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Recommendations for Prevention and Control of Influenza Outbreaks in Skilled Nursing and Assisted Living Facilities

This document provides general guidance to long term care facilities (LTCF) on preventing, detecting, reporting, and controlling suspected and confirmed influenza outbreaks. Additional guidance for managing influenza outbreaks in long term care facilities is available at: http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm

Preventing Outbreaks

Influenza Vaccination	• Upon admission, state law (RCW 74.42.285 and WAC 388-97-1340) requires LTCFs
	  ○ to inform, verbally and in writing, residents or their legal representative about the benefits of receiving flu vaccination.
	  ○ to make available flu vaccination annually to their residents.
	• Influenza vaccination is the best means to prevent influenza and its complications among residents and staff of LTCFs.
	• ***Therefore, unless contraindicated for medical reasons, influenza vaccination is strongly recommended annually for all residents and employees (both medical and non-medical) of LTCFs.***

Other Prevention Measures	• Standard Precautions
	  ○ Strict attention to hand hygiene and cough etiquette with all resident care as a year-round prevention measure
	• Visitation and Staff illness policy & procedure
	  ○ Exclusion of symptomatic staff and visitors from the facility
	• Transmission Based Precautions
	  ○ Adherence to appropriate infection control precautions, including isolation of symptomatic and influenza-confirmed residents
	• Influenza Outbreak Management Plan
	  ○ Early recognition and testing of suspected influenza cases.
	  ○ Report all suspected and confirmed outbreaks to appropriate local health jurisdiction.

Detecting and Reporting Outbreaks

Detecting Influenza

Testing for influenza should occur when any resident has signs and symptoms that could be due to influenza and not an alternative diagnosis. Testing for influenza in symptomatic individuals is recommended when influenza is circulating[1] in the surrounding community (e.g., county) of the LTCF.

Common signs and symptoms of Flu	Warning signs of Flu	Subtle symptoms
• Fever* or feeling feverish/chills • Cough • Sore throat • Runny or stuffy nose • Muscle or body aches • Headaches • Fatigue (tiredness) • Some people may have vomiting and diarrhea *Not everyone with flu will have a fever; the elderly are less prone to developing a fever	• Difficulty breathing or shortness of breath • Persistent pain or pressure in the chest or abdomen • Persistent dizziness, confusion, inability to arouse • Seizures • Not urinating • Severe muscle pain • Severe weakness or unsteadiness • Fever or cough that improve but then return or worsen • Worsening of chronic medical conditions	Note that elderly patients may experience subtle symptoms, including: • Anorexia • Mental status changes • Pneumonia • Low-grade or no fever • Worsening of chronic respiratory conditions • Worsening congestive heart failure

*2 **These lists are not all inclusive. Please consult a medical provider for any other symptom that is severe or concerning.*

1 State influenza surveillance data is available and can be used to determine influenza circulation: https://doh.wa.gov/sites/default/files/2023-05/420-100-FluUpdate.pdf

2 CDC Flu Symptoms & Complications: https://www.cdc.gov/flu/symptoms/symptoms.htm

Other Communicable Disease Considerations	• If symptoms are compatible with other agents during periods with high levels of respiratory virus infections, consider testing for COVID-19 or infections with specific treatment available (e.g., legionellosis, other bacterial pneumonia).
Reporting	**Long term care facilities are required to report all suspected and confirmed outbreaks to their local health jurisdiction (LHJ) per Washington Administrative Code (WAC) 246-101-305.** LTCFs are required to report the following: • A sudden increase in acute febrile respiratory illness* over the normal background rate (e.g., 2 or more cases of acute respiratory illness occurring within 72 hours of each other) **OR** • Any resident who tests positive for influenza. *Acute febrile respiratory illness is defined as fever ≥ 100.4°F AND one or more respiratory symptoms (runny nose, sore throat, laryngitis, or cough). However, please note that elderly patients with influenza may not develop a fever.

