SEASONAL INFLUENZA MANAGEMENT
2017-18 Season Update

Long Term Care Resource Guide
# Table of Contents

Contributors ........................................................................................................................................... 4  
Purpose ...................................................................................................................................................... 5  
Introduction .................................................................................................................................................. 6  
Reporting Requirements ............................................................................................................................... 7  
Definitions .................................................................................................................................................... 7  
ROLES & RESPONSIBILITIES ......................................................................................................................... 10  
  Unit Health Care Aides ............................................................................................................................... 10  
  Unit Nurses .................................................................................................................................................. 11  
  Unit Clerks/designates ............................................................................................................................... 14  
  Unit Managers .......................................................................................................................................... 15  
  Site LTC Infection Control Professional/designates .................................................................................. 16  
  Medical Director/ designate ....................................................................................................................... 21  
  Facility Senior Management/ Administration .............................................................................................. 22  
  Facility Occupational Health/designate ...................................................................................................... 23  
  Facility Environmental Support Services/Housekeeping ......................................................................... 24  
  Facility Nutrition/Dietary/Food Services .................................................................................................. 25  
  Facility Recreation Manager/Unit Recreation ............................................................................................ 26  
  Facility Pharmacist/Pharmacy ................................................................................................................... 27  
  Resident’s Attending Prescribers ............................................................................................................... 28  
  Manager WRHA LTC Program IP&C .......................................................................................................... 29  
  Communicable Disease Coordinators ...................................................................................................... 30  
  Medical Officer(s) of Health (MOH) ........................................................................................................ 31
Evaluation ........................................................................................................................................... 33
References ........................................................................................................................................... 34
Appendices .......................................................................................................................................... 36
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New for 2017

1. Manitoba Health Seniors and Active Living (MHSAL) has approved and is funding the use of a high-dose (HD) version of the seasonal influenza immunization called Fluzone® High Dose. Fluzone® High Dose has been approved for use in Canada since the fall of 2015. Based on the available evidence, the National Advisory Committee on Immunization (NACI) concludes that there is evidence that high dose influenza vaccine should provide superior protection compared with standard dose vaccine for adults ≥65 years of age. This superior relative protection compared to standard dose vaccine appears to increase with increasing age over 65 years. The HD version contains 60 μg of antigen per strain and the regular version contains 15 μg. The risk of becoming severely ill or dying when infected with influenza increases as adults age. During the influenza seasons from 2003-04 through 2010-11, excepting the pandemic of 2009, 55-65% of hospital separations in Canada and about 87% of deaths due to influenza occurred in citizens 65 years or older, although this age group only made up about 14% of the population. Although vaccination against influenza is the best strategy to prevent illness, studies show a reduced response to vaccines as people age. Other studies have shown that vaccine efficacy in older adults was 50-75% lower than that of younger adults. In one large randomized controlled trial, people 65 years and older who received Fluzone® High Dose were 18-24% less likely to have laboratory-confirmed influenza than people who received Fluzone® (standard dose). Fluzone® High Dose vaccine has been shown to have significantly higher rates of antibody production than the traditionally available influenza immunization. The high dose vaccine did induce higher rates of reaction post-injection than the standard dose, but they were short-lived. Rates of systemic reactions in the first 7 days after vaccination include (15μg versus 60μg, respectively): myalgia (15-18% vs. 13-29%), malaise (13-14% vs. 16-18%), headache (14-17% vs. 11-17%), and fever (0.5-2.3% vs. 0.7-4.4%). Rates of local reactions include: (15μg versus 60μg, respectively): pain (14-24% vs. 36-53%), redness (5-28 v 9-29%), and swelling (3-18% v 6-24%). Serious adverse events were similar in frequency between the 15- and 60-μg HA/strain vaccines. In 25,440 older adults who received the 60μg HA/strain vaccines, six (2.36/10,000) vaccine-related serious adverse events were reported including cardiac chest pain, oculorespiratory syndrome, cranial nerve VI palsy, hypovolemic shock, acute disseminated encephalomyelitis, and Crohn’s disease exacerbation. These events were classified by the study investigators as being vaccine-related.

2. Generic oseltamivir 75 mg (NAT-oseltamivir) is now available in Canada and is listed on the Pharmacare formulary as interchangeable with its brand name counterpart Tamiflu®, but at a reduced cost. Once the Pharmacy has depleted their supply of Tamiflu® 75 mg, the Pharmacy will dispense NAT-oseltamivir 75 mg for refills to the stat box supply or when filling orders for pre-outbreak treatment doses. Oseltamivir 30 mg will remain as the Tamiflu® brand. The MHSAL warehouse stock will continue to carry the brand name version, Tamiflu®, from their national contract. Although the drug may look different depending on the manufacturer, both NAT-oseltamivir and Tamiflu® are equivalent and sites may see one or both versions throughout the season.

3. A new formula for the calculation of creatinine clearance is being used this season and on a go forward basis to bring practice in line with current evidence informed standards. The Cockcroft-Gault equation
**without** weight will be used by pharmacies throughout the region and has been embedded into Appendix C - Resident Oseltamivir and Immunization Spreadsheet. Oseltamivir dosing will continue to be based on calculated creatinine clearance.

4. A new timeline has been added to the request for site ICPs/designates to submit a password encrypted copy of their Outbreak Investigation Form to the Manager of IP&C for the WRHA LTC Program. These investigation reports are due no later than 1 week after the outbreak has been declared over.

5. The National Advisory Council on Immunizations (NACI) no longer supports the preferential use of FluMist Quadrivalent in children and adolescents (2–17 years of age). Any of the following vaccines can be used in this age group: quadrivalent live attenuated influenza vaccine (FluMist Quadrivalent), an injectable quadrivalent inactivated influenza vaccine or an injectable trivalent inactivated influenza vaccine. However, a quadrivalent vaccine is preferred because of the burden of influenza B disease in children (the quadrivalent vaccine provides protection against one additional B strain compared to the trivalent vaccines). If a quadrivalent vaccine is not available, a trivalent inactivated influenza vaccine should be used.(1)

**Purpose**
- To prevent and/or minimize the mortality (death) and morbidity (illness) of influenza outbreaks in the Winnipeg Health Region by providing a consistent and practical guideline to manage influenza outbreaks.
- To provide a structure for coordinating the activities of the various provincial, regional, facility and laboratory agencies that have responsibility for the investigation, prevention, and control of respiratory disease outbreaks in long term care facilities in the Winnipeg Health Region.
- To define the roles and responsibilities of key stakeholders during the course of a facility outbreak.

