded (e.g., refusal, allergy). Records of consent for antiviral treatment and/or prophylaxis should also be available in the event of an outbreak.

MASKING

- Masks are required based on a point-of-care risk assessment (PCRA).
- Masks are required based on Work Modification for Symptomatic Staff
- Each ARF should develop policies and procedures to address the need for increased mask usage within their homes.

- During the respiratory season, operators should encourage direct care staff to mask when caring or interacting with residents. Homes may expect enhanced masking guidance throughout the year if the risk of viral respiratory illness activity increases.
- Masks will continue to be provided to operators so that they can be made available as necessary.
- On any unaffected unit(s), until the outbreak is declared over, all staff, volunteers, visitors, and Designated Support Persons (DSPs) are required to wear a medical-grade face mask in all resident-facing areas. Medical grade face masks shall remain available for anybody wishing to wear one at any time.
- During an outbreak, strict adherence to masking will be required.

PRACTICE RESPIRATORY HYGIENE

Tiny droplets from a cough or sneeze can make other people sick. Following basic respiratory hygiene (Table 7.0) can help to stop the spread of germs. Respiratory hygiene should be encouraged for everyone, and particularly for those who have respiratory symptoms.

Table 8.0 Basics of Respiratory Hygiene

	When you cough or sneeze, turn your head and step away, to give others space.
	Cover your mouth and nose with a tissue. Dispose of tissue in a garbage can. Perform hand hygiene. If a tissue is not available, cough or sneeze into your elbow instead of your hands.
	Wear a well-fitted mask if you have symptoms and others are present in the room, or if you have recently recovered from illness.
	Wash your hands with soap and water or hand sanitizer frequently.

HAND HYGIENE

Hand hygiene is an effective way to reduce the spread of germs on hands and should be part of the daily routine of clients, staff, and visitors. Soap and water should always be used if hands are visibly soiled and after personal toileting. For ARFs, it is best practice for alcohol-based hand rubs (ABHR) to contain between 70-90% ethyl alcohol. Consider using an adapted

dispenser if clients are likely to ingest alcohol-based products.

Hand hygiene should be performed throughout the day, not only when visibly soiled. Clean your hands at the point of care, and **during these 4 critical moments:**

1. Before the first contact with the resident or their environment
2. Before aseptic procedures (i.e., changing a bandage)
3. After risk of exposure to bodily fluids
4. After contact with a resident or their environment.

It is equally important to practice hand hygiene:

- before entering the facility
- before meals or before feeding others
- before and after preparing food
- before and after caring for or visiting with others
- before and after using disposable gloves
- after using the toilet; as well as after changing diapers or helping someone toileting
- after blowing your nose, coughing, or sneezing
- after using shared items or electronics.

For proper handwashing methods refer to these resources:
https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/WASH_LAVEZ.pdf

PERFORM ENVIRONMENTAL CLEANING AND DISINFECTION

Continue regular cleaning and disinfecting of all general surfaces and high touch areas i.e., doorknobs, handrails, etc. with a Health Canada approved cleaning product. It should contain a Drug Identification Number (DIN) and labelled as a broad-spectrum viricide. Follow the cleaning and contact directions provided for the product being used.

When illness is present in a facility, more frequent cleaning is advised. All surfaces, especially those that are horizontal and frequently touched, should be cleaned and disinfected at least twice daily and when soiled, as per the table below:

Table 9.0 Cleaning and Disinfection Guidance

Cleaning & Disinfection	
Area and Description	**Frequency (min)**
Surfaces: in resident rooms and central areas	
Horizontal (e.g. tables)	Twice Daily (and when soiled)
High touch (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 handle and showe handles, faucets or shower chairs, grab bars, outside of paper towel dispenser.)	
Low touch (e.g., shelves, bedside chairs or benches, windowsills, headwall units, overbed light fixtures, message or white boards, outside of sharps containers).	Once Daily (and when soiled)
Resident Care Equipment	
E.g., BP cuffs, electronic thermometers, oximeters, stethoscope etc. Hospital grade disinfectant (e.g., cleaner and disinfectant wipes) using the recommended contact time should be used to clean and disinfect smaller resident care equipment. Important Note: Ensure all staff responsible for utilizing resident care equipment is adhering to required cleaning and disinfection practices.	After Each Use
Single Use Devices: discard in a waste receptacle after a single use on one resident. Single person/resident devices: discard after use with one resident (may be more than one use).	
Outside Resident Room (e.g., surfaces that are touched by or in contact with staff)	
Computer carts and/or screens, medication carts, charting desks or tables, computer screens, telephones, touch screens, chair arms. Staff should ensure that hands are cleaned before touching the above-mentioned equipment.	Once Daily (minimum) and when soiled.
Floors and Walls: Kept visibly clean and free of spills and debris.	
Terminal Cleaning and Disinfecting	
Items that cannot be appropriately cleaned and disinfected should be discarded upon resident transfer or discharge. Toilet brushes, unused toilet paper and other disposable supplies should be discarded. Privacy curtains should be removed and laundered upon a resident's discharge or transfer.	After discharge, transfer or discontinuation of contact droplet precautions.
Ensure all staff responsible for environmental cleaning adhere to required cleaning and disinfection practices.	

APPENDIX B: ANTIVIRAL ELIGIBILITY AND STANDING ORDER FORM

This form must be completed on admission and annually by the prescriber who is performing the assessment for influenza antiviral prophylaxis and/or treatment.