Responding to an Outbreak

Establish presence of an influenza outbreak	• If there is one laboratory-confirmed influenza positive case along with other cases of respiratory infection in a LTCF, an influenza outbreak might be occurring.
Implement appropriate transmission-based precautions to prevent spread	• Most healthy adults can infect others beginning 1 day **before** symptoms develop and up to 5 to 7 days **after** becoming sick. Some people, especially those with weakened immune systems, may be infectious for longer. https://www.cdc.gov/flu/about/keyfacts.htm • Remember that the time from when a person is exposed to flu to development of symptoms is about 1 to 4 days, with an average of 2 days. • Note that an influenza outbreak can generally be considered over 7 days from the last onset (the clock starts again with each new onset).
Communicate	• As soon as an influenza outbreak is established, notify staff, residents, family members, and visitors. • Report all suspected and confirmed outbreaks to LHJ.
Follow state public health and local health recommendations	• See **Checklist for Controlling Influenza Outbreaks in Long Term Care Facilities** below • These recommendations do not supersede those of the local health jurisdiction. • **Always** report a suspected or confirmed respiratory illness outbreak to local public health.

In general, the measures in the following checklist should be implemented once an outbreak of influenza has been identified in a LTCF.

Checklist for Controlling Influenza Outbreaks in Long Term Care Facilities

Recommendations	Recommended By LHJ	Implemented By Facility
Ill Residents		
Administer antiviral treatment to all residents or staff with **suspected or confirmed** influenza according to current CDC recommendations. Do *not* wait for laboratory confirmation of flu to initiate treatment. Note that the usual first line treatment is oseltamivir 75 mg twice daily for five days. https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm		
Implement droplet precautions in addition to standard precautions for suspected or confirmed cases for 7 days after illness onset or until 24 hours after resolution of fever and respiratory symptoms, *whichever is longer*.		
Healthcare providers should wear NIOSH-approved respiratory protection such as a fit-tested particulate filtering facepiece (e.g., N95) or higher (e.g., powered air-purifying respirator, elastomeric respirator) during aerosol-generating procedures. https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm		
Restrict ill residents to their rooms, a private room is preferred. • If private rooms are not available, consider other placement options such as cohorting ill residents with the same condition, or ensuring at least 3 feet of separation and a physical barrier (e.g., curtain) between ill and well roommates.		
Ill residents who must leave their room should wear a facemask and be instructed to cover coughs and sneezes and practice good hand hygiene.		
If requested by the local health jurisdiction, obtain specimens for viral culture or PCR on a subset of residents and/or staff with most recent onset of illness. • **Upon local health jurisdiction approval**, specimens can be submitted to the Washington State Public Health Laboratories (PHL) for influenza testing free of charge per instructions available at: http://www.doh.wa.gov/Portals/1/Documents/pubs/301-018-InfluenzaTestingPHL.pdf		

Staff		
Exclude ill staff, including volunteers, from work for **at least** 24 hours after resolution of fever* (without the use of fever-reducing medications). • Those with ongoing respiratory symptoms should be evaluated to determine appropriateness of contact with patients.		
Designate staff to care for ill residents and others to care for well residents. Minimize staff movement between areas in the facility with illness and areas not affected by the outbreak. • Consider setting up a separate break room for staff caring for ill residents, and disinfect surfaces used by all staff (such as time clocks) or set up an interim system to avoid contamination of shared surfaces.		
Vaccination		
Administer influenza vaccine to all previously unvaccinated residents and staff according to ACIP guidelines. https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html		
Administration of Chemoprophylaxis		
When at least 2 patients are ill within 72 hours of each other **and** at least one resident has laboratory-confirmed influenza, administer chemoprophylaxis to **all non-ill residents regardless of vaccination status across the facility.** • Remember that ill persons should receive antiviral treatment. • Note that the usual chemoprophylaxis dose is Oseltamivir 75 mg once daily for a minimum of 2 weeks, continuing for at least 7 days after identification of last known case. Priority for chemoprophylaxis can be given to residents in the same area of the facility as the cases. However, since staff and residents may spread influenza to residents on other units, floors, or buildings of the same facility, all non-ill residents are recommended to receive antiviral chemoprophylaxis to control influenza outbreaks. CDC antiviral guidance: http://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm *Note: Persons who develop acute respiratory illness >72 hours after beginning antiviral chemoprophylaxis should be immediately tested for influenza and reported to the LHJ.*		
Consider administering chemoprophylaxis to previously unvaccinated staff. • In addition, chemoprophylaxis may be considered for all employees, regardless of their influenza vaccination status, if indications exist that the outbreak is caused by a strain of influenza virus that is not well matched by the vaccine. Consult local public health about the administration of chemoprophylaxis for previously unvaccinated staff.		