**Introduction**
Respiratory disease outbreaks occur frequently in long-term care facilities. Most influenza outbreaks occur during the winter months. Facility staff should watch for clusters of upper or lower respiratory tract infections as early recognition of an outbreak is vital to effective management. Outbreaks are disruptive and costly; however, influenza outbreaks are often milder in facilities with high staff and Resident vaccination rates. It is critical that all Residents be vaccinated against influenza to prevent or reduce the impact of outbreaks during the winter season. It is even more critical that health care workers receive the influenza vaccine to protect themselves, their families and more importantly to build **herd immunity** to protect Residents. Health care workers can transmit respiratory viruses to high-risk, vulnerable Residents even when those vulnerable Residents have been immunized themselves. Health care worker immunization is associated with substantial decreases in illness and death among Residents. Most deaths associated with influenza in industrialized countries occur in individuals 65 years of age and older. LTC Residents are at most risk for complications from influenza infection; therefore they rely on health care workers to provide the highest standard of care which includes annual influenza immunization.
The Public Health Agency of Canada states that “refusal of health care workers who are involved in direct patient care to be immunized against influenza implies failure in their duty of care to their patients.” (Click here to see reference)

*Information regarding the provision of staff chemoprophylaxis will be address under separate cover if a regional strategy is developed.*

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Manitoba Health, Active Living and Senior’s Public Health Branch has included the following statement in the 2016 protocol update;

“For HCWs who are unimmunized, in accordance with Workplace Safety recommendations, a procedure/surgical mask should be worn consistently within the institution as additional protection for themselves and their patients/residents.”

Sites are responsible for weighing the risks and benefits of directing unimmunized staff to wear a mask during outbreaks, and may want to reserve the use of a mask for direct care only when outbreaks are occurring. Inappropriate use of masks can cause the mask itself to become a source of hand contamination and subsequent transmission. Sites desiring assistance in making the choice to use masks for unimmunized healthcare workers are encouraged to contact the WRHA LTC Program Manager of Infection Prevention and Control.

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**Reporting Requirements**

Under legislation of the Reporting of Diseases and Conditions Regulation (37/2009) of The Public Health Act (C.C.S.M. c. P210); “If a health professional becomes aware that a person has a disease or condition that is potentially serious but is not otherwise reportable under this regulation, the health professional must make a report respecting it if the disease or condition is occurring in a cluster or outbreak” as such, influenza outbreaks are to be reported to the Chief Public Health Officer or designate at Manitoba Health. In Winnipeg, notification of a suspected or confirmed influenza outbreak shall occur as outlined here.

**Definitions**

**Alcohol based hand rub (ABHR):** An alcohol based antiseptic with a minimum of 60% alcohol that is applied to all surfaces of the hands to reduce the number of microorganisms present on the hands.

**Chemoprophylaxis:** The use of a chemical agent or drug to prevent infection (e.g., use of oseltamivir in an influenza outbreak for residents who may have been exposed).

**Cohorting:** Two or more individuals colonized or infected with the same organism, placed/roomed together to minimize their contact with other unaffected individuals on the same unit.
Hand Hygiene: A general term that applies to hand washing, antiseptic hand wash, antiseptic hand rub, or surgical hand antisepsis.

Herd Immunity: When a large percentage of the population is vaccinated in order to prevent the spread of certain infectious diseases. Even individuals not vaccinated (such as newborns and those with chronic illnesses) are offered some protection because the disease has little opportunity to spread within the community; also known as “community immunity”. In terms of Influenza immunization, some scientists argue that herd immunity is not possible with influenza (due to the ability of the virus to change rapidly); rather a “herd effect” can be observed when those who are immunized do not transmit disease to others.

Impaired Renal Function: Creatinine clearance of less than 60 mL/minute and those receiving dialysis.

Informed Consent: a process involving dialogue, understanding and trust between the patient/resident/client or Substitute Decision-Maker and the Responsible Party or Authorized Designate.
Informed Consent requires:
a) The patient/resident/client or Substitute Decision-Maker to have Decision-Making Capacity;
b) Requires disclosure of the Information;
c) Must be specific to the act performed; and
d) Requires the consent to be given freely and voluntarily, without undue promise of favorable outcome, threat of penalty for non-compliance, or overt or covert coercion.

Influenza-like illness (ILI): Acute onset of respiratory illness with fever* and cough and with one or more of the following:

- Sore throat
- Arthralgia (joint pain)
- Myalgia (muscular pain)
- Prostration (extreme exhaustion) that could be due to influenza virus
  - In children less than 5 years of age, gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea) may be present
  - In residents less than 5 years or greater than or equal to 65 years of age, fever may not be prominent
  - *In the elderly, fever is defined as:
    - a single oral temperature greater than 37.8°C or
    - repeated oral temps greater than 37.2°C or
    - a single oral temperature greater than 1.1°C above baseline from any site

Influenza-like Illness Outbreak: The occurrence of two or more cases of influenza-like illness (ILI) occurring within 7 days and evidence of spread in excess of the expected number of cases in the facility.

Outbreak: The occurrence in a facility/unit of cases of an illness with a frequency clearly in excess of normal expectancy. The number of cases indicating presence of an outbreak will vary according to the infectious agent, size and type of population exposed, previous experience or lack of exposure to the disease, and time and place of occurrence. Therefore, the status of the outbreak is relative to the usual frequency of the disease in the same facility/unit, among the same population, at the same season of the year.
Progressive Influenza illness: Typical influenza symptoms (see ILI above) plus signs or symptoms suggesting more than mild illness: chest pain, poor oxygenation (e.g., tachypnea, hypoxia, laboured breathing), cardiopulmonary insufficiency (e.g., low blood pressure), central nervous system impairment (e.g., confusion, altered mental status), severe dehydration or exacerbations of chronic conditions (e.g. asthma, chronic obstructive pulmonary disease, chronic renal failure, diabetes or cardiovascular disease).

Resident: An individual living in a Long Term Care Facility (LTCF) or Personal Care Home (PCH). For the purposes of this document the word Resident will be used to reflect Patients, Residents, and Clients.

Respiratory Hygiene: A combination of measures to be taken by an infected source designed to minimize the transmission of respiratory microorganisms.
http://www.wrha.mb.ca/extranet/ipc/files/routine-practices/RepiratoryHygieneEducation.pdf

Routine Practices: A minimum standard of infection prevention and control precautions and practices used for all direct resident care regardless of the Resident’s presumed infection status or diagnosis.
http://www.wrha.mb.ca/extranet/ipc/files/routine-practices/InfoSheet-Education.pdf

Severe (influenza) illness: severe or complicated illness characterized by signs of lower respiratory tract disease (e.g., hypoxia requiring supplemental oxygen, abnormal chest radiograph, mechanical ventilation), central nervous system abnormalities (e.g., encephalitis, encephalopathy), complications of low blood pressure (e.g., shock, organ failure), myocarditis or rhabdomyolysis, or invasive secondary bacterial infection based on laboratory testing or clinical signs (e.g., persistent high fever and other symptoms beyond 3 days).
ROLES & RESPONSIBILITIES

Routine Practices are a minimum requirement for all health care professionals.

Unit Health Care Aides are responsible to:

PRE INFLUENZA SEASON

- Get immunized! Herd immunity is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.

INFLUENZA SEASON/OUTBREAK MANAGEMENT

- Report Resident signs and symptoms of ILI to nursing staff immediately upon recognition.
- Assist with the implementation of outbreak measures, for example: helping to hang signage (Appendix B), redirecting ill residents back to their rooms, notifying the individual responsible for supply orders when stocks of personal protective equipment (PPE) need replenishment.
- Assist with outbreak mitigating measures specific to meal times. Feed residents who are on precautions in their rooms and/or assist with cohorting residents on unit contained dining rooms where they exist but resources do not permit 1:1 feeding in rooms. In facilities lacking the infrastructure and resources to feed residents on outbreak affected units on the units, every effort should be made to cohort residents from the outbreak affected areas while in the communal dining room.
- Collaborate with nursing staff to determine who should be cohorted. The unit clerk should assist by making copies of the dining room seating plan.