- *Provide this form to the dispensing pharmacy and send a copy to the adult residential facility (ARF) operator. The Standing Order prescription will remain on file for 1 year.*
- *Forward requisitions for testing to the ARF operator.*

SECTION 1.0: RESIDENT INFORMATION

Resident last name	First name	Medicare Number	Date of Birth
			YYYYMMDD

Name of Facility	Street Address	City

Province	Postal Code	Guardian, if applicable	
		Facility Phone Number	
Weight:	Height:	Sex at Birth: ○Male ○Female	

SECTION 2.0: RESIDENT ELIGIBILITY STATUS

	No	Yes	Unknown
Treatment eligibility: Is this resident eligible to receive influenza antiviral medication for treatment? *(Is a member of an at-risk group or has comorbidities that predispose them to severe influenza. i.e., History of chronic condition/illness related to lungs, heart, kidneys, blood. Presence of diabetes/metabolic conditions, neuromuscular disease/disorders, cognitive dysfunction, or immune compromised.)* **If 'Yes',** please consider providing a standing order prescription and corresponding laboratory testing requisitions described in Section 3.0 in advance of annual respiratory illness season.			

Prophylaxis eligibility: Some Adult Residential Facilities have been designated as sites where prophylaxis may be offered, if advised by the Regional Medical Officer of Health during an outbreak. Antiviral prophylaxis or early access to treatment (if symptomatic) will follow guidelines from the Association of Medical Microbiology and Infectious Disease Canada.
In Section 3.0, please consider providing a standing prescription order for the resident under your care to access time-sensitive influenza antiviral medications for prophylaxis.

Additional information:

SECTION 3.0: STANDING ORDERS FOR RESIDENTS OF ADULT RESIDENTIAL FACILITIES (ARFS)

Orders for Lab Testing: ** Must be ordered by a physician or nurse practitioner. Register for testing according to usual Regional Health Authority processes.

Perform serum creatinine on admission if a result is not available within the past 12 months. Repeat annually.

Perform PCR test for Covid-19, Influenza, and Respiratory Syncytial Virus, if resident has new or worsening symptoms of respiratory illness.
Note: *If an outbreak is declared, symptomatic individuals will be presumed positive and will remain eligible for treatment, if indicated. If presumed positive, lab confirmation may not be required.*

Repeat serum creatinine, when administering influenza antiviral therapy, if there is reason to believe the resident has kidney disease.

Resident Name
Date of Birth
Medicare

Influenza Antiviral Eligibility and Standing Order Form

Adult Residential Facilities

Prescription Orders: *Prescribing antiviral medication for the treatment of influenza falls within the scope of practice for nurse practitioners and physicians; however, influenza antiviral prophylaxis may be prescribed by nurse practitioners, physicians, or pharmacists. The prescription will remain on file for 1 year.*

If Public Health identifies an influenza outbreak in this resident's special care facility, and influenza antiviral prophylaxis has been recommended by the Regional Medical Officer of Health, administer as outlined below:

- If no symptoms, give prophylactic (preventative) dose
- If symptoms are present for less than 48 hours, give treatment dose. Note: Resident is presumed positive, influenza testing is not required.
- If symptoms are present for greater than 48 hours, **DO NOT TREAT.**

Begin Influenza Treatment Dose if resident tests positive/presumed positive for influenza or develops symptoms while on prophylaxis protocol. Oseltamivir 75 mg orally twice daily for 5 days	No	Yes
Begin Influenza Prophylaxis Dose if the facility where the resident lives is experiencing an influenza outbreak: Oseltamivir 75mg orally once daily for 10 days, with two (2) refills for five (5) days each if outbreak is ongoing. If symptoms emerge, adjust dose to treatment protocol.	No	Yes

Pharmacist will adjust dosage according to renal function, if required.

Creatinine Clearance (mL/min)	Oseltamivir Prophylaxis Dose	Oseltamivir Treatment Dose
> 60 mL/min	75 mg once daily	75 mg twice daily for 5 days
30-60 mL/min	30 mg once daily	30 mg twice daily for 5 days
10-29 mL/min	30 mg on alternate days	30 mg once daily for 5 days
<10 mL/min (renal failure)	30 mg once (Use with caution)	Single 75 mg dose (Use with caution)
Dialysis Patients	Contact Dialysis Unit for direction	Contact Dialysis Unit for direction

SECTION 4.0: PRESCRIBER INFORMATION

Last Name:	**First Name:**
License Number:	**Telephone:**
Signature:	**Date:**

Should you decide to provide all of the information requested on the form, it is important to know that its submission constitutes consent to the collection, use and disclosure of your personal information. The collection use and disclosure of personal information is protected by the *Right to Information and Protection of Privacy Act* (RTIPPA), *Personal Health Information Privacy and Access Act* (PHIPAA) and all other applicable legislation, regulation or policy.
If you wish to know more about your privacy rights, please consult: gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/HealthActs/PrivacyNotice.pdf

APPENDIX C: INFORMED CONSENT FORM FOR INFLUENZA ANTIVIRAL MEDICATION

INFORMATION ABOUT Influenza Antiviral Medication Oseltamivir

If an outbreak of influenza occurs in an adult residential facility (ARF), residents who are at risk for more severe illness may be eligible for influenza antiviral medication. This medicine can help to reduce the severity of influenza symptoms and how long they last. It can also help to prevent infection if taken shortly after exposure. The resident's nurse practitioner, doctor, or pharmacist will determine if the resident qualifies for antiviral medication.