Education/Hand Hygiene		
• Educate staff, residents and visitors regarding outbreak and control measures. Provide hand and respiratory hygiene education. • Post signs alerting staff, residents, and visitors to the outbreak.		
Resident Movement/Admissions/Transfers		
Limit large group activities in the facility and consider serving all meals in rooms if the outbreak is widespread.		
Do not move residents to other wards or facilities unless medically indicated. • If residents are transferred, provide the receiving facility with healthcare information for the resident and let the receiving facility know of the influenza outbreak so that the resident may be appropriately monitored for symptoms and/or treated if ill.		
If appropriate infection control measures are maintained, facilities can admit new residents. It is important to inform potential new residents of the outbreak so they may choose whether to postpone their admission. In determining whether to admit residents, facility leadership should consider the capability and capacity to safely care for residents. Appropriate infection prevention precautions and influenza measures must be maintained.		
Visitors		
Exclude ill visitors from the facility.		
Alert visitors to wear masks and of the need for good hand hygiene while visiting a resident ill with influenza-like illness.		
Limit visitation until the outbreak is over.		
Active Surveillance / Communication		
Initiate active daily surveillance for influenza-like illness (ILI) among residents and staff until 1 week after last onset of illness. Record illnesses on the line list provided.		
Report outbreak to the Department of Social and Health Services or other licensor per WAC 388-97-1320 for Skilled Nursing Facilities and WAC 388-78A-2610 for Assisted Living Facilities.		
Communicate with the local health jurisdiction daily.		

*Healthcare providers with confirmed or suspected influenza should not care for patients in Protective Environments such as stem cell transplant patients until 7 days from symptom onset or until resolution of symptoms, whichever is longer.

Guidance and Recommendations

CDC. Guidance on Influenza Outbreak Management in Long Term Care Facilities
http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm

CDC. Guidance on Infection Control in Healthcare Facilities
http://www.cdc.gov/flu/professionals/infectioncontrol/

CDC. Prevention and control of seasonal influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices—United States, 2017–2018 Influenza Season. MMWR 2017; 66(2):1-20. https://www.cdc.gov/mmwr/volumes/66/rr/rr6602a1.htm

CDC. Antiviral Drugs: Recommendations of the Advisory Committee on Immunization Practices (ACIP): Information for Health Care Professionals.
http://www.cdc.gov/flu/professionals/antivirals/index.htm

CDC. Flu Symptoms & Complications https://www.cdc.gov/flu/symptoms/symptoms.htm

Educational Resources

Centers for Disease Control and Prevention materials
https://www.cdc.gov/flu/resource-center/freeresources/index.html

CDC Cover your cough materials https://www.cdc.gov/flu/pdf/protect/cdc_cough.pdf

Knock Out Flu educational materials from the Washington State Department of Health
https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Flu

Knock Out Flu: Think of It as Essential toolkit
https://doh.wa.gov/you-and-your-family/illness-and-disease-z/flu/materials-and-resources/knock-out-flu-toolkit

Wash Your Handsington materials
https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Flu/WashYourHandsingTon

For information on COVID-19 outbreaks in LTC
SARS-CoV-2 Infection Prevention and Control in Healthcare Settings Toolkit (wa.gov)