Return to Roles and Responsibilities List
**Unit Nurses** are responsible to:

**PRE INFLUENZA SEASON**

- **Get immunized!** Herd immunity is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.
- Ensure that Informed Consent for influenza vaccine has been obtained before the resident is immunized. Appendix A is WHRA LTC form for documenting consent which should be done at the last annual care conference. If sites have not obtained consent at the annual care conference, it must be newly obtained and documented within the last year. If applicable, pneumococcal vaccine consent should also be obtained. One dose of pneumococcal polysaccharide vaccine is routinely recommended in a lifetime unless there are chronic underlying diseases that could warrant a second immunization. See section 6 of the WRHA LTC IP&C manual for additional detail on pneumococcal vaccine.
  - The MB Health recommended seasonal influenza vaccine fact sheet for Residents over 65 years of age is available at http://www.gov.mb.ca/health/publichealth/factsheets/flu_ltc.pdf
  - The MB Health recommended seasonal influenza vaccine fact sheet for Residents under 65 years of age is available at http://www.gov.mb.ca/health/publichealth/factsheets/seasonal.pdf
- Verify serum creatinine levels are current; within the year for those with normal renal function and within the last 6 months for those with impaired renal function. This is usually done every August/September.
- Administer influenza and pneumococcal immunizations to all eligible Residents as directed by, or in conjunction with, the facility ICP. See the WHRA Immunization Manual available at http://www.wrha.mb.ca/professionals/immunization/manual.php for immunization competencies and additional information.
  - All individuals institutionalized in a personal care home setting are eligible for influenza immunization. Additional details regarding eligibility criteria can be found at http://www.gov.mb.ca/health/publichealth/cdc/vaccineeligibility.html
  - Adverse effects following immunization are reportable to Manitoba Health. Complete the Manitoba Health Adverse Effects Following Immunization form at www.gov.mb.ca/health/publichealth/cdc/docs/aefi_form.pdf. Refer to the WRHA LTC Anaphylactic Shock Operational Guideline for adverse events including anaphylaxis.

**INFLUENZA SEASON/OUTBREAK MANAGEMENT**

- Continuously monitor Residents for signs and symptoms of an influenza-like illness (ILI) throughout the season and document assessment findings in the Integrated Progress Notes (IPNs).
- Initiate droplet-contact precautions without delay when ILI is suspected. See the WRHA LTC IP&C Manual, Droplet-Contact Precautions at http://www.wrha.mb.ca/extranet/ipc/files/manuals/ltc/ManualPCH_Sec05.pdf#page=21 for further information.
  - Keep ill Residents in their rooms and/or re-direct them to their rooms in the acute stage of illness when possible.
  - Offer ABHR frequently to ill residents who cannot be successfully redirected to their rooms to reduce the amount of contact transmission.
  - Institute visitor restrictions by discouraging visitation while the outbreak is occurring, and/or limiting the number of visitors permitted. Post a sign (sample Appendix B) at entrance of facility and/or entrance...
into affected units/areas for public awareness of the outbreak and accompanying restrictions (facility specific signage must be Senior Management approved before posting).

- Report any ILI cases to the ICP / designate promptly.
  - ILI is reportable in the WHRA LTC Surveillance program. Cases that meet definition for ILI shall also be reported to the ICP via telephone or other mechanism that ensures the ICP is informed in a timely fashion.
- Report any Residents who meet the ILI definition to the attending prescriber and inquire about an order for antiviral (e.g. oseltamivir) treatment.
- The treatment tab of Appendix C will calculate the required treatment dosage of oseltamivir based on creatinine clearance and age for adults, or weight and age for pediatric cases.
- All unit nurses should be aware of the location of the facility’s completed Appendix C. If the location is unknown contact the facility ICP/designate or download and complete a new copy for the Residents on the unit from http://www.wrha.mb.ca/extranet/ipc/files/manuals/ltc/InfluenzaAppendix?.XLSX
- Document administered doses of oseltamivir on each Resident’s Medication Administration Record (MAR). Pre-printed transparent oseltamivir prophylaxis labels can be used. A template is provided in Appendix D.
- The use of antivirals (e.g. oseltamivir) for treatment of ILI is not contingent upon an outbreak being declared and should be initiated without delay. Prompt treatment prevents further morbidity and mortality in the ill resident themselves, and prevents transmission to others, possibly stopping an outbreak from occurring.
- When indicated, treatment with antivirals (e.g. oseltamivir) should be initiated as rapidly as possible after onset of illness. Benefits of treatment are much greater when initiated less than 12 hours after onset than at 48 hours.
- Collect nasopharyngeal specimens using flocked swabs (see Appendix E: Collection of Nasopharyngeal Specimens), immediately when ILI is suspected. Specimens may also be required upon the direction from facility ICP/ designate, Population and Public Health, WRHA LTC Program Manager of Infection Prevention & Control, and/or prescriber/Medical Director; however nurses should never wait for direction to swab if a resident is exhibiting signs and symptoms of ILI. Specimens must be sent with a Cadham Lab requisition that includes an outbreak code (see sample Appendix F).

If you do not have an outbreak code, contact the ICP or designate who can obtain one. If the ICP or designate is unavailable (e.g., after hours and on weekends) follow the directions in the ILI outbreak Quick Reference Guide (Appendix N).

- Courier specimens with an ice pack enclosed directly to Cadham Provincial Laboratory at 750 William Avenue to minimize the deterioration of the specimen.
  - To make arrangements to deliver specimens to Cadham Lab after hours or during holidays and weekends, please call 204-945-6123 (security guard will answer).
  - Do not hold specimens longer than 24 hours at a refrigerator temperature of 4°C prior to shipping. Do not freeze.

**NOTE:** Usually 6 nasopharyngeal specimens are obtained on newly symptomatic Residents (i.e., have become ill within last 24-48 hours). If there is an indication of ongoing transmission, submit additional specimens on newly ill cases every 3 days.
• Complete the *Outbreak Investigation Form* (Appendix H) in the event of an outbreak or suspected outbreak. This form is used by the facility ICP, facility Medical Director, and the WRHA LTC Program Manager of IP&C for the purposes of outbreak investigation and to facilitate decision making around outbreak mitigation. This form cannot be transmitted outside of the facility unless measures to preserve confidentiality have been taken.

• **Cohort** symptomatic Residents where possible and as directed by the facility ICP/designate. Often it is not possible to make room changes to cohort ill residents but consideration for cohorting at meal times can be an effective and achievable outbreak mitigating measure. Assist HCAs to determine who should be fed in their rooms and how they could be cohorted in the dining room. The unit clerk should assist by making copies of seating plans.

• Feed residents who are on precautions in their rooms and/or cohort residents on unit contained dining rooms where they exist but resources do not permit 1:1 feeding in rooms. In facilities lacking the infrastructure and resources to feed residents on outbreak affected units on the units, every effort should be made to cohort residents from the outbreak affected areas while in the communal dining room.

• Inform the Resident’s prescriber, per the facility communication process, in the event of an outbreak, if outbreak measures are initiated and plans for **Chemoprophylaxis** of non-symptomatic Residents is required.

• Communicate the facility plan and interventions to other unit staff, Residents and family members/visitors in the event of an outbreak. For example, post outbreak signs, discuss outbreak measures in shift report, and speak to the Residents on the affected unit about the restrictions in place.