Antiviral medication works best when taken as soon as possible after symptoms develop or exposure. The following information has been provided to help inform you or your substitute decision maker's decision whether to take this medication.

What is influenza?

Influenza, or the flu, is an infection caused by the influenza virus, and is different from COVID-19. It is most common in the fall and winter. The flu is highly contagious. The virus usually enters the body through the mouth, nose, or eyes. When a person with the flu coughs or sneezes, the virus can be passed on to anyone nearby. Symptoms of the flu include fever, cough, sore throat, headache, muscle aches and extreme fatigue, sometimes lasting for seven days or longer.

Influenza can make heart, lung, and kidney problems worse and can result in pneumonia, hospitalization, and death. About 3,500 Canadians are estimated to die from complications of seasonal influenza each year.

All individuals should be encouraged to receive their annual influenza immunization; however, even with high immunization rates, outbreaks of influenza commonly occur.

Why is influenza a special concern for more vulnerable individuals in adult residential facilities?

Some individuals who live in an ARF may be more likely to experience severe illness from influenza.

- Living together makes germs spread more easily from person to person.
- The immune system of individuals who are elderly or immune compromised may not respond as well as it used to.
- Chronic heart, lung, or kidney problems, as well as diabetes may worsen when a person is ill with influenza.
- Conditions such as obesity may also lead to more severe respiratory illness.

For those who are more vulnerable, severe influenza illness may lead to reduced health status, loss of independence, as well as hospitalization.

What is influenza antiviral medication?

Oseltamivir is an influenza antiviral medication that is taken by mouth which can be used to prevent an influenza infection if taken shortly after exposure.

In addition, influenza antiviral medication has also been shown to reduce the length of symptoms and likelihood of complications for individuals who have tested positive for influenza.

What are the side effects of Oseltamivir?
Oseltamivir does not usually cause many side effects. The most common side effects are nausea, vomiting and diarrhea in 4 - 6% of people. These do not last long and usually occur with the first dose. Taking Oseltamivir with food may reduce these side effects.

How long will influenza antiviral medication be given for prophylaxis?
Oseltamivir is usually given for about 10 days, the average time that an influenza outbreak lasts.

What happens if a person who was exposed to influenza develops symptoms while taking antiviral medication?
Since oseltamivir can reduce the length of symptoms and complications, it will be given at a higher treatment dose for 5 days and then stopped.

Do residents/patients have to take influenza antiviral medication?
No. If a decision is made not to take this medication, standard supportive influenza care will continue to be provided. Please note that their isolation period will likely be longer without antiviral medication.

Is there a cost?
Influenza antiviral medication is publicly funded for ARF residents who do not have existing drug coverage for Oseltamivir.

Who should <u>not</u> take antiviral medication for influenza?

- Anyone who has had a severe allergic reaction to the specific antiviral prescribed.
- Persons with severe kidney or liver disease (Check with prescriber).
- Persons who are pregnant, may become pregnant or are breast-feeding.

If additional information is required, please consult with your primary care provider (doctor or nurse practitioner) or pharmacist. ***NOTE**: This form must be shared with the prescribing pharmacy.*

I have reviewed and understand the information provided about influenza.	**Yes**	**No**	
I give consent for myself or _____ to receive: *Insert name of resident*			
Influenza antiviral treatment to reduce the severity of illness.	**Yes**	**No**	
Influenza antiviral for prophylaxis, to reduce likelihood of becoming ill after exposure.	**Yes**	**No**	
Name of Resident: **Date of Birth:**			
Print name of Substitute Decision Maker, if applicable **_____** **(With legal authority to consent)**	**Signature:** **Date:**		

APPENDIX D: PERSONAL PROTECTIVE EQUIPMENT (PPE)