• Promote influenza immunizations to staff, Residents, volunteers and families not yet immunized. For example, review the list of Resident immunizations and offer vaccination to those who have not been immunized, and remind staff at shift report about the importance of **herd immunity**.

*Return to Roles and Responsibility List*
**Unit Clerks/designates** are responsible to:

### PRE INFLUENZA SEASON

- **Get immunized!** [Herd immunity](#) is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.

- Check that serum creatinine levels are current; within the year for those with normal renal function, or within the last 6 months for those with [Impaired Renal Function](#).
  - Inform nursing staff of any Residents who require a serum creatinine level.
  - An order for a serum creatinine level is required when standing orders are not in place in the facility.

- Ensure Medication Standing Orders include oseltamivir prophylaxis and are signed for each Resident.

- Complete the [Immunization and Oseltamivir Form for LTC](#) (Appendix C).

- Ensure Medication Standing Orders include oseltamivir prophylaxis and are signed for each Resident.

- Report the numbers of Residents immunized with influenza and pneumococcal vaccine to the facility ICP/designate at the end of the season. The facility ICP will communicate the deadline for reporting.
  - Weekly reporting is no longer required during the beginning of the influenza season; however, it may be required in the event of an outbreak as directed by the facility ICP in collaboration with WRHA Population and Public Health and the WRHA LTC Program Manager of Infection Prevention and Control.

- Print the oseltamivir prophylaxis labels for the medication administration record (MAR) using transparent labels (e.g., Avery Easy Peel clear mailing labels item #18663) and the template provided in Appendix D.
  - Transparent labels are required as they prevent any documentation from being covered up in the Resident chart.

### INFLUENZA SEASON/OUTBREAK MANAGEMENT

- Ensure Residents admitted to the facility during influenza season are transferred with a record of serum creatinine, or a serum creatinine level is ordered on admission. Enter this Resident information into the Immunization and Oseltamivir Form for LTC (distributed electronically to facility ICPs).

- Assist with cohorting of ill residents in dining rooms by printing and/or copying dining room assignments so that nurses and HCAs can re-organize the seating plan.

- Assist with communication of the facility plan and interventions to unit staff, Residents and family members/visitors in the event of an outbreak. For example, post outbreak signs and speak to the families/visitors that approach the desk about the restrictions in place. Some facilities choose to have the unit clerk call all families in the affected area to inform them of the outbreak.

[Return to Roles and Responsibility List](#)
**Unit Managers** of affected area(s) are responsible to:

**PRE INFLUENZA SEASON**
- Get immunized! herd immunity is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.
- Ensure the preparatory work preceding immunizations is complete. Serum creatinine results are current, consents have been obtained, and the *Influenza Season Immunization and Oseltamivir Form for LTC* (Appendix C) is completed.
- Coordinate, implement and promote the Resident and staff influenza immunization campaign.
  - Vaccines can be ordered from the provincial vaccine warehouse before the seasonal influenza kick off is announced. Delivery will occur once the vaccine is available and can be obtained by completing the Influenza and Pneumococcal Vaccine Order Form available at [http://www.gov.mb.ca/health/publichealth/cdc/protocol/influpnevcorderform.pdf](http://www.gov.mb.ca/health/publichealth/cdc/protocol/influpnevcorderform.pdf).

**INFLUENZA SEASON/OUTBREAK MANAGEMENT**
- Ensure that the responsibilities under the Unit health care aide, Unit clerk, and Unit nurse have been completed.
- Collaborate with facility Senior Management and ICP to determine and obtain resources required for outbreak management.
- Ensure staff have access to required PPE (Personal Protective Equipment) and signage to facilitate the initiation of droplet-contact precautions immediately upon suspicion of an ILI case and/or outbreak.
- Restrict staff movement from outbreak affected areas to non-affected areas as resources permit.
- Consult Appendix I: *Guidelines for Admissions, Transfers, and Respite during Outbreaks* to determine if/when facility closure is warranted in collaboration with members of the facility Senior Management/Administration team, facility ICP, and the WRHA LTC Program Manager of Infection Prevention and Control.
- Disseminate information such as outbreak updates and WRHA media releases as required to staff.
- Facilitate meetings to update administration and staff as required.
- Address performance issues when staff do not comply with outbreak mitigating measures as required.
- Develop crisis staffing contingency plans in collaboration with Senior Management as required.
- Promote influenza immunizations to staff, Residents, volunteers and families not yet immunized.
- Communicate the outbreak measures required to staff, explain their role in preventing transmission and the importance of following precautions.

[Return to Roles and Responsibility List](#)
Site LTC Infection Control Professional/designates are responsible to:

PRE INFLUENZA SEASON

- **Get immunized!** Herd immunity is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.
- Ensure viral test supplies (frozen Viral Transport Media (VTM) and flocked swabs) are available. Refer to Instructions for Ordering (Appendix J) and order supplies using Cadham Lab Supply Request Form (Appendix K).
- Orders take 48 hours to fill, so ensure you have stock on hand and it has not expired before an outbreak occurs.
- Also ensure the supplies do not expire in the midst of the outbreak season. Take note of the stock on hand and its expiry date and then ensure new stock is re-ordered before the expiration.
- Assist and/or direct nursing staff to administer influenza and pneumococcal immunizations to eligible Residents. See the WHRA Immunization Manual available at http://www.wrha.mb.ca/professionals/immunization/manual.php for immunization competencies and clinical practice guidelines.
- Coordinate the collection of the numbers for Resident immunizations, communicate the plan for data collection (method and frequency) to the appropriate individuals, and then report the findings to the immunization clerk as directed by WRHA Population and Public Health.
  - Reporting of immunizations is no longer required weekly at the beginning of the immunization season. Facility ICPs remain responsible for reporting the final numbers of influenza and pneumococcal vaccine provided to residents to epi@wrha.mb.ca by December 31st of each year. WRHA Population and Public Health will distribute the invoice annually via email.
  - Facility ICPs are responsible for the invoice submission and accompanying lists of Resident immunizations (i.e., the Public Health Submission tab of Appendix C) for entry into the population and public health database. The invoice and data set must be couriered and a signature is required upon delivery. (Regular post is not an acceptable means due to risk of PHIA breeches unless the information is sent on a password protected and encrypted USB stick and the password is sent separately from the data) to the immunization clerk no later than December 31st of the year.
    - Immunizations given after December 31st should be included in the next year’s invoice and data set for Population and Public Health database entry.
    - If the facility ICP is also responsible for staff immunization administration and/or reporting, please refer to the reporting requirements for Occupational and Environmental Safety and Health (OESH) (click here to be directed to the OESH section).
- ICPs giving immunizations are also responsible for reporting adverse effects to Manitoba Health using the Adverse Effects Following Immunization form at: www.gov.mb.ca/health/publichealth/cdc/docs/aefi_form.pdf. Refer to the WRHA LTC Anaphylactic Shock Operational Guideline for adverse events including anaphylaxis.

INFLUENZA SEASON/OUTBREAK MANAGEMENT

- Investigate reports of ILI to determine and/or confirm that an ILI outbreak is occurring. For information on how to investigate an outbreak see: http://www.gov.mb.ca/health/publichealth/cdc/protocol/investigation.pdf.
- Determine how outbreaks will be declared in collaboration with the facility Medical Director. Often the ICP assumes the responsibility of declaring the outbreak/leading outbreak management efforts and then
informing the Medical Director and other facility Administrators as appropriate. Allowing the ICP to
determine outbreaks autonomously results in faster outbreak response. The determination of an outbreak
can also be done in collaboration with the facility Medical Director and/or the WRHA LTC Manager of
Infection Prevention and Control if/when the outbreak data collected is unclear.

- Obtain an Outbreak code from the appropriate Communicable Disease Coordinator (CDC) upon confirmation
  of an ILI outbreak. See Table 1 for contact information.

Table 1.  CDC Contact Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
<th>Tel:</th>
<th>Fax:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corinne Adams</td>
<td><a href="mailto:cadams@wrha.mb.ca">cadams@wrha.mb.ca</a> Actionmarguerite St. Boniface, Actionmarguerite St. Vital, Bethania, Concordia Place, Donwood Manor, Golden Links Lodge, Holy Family, Kildonan, Meadowood Manor, Park Manor, River East, River Park Gardens, St. Amant, Vista Park Lodge</td>
<td>204-940-2326</td>
<td>204-940-2690</td>
</tr>
<tr>
<td>Lynn Klassen Semeniuk</td>
<td><a href="mailto:klassensemiuk@wrha.mb.ca">klassensemiuk@wrha.mb.ca</a> Poseidon, Charleswood CC, Convalescent, Deer Lodge, Golden Door, Golden West, Heritage Lodge, Oakview, Pembina Place, Riverview, Simkin, Southeast, St. Norbert, Tuxedo Villa, West Park Manor</td>
<td>204-940-3641</td>
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<tr>
<td>Jennifer Omaga</td>
<td><a href="mailto:JOmaga@wrha.mb.ca">JOmaga@wrha.mb.ca</a> Beacon Hill, Calvary, Fred Douglas, Lions Manor, Luther Home, Maples, Middlechurch, Misericordia, Parkview, Actionmarguerite St. Joseph’s</td>
<td>204-940-8280</td>
<td>204-940-2690</td>
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- Ensure appropriate infection control measures are instituted in a timely fashion, which may include but are not limited to:
  - Educate/reinforce good Hand Hygiene and Respiratory Hygiene
  - Advocate for treatment for Residents who are symptomatic with the prescriber as needed to ensure that single cases of ILI outside the context of outbreaks are treated promptly
  - Notify the facility Medical Director/Senior Administration and other stakeholders deemed relevant by the facility of the outbreak. Medical Directors will have received information about the seasonal influenza protocol from the MOH and WRHA LTC Program Manager of IP&C.
  - Communicate with facility Senior Management/Administration and Unit Manager to determine and obtain required resources
  - Delegate the Cohorting of symptomatic Residents (where possible) to the unit nurses and HCAs. The unit clerk should also assist by printing dining room seating plans that can be amended to reflect the temporary cohorts.
  - Respond to concerns from staff, Residents, visitors and families regarding outbreak mitigating measures.
  - Collaborate with Occupational Health/designate and facility Senior Management/Administration to restrict ill staff from attending work while symptomatic.
- Collaborate with Housekeeping/Environmental Services to increase cleaning. High touch surfaces (e.g., light switches and doorknobs etc.) shall be cleaned at least daily, preferably twice per day, as resources permit, for the duration of the outbreak.
- Consult Appendix I: Guidelines for Admissions, Transfers, and Respite during Outbreaks to determining if/when facility closure is warranted in collaboration with members of the facility Senior Management/Administration team, facility ICP, and WRHA LTC Program Manager of Infection Prevention and Control.
- Assist with the education of staff, Residents, families/visitors (see Outbreak Information for Residents, Families, Staff and Visitors (Appendix L).
- It is recommended to post a sign at the beginning of Influenza season at the public entrance to the facility asking visitors not to visit when ill (Appendix M). Signs are also available for order from HSC Print Shop. Send a purchase order form (http://home.wrha.mb.ca/corp/logistics/files/PrintingServicesWorkOrder.xls) via email to printserv@hsc.mb.ca or fax (204) 787-2086. Reference your work order number or purchase order number in the subject line of your email.
  - Specify on the purchase order which educational materials/signs you wish to order, the Printing Shop order number, and the quantity required (see table below).
  (For time sensitive requests, please call (204)787-4072 to ensure your deadline can be met.)

<table>
<thead>
<tr>
<th>Form #</th>
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<th>Laminated</th>
</tr>
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<td>$4.50</td>
</tr>
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<td>Visitor Restrictions Sign - French 8.5 x 11</td>
<td>$1.50</td>
<td>$2.50</td>
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</table>

- Ensure collection of up to 6 nasopharyngeal specimens at the outset of an outbreak during the infectious period of the Residents being tested. In discussion with CDC, when there is continued transmission despite initiation of precautions and/or Chemoprophylaxis, additional nasopharyngeal specimens may be warranted.
- Assist with the coordination of Chemoprophylaxis of asymptomatic Residents when released by the facility Medical Director (e.g. using oseltamivir to prevent influenza illness among exposed Residents). See more detailed information in section 5.5.13
- Collaborate with support services (e.g. dietary, laundry, laboratory, recreation etc.) to determine additional responsibilities and prepare for possible increased demand for services/supplies due to the outbreak
- Encourage staff, Residents, families, visitors and volunteers not yet immunized to receive the influenza vaccine.
- Report performance issues to the appropriate Unit Manager and/or facility Senior Management/Administration when staff do not comply with outbreak mitigating measures and education does not resolve the issue as required.
• Supply the facility Medical Director with information to facilitate decisions to initiate Chemoprophylaxis (e.g. oseltamivir) by submitting the Outbreak Investigation Form (Appendix H) per the direction of the Director via email.
  • Once Chemoprophylaxis has been initiated, reporting can occur less frequently for the remainder of the outbreak unless ongoing new ILI cases are identified.
• Notify Manitoba Health of the outbreak by completing an outbreak summary using the Canadian Network for Public Health Intelligence (CNPHI). A username, password and training are required to complete CNPHI outbreak reports. Contact the WRHA LTC Program Manager of IP&C for assistance with training.
  • Click here to apply for a new CNPHI account if you do not already have one.
  • Under “name of the application you want access to” please indicate: Outbreak Summaries-Enteric and Respiratory/VPD Modules.
  • Specify that you were referred by: Manitoba Health Outbreak Surveillance.
  • Please also ensure to sign and return the User Agreement to CNPHI to complete your registration
• Ensure all new cases are recorded in a fashion that facilitates case counting and collection of other information for reporting to be easily retrieved. Line listing new Resident cases and collaborating with Occupational Health or designate and Human Resources/Staffing to complete the Outbreak Investigation Form (Appendix H).

Note: The Outbreak Investigation Form contains confidential Resident and staff information shall not be disseminated outside of the facility firewall unless the document is password protected.

• Facilitate the acquisition of oseltamivir if Chemoprophylaxis and/or treatment is required (see Appendix C for dosing).