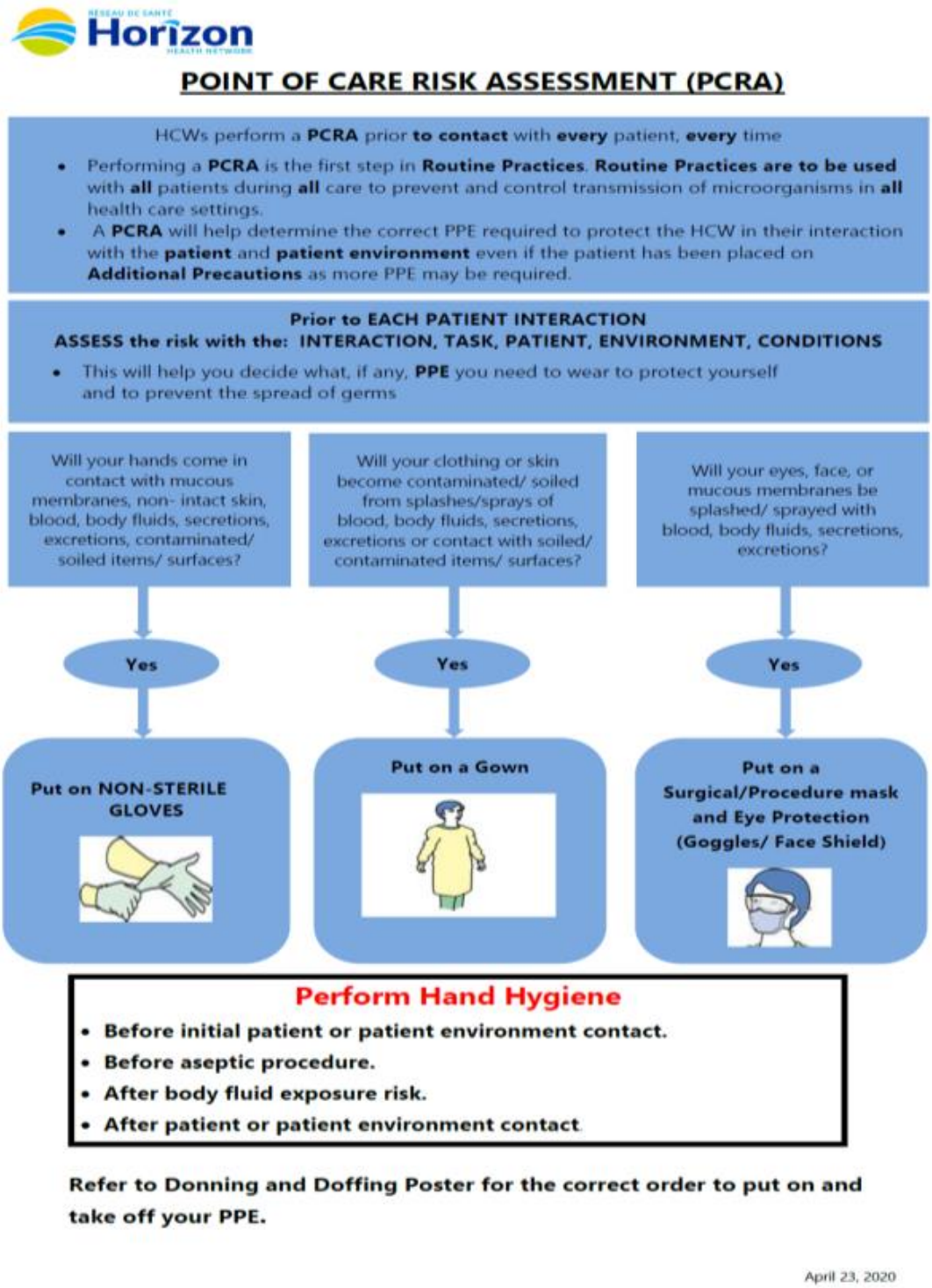
To be used when providing direct care to a resident who is on isolation precautions due to suspected or confirmed respiratory illness.

ALL PPE MUST BE CHANGED IF IT BECOMES SOILED, WET OR DAMAGED		
Type	**Description**	**Tips**
Masks	Face masks (ASTM level 1) provide a physical barrier that help prevent the transmission of the virus from person to person by blocking large particle respiratory droplets propelled by coughing or sneezing	Must be changed upon exit of an isolation room, UNLESS providing sequential care between POSITIVE residents with the same pathogen OR providing sequential care between asymptomatic residents**.**
N95 respirators	Respiratory protective device designed to have a very close facial fit and efficient filtration of airborne particles.	Edges of the respirator are designed to form a seal around the nose and mouth.
Eye Protection	Eye protection (e.g., goggles, face shields etc.) protect the mucous membranes of the eyes during case/probable case/suspect case care or activities likely to generate splashes or sprays of body fluids including respiratory secretions. **Prescription eyeglasses alone are not adequate protection against respiratory droplets.**	Must be changed (or cleaned if using non-disposable eye protection) upon exit of an isolation room, UNLESS providing sequential care between like POSITIVE residents OR providing sequential care between asymptomatic residents**.**
Gloves	Disposable single use gloves should be worn when in direct	

	contact with the ill person, cleaning contaminated surfaces, and handling items soiled with body fluids, including dishes, cutlery, clothing, laundry, and waste for disposal.	**Must be changed between each resident.** **Not a substitute for hand hygiene**; staff must perform hand hygiene before putting on and taking off gloves. Not for continuous use outside of an isolation room. Gloves should be removed, hand hygiene performed, and new gloves applied when they become soiled or torn during care. Double gloving is not necessary.
Gown	AAMI Level 2 gowns are used to protect your clothing and skin from becoming contaminated/soiled from: splashes/sprays of blood, body fluids, secretions, or excretions, contact with soiled/contaminated items/surfaces.	**Must be changed between each resident.** Not for continuous use outside of an isolation room. Must be tied at the neck and the back. If clothing exposed underneath, two gowns should be worn, first covering the back (tied in front), second covering front (tied in back).
Donning & Doffing	Proper donning and doffing (putting on and taking off) of PPE is key in preventing the spread of pathogens from one individual to another. **When removing PPE (doffing):** • **PPE below the neck**: gown and gloves, are removed *in the room (close to the door)*. • **PPE above the neck**: eye protection and masks, are changed/removed *outside of the room*.	

APPENDIX E: POINT OF CARE RISK ASSESSMENT

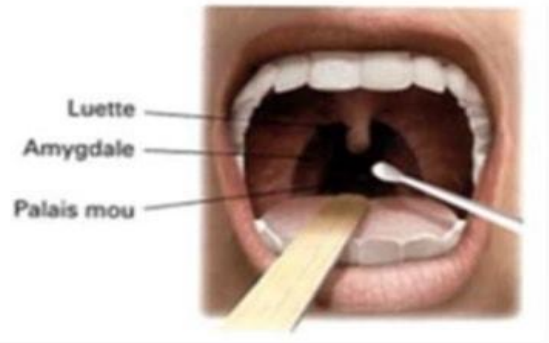
Figure 1.0 Patient Care Risk Assessment:



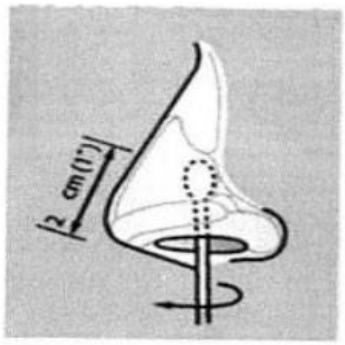
APPENDIX F: THROAT-NASAL SWAB POINT OF CARE TESTING FOR COVID-19

A throat-nasal swab may be performed by a healthcare professional or an ARF staff member who has participated in education on this topic and demonstrated competency in this technique.

- Advise resident not to eat, drink, vape, smoke, brush teeth, or chew gum 30 minutes prior to testing.
- Prepare the test according to package instructions: Tests vary by brand. Note that some swabs are scored to break easily. Hold the swab with the thumb and index finger on the score line to prevent breakage when swabbing.
- Obtain Throat Swab: Swab the tonsil area in the back of the throat for five seconds on each side (avoiding the tongue, teeth and lips).
- Obtain Nasal Swab: Swab the nostrils using the same swab. Gently insert the swab about 1-2 cm into the first nostril, or until resistance is felt. Rotate five times, remove and repeat on the other side.
- Process the sample: Place the swab in the tube. Follow the test kit instructions.



(a) Throat technique



(b) Nose technique

References:

- EM/ANB Throat/Nose Specimen Collection.pdf
- Provincial Public Health Laboratory Nova Scotia instructions-alternate-collection-throat-and-nares-covid.pdf
- Throat and Nares (Nasal) swabbing for Rapid Antigen Tests | SaskHealthAuthority
- Virus Respiratory (Combined Throat and Both Nostrils) Specimen Collection Instructions | Public Health Ontario

APPENDIX G: HOW TO ISOLATE WITH CONTACT AND DROPLET PRECAUTIONS

Infection Prevention and Control Precautions must be balanced with supporting a healthy social lifestyle for the resident.

Accommodation

- Isolate in single room, if possible. If isolation in a single room is not possible, space beds a minimum of 2 meters apart, and privacy curtain must remain pulled. Consider masking residents in that room while awake, as able.
- Prioritize residents who cannot maintain spatial separation of ≥ 2 meters from others for a private room / private bathroom.
- The resident's door may remain open if the distance from the resident to the door is ≥ 2 meters; and it is not a risk to other residents who may not adhere to isolation precautions.

Personal Protective Equipment

- If entering an isolation room or bed space of a shared room, be prepared to interact with the resident by wearing all PPE listed in Figure 1.0.
- Instruct visitors on necessary infection control measures including:
  o How to put on and remove isolation attire
  o Hand Hygiene (alcohol-based hand rub and/or soap and water)

Hand Hygiene

- Clean hands before and after contact with the resident and/or resident's environment with alcohol-based hand rub or with soap and water.
- Do not use the resident's bathroom sink for hand hygiene.

Isolation Supplies

If possible, gather items together to create an Isolation Kit in advance:	
Alcohol based hand rub 70 – 90% (method of choice for hand hygiene in all healthcare facilities)	Laundry hamper
Long sleeved isolation gowns	Waste containers
Gloves	Pen
Eye protection	Post-it notes
Surgical masks	Isolation Signage (Contact and Droplet Precautions)
Dedicated thermometer, if applicable	Approved disinfectant for equipment cleaning (e.g., accelerated hydrogen peroxide).
Stethoscope, if applicable	

Resident Care Supplies

- Limit the disposable supplies taken into the room to the amount anticipated for use.
- Disposables not used cannot be returned to stock, they must be discarded.
- Provide the resident with tissues, a waste container for used tissues and a mechanism to perform hand hygiene following coughing/sneezing.

Isolation Room Set up

- Post clearly visible signs with the required precautions (both official languages) outside the resident room.
- Waste can and laundry hamper in resident room.
- Set up the personal protective supplies outside the resident room (anteroom or corridor).

Entry/Exit Procedure:	
Before entering room, cubicle, or bed space in a shared room:	**To exit** room, PPE is removed in the following order prior to exiting the room
▪ Perform hand hygiene	▪ Remove gloves and dispose. Perform hand hygiene.
▪ Put on gown— if required	▪ Remove gown (if worn), touching only the inside of gown and place in hamper. Perform hand hygiene
▪ Put on surgical/procedure mask	▪ Remove eye protection (front of eye protection is contaminated) *. Perform hand hygiene.
▪ Put on eye protection	▪ Remove mask-remove by ties (front of the mask is contaminated). Perform hand hygiene.
▪ Put on gloves.	**Note: Re-usable eye protection must be cleaned and disinfected after each use*
NOTE: PPE donning and doffing posters are available at SD_CRT@gnb.ca	

Charting

Do not take any part of the resident chart into the room. To transfer information from the resident room:

- Keep dedicated pen and post-it notes inside resident room.
- Write information on post-it and stick-on window/door of resident room.
- Exit the resident room following the Enter/Exit Room Procedure.
- Use another pen outside the room to record information on chart/paper.