During a confirmed or suspected Influenza outbreak:
  ▪ The facility ICP/designate must contact the facility Medical Director to acquire approval for the release of oseltamivir. A conversation regarding the plan to initiate prophylaxis must occur between the facility Medical Director and facility ICP early in the season before an outbreak begins.
  ▪ Appendix C will calculate how many boxes of oseltamivir 75 mg (10 capsules/box) and how many boxes of oseltamivir 30 mg (10 capsules/box) are required (if using oseltamivir for pediatrics, 45 mg doses may also be required). Do not order excess amounts of oseltamivir as it cannot be returned.
  ▪ The ICP or designate can contact the provincial vaccine warehouse at 204-948-1333 to inform them of the number of doses of oseltamivir required, the lab confirmed organism implicated in the outbreak, and the name of the Medical Director with whom the ICP collaborated with to decide to initiate Chemoprophylaxis.
  ▪ If rapid tests come back negative but there is a strong suspicion the outbreak is caused by influenza, the Medical Director can contact the Medical Officer of Health to request the release of oseltamivir for chemoprophylaxis before lab confirmation. Oseltamivir efficacy is time sensitive; therefore the use of the drug for chemoprophylaxis should not be delayed while waiting for the results of further testing (which could still be influenza positive). The ICP would then contact the provincial vaccine warehouse as indicated above upon the direction of the medical director and inform the warehouse that special approval had been acquired by the MOH to release chemoprophylaxis before lab confirmation.
Treatment of ILI outside of an outbreak;

- Residents who meet the ILI definition should be treated without delay. Treatment is not contingent on having an outbreak declared. [See Figure 1, Antiviral Treatment Considerations](#).
- Pharmacy will supply the oseltamivir for Residents that require treatment outside the context of an outbreak. Oseltamivir is covered by the Personal Care Home Drug Formulary.
- Ensure a box of oseltamivir 75 mg (10 capsules) and a box of oseltamivir 30 mg (10 capsules) will be available in each facility for after-hours initiation of treatment (e.g. in the stat box).
- Declare the outbreak over 8 days after the onset of the last symptomatic case. This represents the period of communicability plus one incubation period for influenza.
  - If an additional pathogen is identified in the outbreak, the ICP must use the period of communicability plus one incubation period for whichever organism has a longer duration. Incubation periods for common respiratory pathogens can be found in the Communicable Disease Management table of the WRHA LTC IP&C manual. [Click here](#) to be directed to the table.
- Report deaths per the Public Health Act, Reporting of Diseases and Conditions Regulation, under the following circumstances:
  - At death, if the health professional reasonably believes that the resident may have had the reportable disease at the time of death or the reportable disease contributed to the death.
  - Upon becoming aware that a person has a disease or condition that is not otherwise reportable, if the disease or condition is occurring in a cluster or outbreak, or has presented itself with an unusual clinical manifestation.
    - The ICP shall report diseases and conditions occurring in the context of an outbreak on CNPHI. Deaths occurring in the context of an outbreak are required to be reported using the revised Clinical Notification of Reportable Diseases and Conditions reporting form available at: [http://www.gov.mb.ca/health/publichealth/cdc/protocol/form13.pdf](http://www.gov.mb.ca/health/publichealth/cdc/protocol/form13.pdf)
    - Any deaths reported under the aforementioned Public Health Act must also be reported via CNPHI’s outbreak summary report.
  - To measure the efficacy of the seasonal influenza response, facility ICPs are to collect data on deaths occurring during influenza outbreaks up to 6 weeks after the outbreak has resolved on the Outbreak Investigation Form. These measures will help further quantify the morbidity and mortality associated with influenza outbreaks, and assists the LTC Program in understanding the impact outbreaks have on patient/resident flow throughout the health region and to assist in evaluating the efficacy of the outbreak response process. These deaths occurring up to 6 weeks after an influenza outbreak do not need to be reported to MB Health (via CNPHI or on the Clinical Notification of Reportable Diseases and Conditions) unless they meet the criteria outlined above. Site ICPs/designates **must** submit a password protected copy of their Outbreak Investigation Form to the Manger of IP&C for the WRHA LTC Program no later than 1
week after the outbreak has been declared over. If additional deaths occur in the 6 weeks following the end of an outbreak, the investigation form must also be resubmitted with the inclusion of all coming mortality post outbreak.

Return to Roles and Responsibility List

**Medical Director/ designate** is responsible to:

PRE INFLUENZA SEASON
- **Get immunized!** *Herd immunity* is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.
- Ensure there is a mechanism to order influenza immunizations to be given to Residents before the influenza season (e.g. standing orders).
- Ensure there is a mechanism to order serum creatinine levels for all Residents in order to facilitate oseltamivir administration in the event of an outbreak (e.g. standing order).
  - Serum creatinine for those without renal impairment should be current within the past year.
  - Those with Impaired Renal Function should have serum creatinine levels drawn within the last 6 months or sooner depending on the severity of the impairment.
- Ensure all facility prescribers are aware of the need to order antivirals (e.g. oseltamivir) for treatment. Residents who meet the ILI definition should be treated without delay and treatment is not contingent on having an outbreak declared. See Figure 1. Antiviral Treatment Considerations.
- Promote influenza immunizations to prescribers, staff, Residents, volunteers and families.
- Act as a resource to the facility ICP /designate, nursing staff, facility Senior Management / Administration and families as required.

INFLUENZA SEASON/OUTBREAK MANAGEMENT
- Facility ICPs are responsible to lead outbreak management efforts. When the need arises, Medical Directors may be asked to collaborate with the facility ICP to determine the presence of an outbreak.
- Approve chemoprophylaxis in the event of an influenza confirmed outbreak. Facility ICPs have been advised to seek approval proactively when an outbreak occurs to eliminate delays in implementing chemoprophylaxis while awaiting test results. It is suggested to come to an agreement on the response plan early in the season.
  - If rapid tests come back negative but there is a strong suspicion the outbreak is caused by influenza, the Medical Director should contact the Medical Officer of Health to request the release of oseltamivir for chemoprophylaxis before lab confirmation. Oseltamivir efficacy is time sensitive; therefore the use of the drug for chemoprophylaxis should not be delayed while waiting for the results of further testing (which could still be influenza positive). The ICP would then contact the provincial vaccine warehouse upon the direction of the medical director and inform the warehouse that special approval had been acquired by the MOH to release chemoprophylaxis before lab confirmation.
- Liaise with the Residents’ prescriber(s) regarding treatment and outbreak management measures as required (e.g., the ICP or unit staff advise that a prescriber is refusing to order oseltamivir for treatment in a
resident who meets the case definition for ILI and staff believe there is no alternate etiology for the presenting signs and symptoms).

- Determine if/when facility closure is indicated in collaboration with other members of the facility Senior Management/Administration team, facility ICP, and WRHA LTC Program Manager of Infection Prevention and Control (IP&C) (see Appendix I).
- Promote influenza immunizations to staff, Residents, volunteers and families not yet immunized.

**Facility Senior Management/Administration** are responsible to:

**PRE INFLUENZA SEASON**

- **Get immunized!** *Herd immunity* is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.
- Collaborate with facility ICP/designate and OESH/designate to determine and obtain resources required for influenza immunization.
- Promote influenza immunizations to staff, Residents, volunteers and families.