Equipment
- Use disposable equipment, when possible.
- Dedicate reusable equipment to this resident and leave in room.
- Clean and disinfect reusable equipment before removing from the room.

Laundry and Waste
- Tie off the laundry and waste bags before leaving the room.
- Place outside the room for pick-up.
- No further special handling is required for laundry and waste.

Food Trays
- Regular dishes and cutlery.
- Regular dishwashing procedures.

Room Cleaning
- Twice daily cleaning of all high touch surfaces, bed rails, light switches, bathrooms, bedside tables, walker, wheelchair, cane, and drawer handles remotes, phone, etc.
- If resident is discharged or transferred out of room, carry out discharge cleaning (per facility policy) and discard all magazines, personal care supplies, disposable supplies, etc.

Resident Transport
- Resident remains confined to room except for medically required activities. Re-schedule all non-urgent medical appointments. If it is necessary to leave the room for tests/facility transfer/therapy:
- Sending facility must notify receiving facility of required precautions.
- Transport Personnel to don Personal Protective Equipment (PPE) to enter resident room.
- Resident to don a surgical/procedure mask and clean clothing.
- Utilize clean linens on the clean transport-wheelchair/stretcher (the resident's linen should not be used for transport).
- Assist resident with hand hygiene.
- When leaving the room with the resident, transport personnel should remove PPE (gowns and gloves), perform hand hygiene, and don clean PPE. The surgical mask and eye protection do not need to be changed.

- Use facility supplied disinfectant (i.e., accelerated hydrogen peroxide) to provide a clean area for hands on the transport equipment.
  If equipment from the resident's room must also be transported, it must be disinfected and allowed to air dry prior to use.
- Use a transport route that avoids populated areas.
- Maintain distance ≥ 2 meters from others.
- Use a dedicated elevator, with no other persons in it.
- Disinfect equipment after transfer.

APPENDIX H: INFLUENZA ANTIVIRAL MEDICATION

If a resident receives a positive test result for influenza:
(Operator may obtain resident's PCR test result from *MyHealthNB*).

ARF Operator notifies the following individuals of positive result for influenza:

- EMP, if resident is a patient of EMP.
- Family/guardian
- Primary Care Provider.

Treatment with influenza antiviral medication is the responsibility of the primary care provider.

An influenza antiviral works best if given within 48 hours of symptom onset or exposure.

If Public Health has declared an outbreak in a Level 3G or 3B facility, and prophylaxis has been recommended by Public Health:

- Public Health will contact the facility's pharmacy by phone and in writing (email or fax) to confirm the outbreak and recommendation for prophylaxis.
- The ARF's pharmacy has the completed ***Influenza Eligibility and Standing Order form*** on file from the primary care provider and will begin to fill resident prescriptions.
    - The facility operator will provide the pharmacist with **consent forms for influenza antiviral therapy** that have been completed by the resident/designated decision maker. Consents MUST be provided to the pharmacy for the prescription to be filled.
- If a Standing Order Prescription is not on file for the resident, the operator may contact EMP, if resident is a client; or the Primary Care Provider (PCP) to obtain a prescription for influenza antiviral medications for prophylaxis.
- If unable to promptly connect with their PCP, ask the Pharmacy to assess the resident for influenza antiviral prophylaxis. Residents who do not have a primary care provider may contact a participating pharmacist or eVisitNB to be assessed for influenza antiviral prophylaxis.
    - If the pharmacist determines that additional bloodwork (i.e., Serum creatinine) is needed to calculate the resident's dosage, the operator may be required to

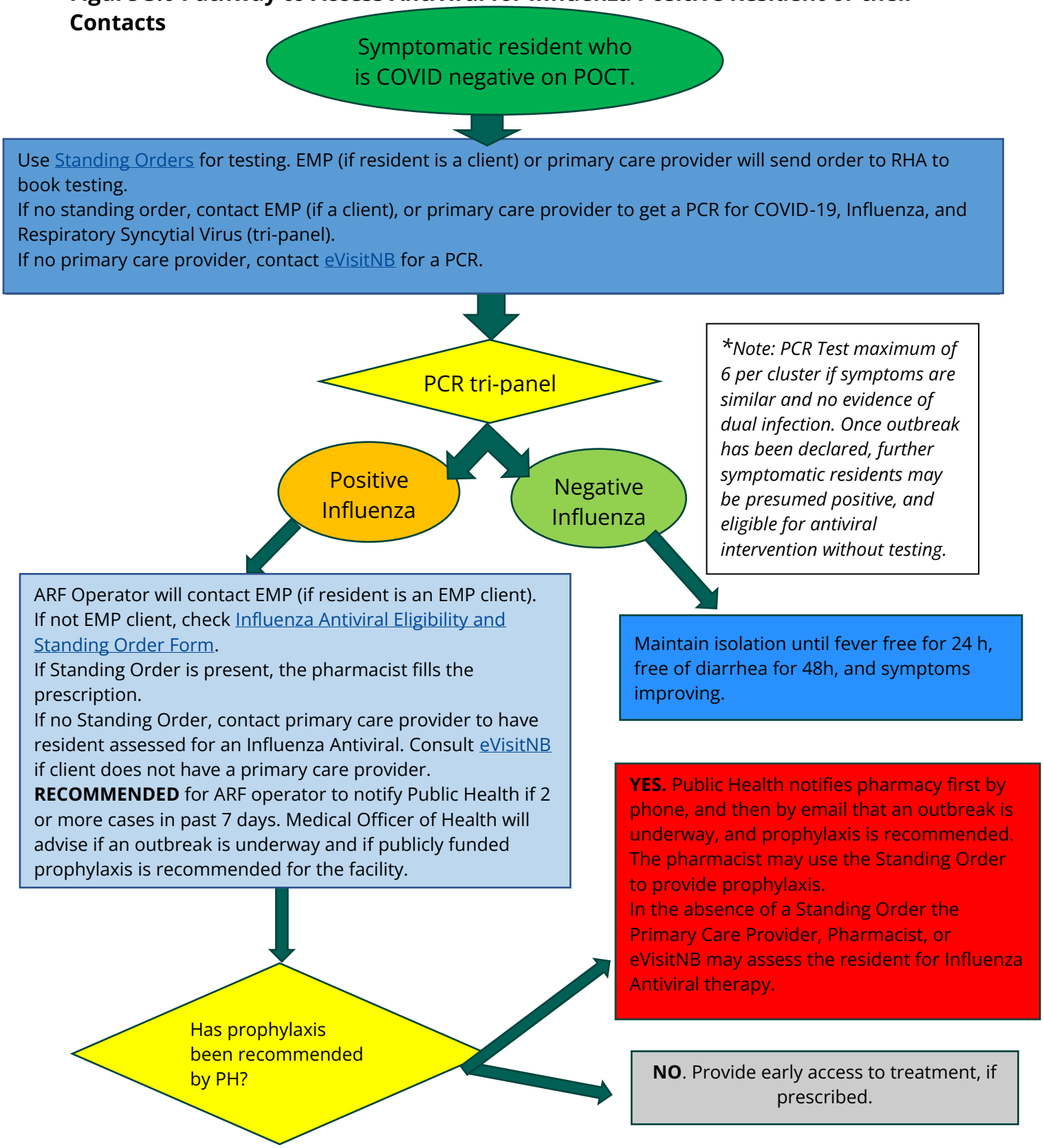
*A recent serum creatinine is **NOT** required before starting Oseltamivir prophylaxis unless there is reason to suspect **significant renal impairment**. Recent means within 12 months for residents who are medically stable or since any significant change of medical status.*

contact the primary care provider or eVisitNB to obtain an order for lab testing.

- The pharmacist will determine resident's eligibility for prophylaxis and prescribe if indicated.

For additional information, refer to Figure 3.0 Pathway to access antiviral for Influenza positive resident or their contacts.

Figure 3.0 Pathway to Access Antiviral for Influenza Positive Resident or their Contacts



APPENDIX I: HOW TO ACCESS PAXLOVID TOOLKIT (FOR USE IN ARFS)

Pre-outbreak considerations: Is My Resident Eligible for Paxlovid (antiviral used to treat Covid 19)? Paxlovid™ is an anti-viral medication intended for those who are at risk to experience more severe illness from COVID-19. There are many criteria that must be met before it can be prescribed. This is not an official eligibility assessment for Paxlovid, but merely a tool to help your facility to be ready for the process.

Complete the following pre-outbreak considerations for each resident in your facility. A resident who has all "Yes" responses is better prepared for a PAXLOVID assessment, should they test positive for COVID-19.

Pre-outbreak considerations:	**Yes**	**No**
1) Can the resident swallow full size pills without crushing? A resident must be able to swallow pills whole to qualify for PAXLOVID.		
2)Does the family/resident consent to resident receiving PAXLOVID, if they qualify? Informed consent of family/resident is required. For more information, review Paxlovid™ Patient Information		
3) Is the resident at risk to experience more severe illness from COVID-19? People at risk to develop more serious forms of Covid 19 include: • ≥ 18 and at higher risk for severe outcomes (see list)		
4) Is the resident's medication list up to date? Some medications cannot be used in combination with PAXLOVID. Contact your attending pharmacist to get a complete list of medications ready for each resident.		
5) Does the resident have a personal account for eVisitNB and MyHealthNB? • PCR test results can be obtained faster using MyHealthNB. • If unable to contact a resident's health care provider, a prescription for Paxlovid may be obtained by contacting participating pharmacy, 811 or eVisitNB. *eVisit is Free until March 2024 with valid New Brunswick Medicare card. For access to this FREE service, please ensure you are assessed by eVisit and not another online service company (EX. Maple)		

If your resident has obtained YES responses for questions 1-4, they may be eligible for Paxlovid. Facility operators can further their readiness by taking the steps outlined in questions 5.

HOW TO OBTAIN A PAXLOVID ASSESSMENT FOR RESIDENTS

1. A resident in your facility has symptoms of COVID-19. Have the resident's symptoms started within the last 5 days? Paxlovid must be started within 5 days of symptom onset. It is intended for people experiencing mild-moderate illness. If symptoms are severe, they DO NOT qualify for PAXLOVID. For a complete list of COVID symptoms go to: About COVID-19 (gnb.ca)

2. Test to confirm COVID-19:

To access Paxlovid, individuals must have a confirmed positive test, either PCR or Point of Care Test (POCT). If a POCT is used, it is recommended to be observed by a health care provider or done by staff trained in POCT. *Note: Contact EMP if concerned about health of resident.