**INFLUENZA SEASON/OUTBREAK MANAGEMENT**

- Remove obstacles to outbreak mitigation measures by collaborating with the facility ICP to determine and obtain resources required for outbreak management.
- Determine if/when facility closure is indicated in collaboration with other members of the facility Senior Management/Administration team, facility ICP, and WRHA LTC Program Manager of IP&C (see Appendix I).
- Disseminate information including internal and external updates and media releases as required.
- Collaborate with the facility ICP to determine if/when an outbreak response team is required and help coordinate and attend meetings. Response teams may not be required for every outbreak, but they are a highly effective and efficient way to organize and coordinate outbreak response measures to prevent further transmission, morbidity, and mortality. The establishment of an outbreak response team and frequency of meetings should be determined in collaboration with the facility ICP/designate.
- An outbreak response team serves as the central coordinating body to reach evidence and consensus based decisions. This may be necessary during large scale outbreaks or when facility leadership direction is required. Members of the team (as appropriate) can be:
  - Facility ICP: Chair of team for single facility outbreaks
  - Facility executive(s), supervisors
  - Unit staff and managers
  - OESH
  - Manager of Housekeeping
  - Allied Health Managers
- Develop crisis staffing contingency plans as required.
- Communicate the outbreak measures required to staff and explain their role in preventing transmission and the importance of following precautions
- Address performance issues if staff do not comply with outbreak mitigating measures as required.
- Promote influenza immunizations to staff, Residents, volunteers and families not yet immunized.

*Return to Roles and Responsibility List*
Facility Occupational Health/designate is responsible to:

PRE INFLUENZA SEASON

- **Get immunized!** **Herd immunity** is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.
- Coordinate, implement and promote the staff influenza immunization campaign.
- Obtain consent for, and administer influenza immunizations to staff using the WRHA OESH consent form http://www.wrha.mb.ca/professionals/immunization/files/05_Form Consent.pdf
- Report the numbers of staff immunizations to the facility ICP/designate. Weekly reporting is no longer required during the beginning of the influenza season; however, it may be required in the event of an outbreak as directed by the facility ICP in collaboration with WRHA Population and Public Health and the WRHA LTC Program Manager of IP&C.
- Facilities wishing to report immunizations provided to staff externally are responsible for developing their own means of tracking and verifying that immunization was given by another party.

INFLUENZA SEASON/OUTBREAK MANAGEMENT

- Manage ill or exposed employees.
- Manitoba Health does not cover the cost of oseltamivir prophylaxis for health care workers; employees seeking prophylaxis or treatment should see their own health care provider at this time. Discussions regarding the provision of staff chemoprophylaxis are underway regionally and will be communicated under separate cover.
- Compile statistics of staff **ILI** cases and report cases to the ICP/designate (use Appendix C as a tool to gather the data).
- Respond to questions and concerns from staff.
- Promote and provide influenza immunizations to staff not yet immunized.

[Return to Roles and Responsibility List]
Facility Environmental Support Services/Housekeeping is responsible to:

PRE INFLUENZA SEASON
- Get immunized! Herd immunity is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.

INFLUENZA SEASON/OUTBREAK MANAGEMENT
- Upon notification that an outbreak has been declared Environmental Services/Housekeeping should plan and arrange for increased cleaning of the affected unit/areas immediately.
- All high touch surfaces in the outbreak affected area(s) should be cleaned and disinfected at least twice daily as resources permit.
- The environmental services director supervisor should consult with the facility ICP and/or the WRHA LTC Program Manager of IP&C as required to ensure the disinfecting chemistry provides adequate cleansing and disinfection and with a contact time that is attainable.
- Inform and update environmental support staff and other relevant stakeholders regarding the outbreak.
- Communicate the outbreak measures required to staff and explain their role in preventing transmission and the importance of following precautions
- Promote influenza immunizations to Environmental Services/Housekeeping staff not already immunized.

Return to Roles and Responsibility List
Facility Nutrition/Dietary/Food Services is responsible to:

PRE INFLUENZA SEASON
- Get immunized! Herd immunity is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.

INFLUENZA SEASON/OUTBREAK MANAGEMENT
- Ensure the infection control measures recommended by facility ICP/designate are instituted.
- Inform and update nutrition/dietary/food services staff and other relevant stakeholders regarding the outbreak.
- Provide hand hygiene to all Residents before meals to prevent the risk of exposure to influenza.
- Resident hand hygiene can be accomplished by providing individually wrapped hand hygiene wipes or by dispensing a pump of alcohol based hand rub into the hands of each Resident and assisting them to rub it in until dry, if necessary.
- Although the delivery of resident hand hygiene is traditionally a HCA function; during outbreaks the HCA’s efforts are redirected into 1:1 feeding in Additional Precautions rooms and/or cohorting for feeding, as such extra support from nutrition/dietary/food services is required for the duration of an outbreak.
- If dietary/food services staff are responsible for cleaning and disinfection of the affected area’s dining room, ensure staff are cleaning and disinfecting those surfaces appropriately to avoid transmission through contamination. Collaborate with the facility ICP/designate for assistance with education if required. If dietary/nutrition/food services staff are not traditionally responsible for cleaning and disinfecting tables, this task should be temporarily re-assigned for the duration of the outbreak (see rationale in 5.10.4.2).
- Communicate the outbreak measures required to staff and explain their role in preventing transmission and the importance of following precautions
- Promote influenza immunizations to dietary/food services staff not yet immunized.

Return to Roles and Responsibility List
Facility Recreation Manager/Unit Recreation is responsible to:

PRE INFLUENZA SEASON
- Get immunized! Herd immunity is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.

INFLUENZA SEASON/OUTBREAK MANAGEMENT
- Cancel group activities for the outbreak affected units immediately and for the duration of the outbreak.
- Under special circumstances and with the collaboration of the facility ICP/designate, it may be acceptable to conduct group activities on affected units with the non-symptomatic Residents of the affected unit only.
  - This decision carries the risk of exposing individuals to fellow residents who have not begun to show signs and symptoms, but who are capable of transmitting disease to others during the incubation period. In areas where there is a high degree of cognitive impairment and lack of recreation/stimulation exacerbates responsive and/or wandering behaviors, the risk of exposing other Residents is less in a group setting restricted to participants from affected areas than from wandering and or responsive Residents exposing others.
  - Meticulous attention to hand hygiene and equipment cleaning must be paid before and after the group activities if they occur.
- Communicate the outbreak measures required to staff and explain their role in preventing transmission and the importance of following precautions.

Return to Roles and Responsibility List
**Facility Pharmacist/Pharmacy** is responsible to:

**PRE INFLUENZA SEASON**
- **Get immunized!** Herd immunity is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.

- Encourage the use Appendix C to calculate creatinine clearances. Facilities who have not used Appendix C in the past have experienced delays in initiation of oseltamivir treatment and chemoprophylaxis. It is used as a tool to calculate the total number of boxes of oseltamivir required in addition to determining creatinine clearance and dose for each Resident. Appendix C uses the Cockcroft-Gault formula (without weight) to determine creatinine clearance:
  - Male: CrCl mL/min= (140 - age) x 88.4 / (serum creatinine (umol/L)
  - Female: CrCl mL/min=0.85 x CrCl (male)

- Encourage the addition of antiviral (e.g. oseltamivir) prophylaxis to the facility standing orders.
- Confirm the availability of a box of oseltamivir 75 mg (10 capsules) and a box of oseltamivir 30 mg (10 capsules) in each facility for after-hours initiation of treatment (e.g. in the stat box).
- Promote influenza immunizations to staff, pharmacists, Residents, volunteers and families.