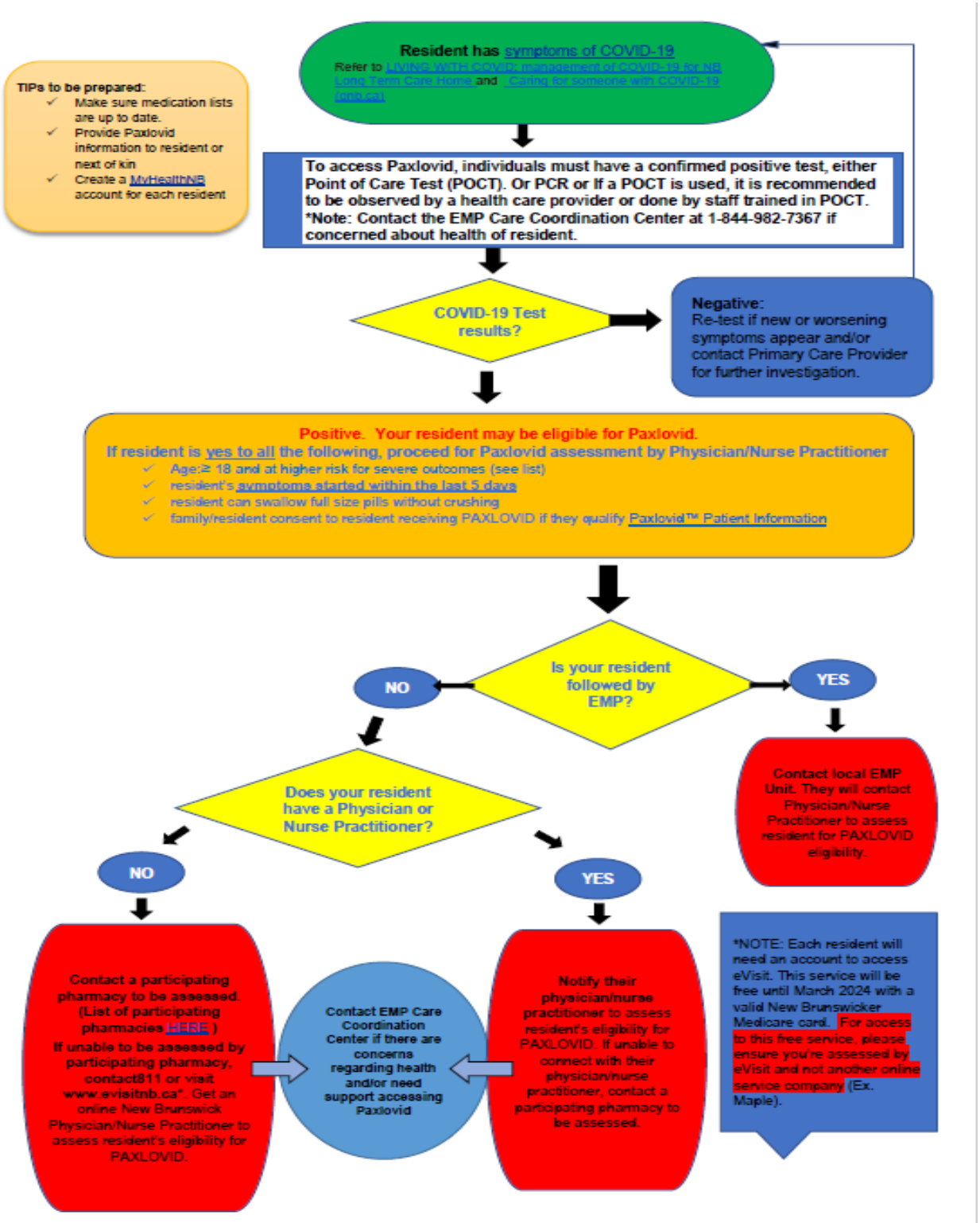
If test result is positive for COVID-19, resident may be eligible for Paxlovid.

If resident is followed by EMP:	**If resident is not followed by EMP but has a primary care provider.**	**If resident is NOT followed by EMP AND does NOT have a primary care provider (or cannot reach their primary care provider).**
Contact EMP. EMP will follow-up with Primary Care Provider to determine if resident is eligible for PAXLOVID and will send completed eligibility form to your attending pharmacy.	**Notify primary care provider** Primary care provider will determine if resident is eligible for PAXLOVID and will send completed eligibility form to your attending pharmacy. If unable to connect with their physician/nurse practitioner, contact a participating pharmacy to be assessed. List of participating pharmacies **HERE**	**Contact a participating pharmacy to be assessed. (List of participating pharmacies HERE)** **If unable to be assessed by participating pharmacy, contact 811 or visit www.eVisitnb.ca*.** Get an online New Brunswick Physician/Nurse Practitioner to assess resident's eligibility for PAXLOVID. For access to this free service, please ensure you're assessed by eVisitNB and not another online service company (Ex. Maple).
	***Note: Contact EMP if concerned about health of resident or need support accessing Paxlovid.**	

ONCE A PRESCRIPTION IS OBTAINED:

3. Obtain PAXLOVID from your attending pharmacy for eligible residents. Carefully follow instructions provided with this medication.

Figure 4.0 How to Access Paxlovid



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