**INFLUENZA SEASON/OUTBREAK MANAGEMENT**
- Advise the Medical Director, Residents’ prescriber, ICP/designate or other nursing staff about the appropriate dosing of oseltamivir for the Resident as required. See Figure 1. Antiviral Treatment Considerations
- Replace the supply of oseltamivir for treatment in the facility as required. Note: oseltamivir for chemoprophylaxis is not the responsibility of pharmacy to supply, it is the responsibility of the ICP/designate to acquire it from the Provincial Vaccine Warehouse (MHSAL warehouse stock) (see 5.4.11)
- Supply the oseltamivir for Residents that require treatment outside of an outbreak by prescriber order. Oseltamivir is covered by the Personal Care Home Drug Formulary. Residents who meet the ILI definition should be treated without delay. Treatment is not contingent on having an outbreak declared.

[Return to Roles and Responsibility List]
Resident’s Attending Prescribers are responsible for:

PRE INFLUENZA SEASON

- Get immunized! Herd immunity is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.
- Order influenza immunization before the influenza season and ensure there is a mechanism to order antivirals for Chemoprophylaxis (e.g. oseltamivir) in the event of an outbreak when recommended by the facility Medical Director (e.g. standing orders).
- Ensure there is a mechanism to order serum creatinine levels for all Residents to facilitate oseltamivir administration in the event of an outbreak (e.g. standing order)
  - Serum creatinine for those without renal impairment should be current within the past year.
  - Those with impaired renal function should have serum creatinine levels drawn within the last 6 months or sooner depending on the severity of the impairment.
- Promote influenza immunizations to staff, Residents, volunteers and families.

INFLUENZA SEASON/OUTBREAK MANAGEMENT

- Assess, diagnose and treat the Resident with ILI. Residents who meet the ILI definition should be treated with oseltamivir without delay, and treatment is not contingent on having an outbreak declared

Figure 1. Antiviral Treatment Considerations

When indicated, treatment with antivirals (e.g. oseltamivir) should be initiated as rapidly as possible after onset of illness because the benefits of treatment are much greater with initiation at less than 12 hours than at 48 hours. Initiation of antiviral therapy greater than 48 hours after onset of symptoms is still considered beneficial in Residents in whom:

- The illness is severe enough to require hospitalization
- The illness is progressive or severe regardless of previous health status
- The Resident belongs to a group at high risk for severe disease.

- The facility ICP is responsible for leading outbreak management and may rely on the Attending Prescriber to act as a resource to the facility ICP/designate, nursing staff, administration and families.
- Promote influenza immunizations to staff, Residents, volunteers and families not yet immunized.

FINAL September 29, 2017
Manager WRHA LTC Program IP&C is responsible to:

PRE INFLUENZA SEASON
- Get immunized! Herd immunity is more effective at preventing morbidity (illness) and mortality (death) from influenza than immunizing elderly individuals alone.
- Review and update the LTC Influenza Management Protocol and supporting documents on an annual basis in collaboration with the LTC ICP committee (or sub-committees), the MOH, CDCs and WRHA LTC Program team as required.
- Provide educational resources and information to facilities to facilitate the launch of the seasonal immunization campaign and seasonal outbreak response preparedness each year.

INFLUENZA SEASON/OUTBREAK MANAGEMENT
- Monitor outbreak reports submitted via CNPHI and correlate CNPHI reports with the Outbreak Investigation Form (Appendix H) as submitted by the facility ICP/designates.
- Notify the following persons/groups of influenza-like illness outbreaks:
  - WRHA LTC Program Team
  - WRHA LTC Medical Director
  - WRHA Chief Nursing Officer and Vice President (responsible for LTC)
  - WRHA Regional Director, Bed Utilization
  - WRHA Regional Director, Infection Prevention and Control Program
  - LTC ICP committee members, facility Executive Directors and Directors of Care
  - MB Health Standards Lead
  - Others as required
- Collaborate with facility ICPs and Administration to determine when the closure of a facility is warranted.
- Update the WRHA IP&C website regarding current outbreaks in the Winnipeg Health Region.
- Act as a resource to facility ICPs, facility Senior Management/Administration and staff.
- Liaise with CDCs, facility ICPs and other relevant stakeholders as required.
- Compile and report statistics as required.
Communicable Disease Coordinators are responsible to:

PRE INFLUENZA SEASON
- Collaborate with the WRHA LTC Program Manager of IP&C to educate and update facility ICPs regarding the annual immunization campaign and Influenza outbreak management.

INFLUENZA SEASON/OUTBREAK MANAGEMENT
- Act as a resource to facility ICPs.
- Communicate information to and from the MOH and others as applicable.
- Obtain and communicate the outbreak code to the LTC ICP/designate.
- Provide the facility ICP/ designate with information regarding type of testing recommended (e.g., rapid testing for influenza virus and number of specimens). Usually 6 specimens are taken in an outbreak, but collaboration between the facility ICP/MOH and CDC may determine additional specimens are warranted.
- Receive viral test results from Cadham Lab and relay results to the ICP/designate.
**Medical Officer(s) of Health (MOH)** are responsible to:

- Collaborate with facility Medical Directors to release oseltamivir for use in chemoprophylaxis before lab confirmation when rapid tests are negative but the outbreak is strongly suspected to be caused by influenza. Results of further virology testing can take another 24-48 hours after the rapid test results are available and due to the time sensitive nature of oseltamivir’s efficacy the MOH can be consulted to alleviate this delay.

- Act as a resource to facility Medical Directors and the WRHA LTC Manager of IP&C as required.

[Return to Roles and Responsibility List]
Evaluation

The seasonal Influenza resource Guide will be re-evaluated every year as MHSAL updates the Influenza Management Protocol, and as information from the WRHA Regional Immunization Committee becomes available. Data collected from site Infection Control Professionals and site outbreak debriefing reports will be reviewed and analyzed each season with lessons learned from these reports incorporated into the following seasonal update.
References


9. Manitoba Health Seniors and Active Living (July 26, 2017). Fluzone® High-Dose Implementation Notice (Email).


13. WRHA Clinical Services Policy. *Informed Consent (for Procedures, Treatments and Investigations).* Policy #100.00.005. Available at: [http://home.wrha.mb.ca/corp/policy/files/110.000.005.pdf](http://home.wrha.mb.ca/corp/policy/files/110.000.005.pdf)


Appendices

Appendices can be downloaded from the following links:

Appendix A - Annual Immunization Consent Form
Appendix B - Visitor Restrictions Sign
- English
- French
Appendix C - Resident Oseltamivir and Immunization Spreadsheet
Appendix D - Oseltamivir Label Templates
- 30 mg Daily
- 30 mg Every Other Day
- 75 mg Daily
Appendix E - Collection of Nasopharyngeal Specimens
Appendix F - Cadham Provincial Laboratory Sample Requisition
Appendix G - Influenza Outbreak Management Quick Reference Guide
Appendix H - Outbreak Investigation Form
Appendix I - Guidelines for Admissions, Transfers, and Respite during Influenza Outbreaks
Appendix J - Instructions for Ordering Supplies
Appendix K - Cadham Lab Supply Request Form
Appendix L - Resident and Family Outbreak Information Handout
Appendix M - Visitor Entrance Sign
- English
- French