

Ministry of Health and Long-Term Care

Guidance for Influenza-like Illness (ILI) Management in Long-Term Care (LTC)

Please refer to Important Health Notice Volume 6, Issue 10 issued on May 19, 2009

Information as of May 19, 2009 indicates that the current H1N1 influenza virus has characteristics similar to seasonal influenza¹ (clinical features, morbidity and mortality, epidemiology). However, because it is a novel virus with pandemic potential, these guidelines are precautionary and will be updated as new information and evidence becomes available.

The current H1N1 influenza A virus has been identified in both travelers to affected areas as well as the local community. The presence of the virus in the community and associated transmission from person-to-person suggests that H1N1 should be assumed to be one of the predominant circulating strains of influenza at this time.

This has been issued to update the previous information provided and should be used as the most current guidance for the management of ILI in the clinical setting.

Background

The Ontario Health Plan for an Influenza Pandemic (OHPIP) advises that it is prudent to wear fit tested N95 respirators while within 2 metres of caring for a patient with an influenza virus of pandemic potential. Because travel history can no longer accurately predict who is infected with the novel H1N1 strain, it follows that a fit tested N95 respirator in addition to droplet and contact precautions should be used by healthcare workers

¹ Influenza is predominantly a droplet-borne disease; however transmission via small airborne sized particles cannot be ruled out. Influenza virus can also survive on surfaces; therefore, both droplet and contact precautions are recommended to prevent transmission.

when within 2 metres of caring for all patients with influenza-like illness(ILI).

The recommendations outlined are based upon implementation of the broadest level of precautionary measures. Where supplies of N95 respirators and other personal protective equipment (PPE) are limited or depleted, N95 respirator and PPE use by healthcare workers should be prioritized as recommended in chapter 7 of the OHPIP. If an N95 respirator is not available, healthcare workers are advised to don a surgical mask wherever an N95 respirator is called for in this document and, if possible, to put a surgical mask on their patient.

Individuals who meet the symptom criteria for ILI should self-isolate and not present to their work setting. The length of time the individual should remain off work will depend on their work setting (see below).

In the long-term care setting, it is particularly important to focus on screening of visitors, family members and staff to look for symptoms of respiratory illness.

Long-term care settings are advised to be on alert for cases of ILI in residents and staff at all times. While associated with the winter months, influenza can occur at any time of the year.

1. Screening

Passive: Post signage at the entry to each long-term care setting reminding persons entering the home NOT to enter if they are having symptoms of ILI such as fever, cough or shortness of breath, muscle aches, or sore throat.

All persons entering the home should practice good hand hygiene. Alcohol-based hand rub (ABHR) should be available at the entrance to the home and at point of care in the resident's room².

Staff should not work if they are experiencing symptoms of ILI. Remind staff of the importance of reporting if they develop ILI. Staff members who develop ILI should remain off work until 7 days after the onset of symptoms and they are afebrile and feeling better. NOTE: It is not unusual for individuals to experience a cough for days to weeks post infection. Presence of a cough, in the absence of other symptoms, is not sufficient to keep an employee away from the work setting.

Ask family members and visitors who are ill with ILI to stay away from the home until 7 days after the onset of their illness and they are afebrile and feeling better.

2. Resident Management

Continue to monitor residents for ILI and continue to report to local public health agencies as per usual practices.

Residents with ILI symptoms who require urgent medical attention and transfer to an acute care setting should be managed using normal processes, including the use of the Patient Transfer Authorization Centre. The long-term care setting should notify the EMS and hospital Emergency staff that the resident requires the additional precautions of fit-tested N95 respirator and eye protection within 2 metres of the resident or when providing direct patient care to ensure that both the transport and receiving agency are prepared to care for the resident safely. In settings where such a separation is not possible, healthcare workers are advised to maintain whatever separation is feasible.

Influenza-like Illness (ILI)

Acute onset of respiratory illness with fever and cough and with one or more of the following: sore throat, arthralgia, myalgia, or prostration, which could be due to influenza virus. In children under 5 years of age, gastrointestinal symptoms may also be

present. In patients aged under 5 years or 65 and older fever may not be prominent.

Infection Prevention and Control Practices

Health Care providers in the long-term care setting should use the following practices for providing direct care to residents with ILI, in addition to Routine Practices.

- If possible, the resident with ILI should wear a surgical mask
- Hand hygiene with alcohol-based hand rub, or soap and running water
- Eye protection
- Gloves and gown if there is a risk of contamination with respiratory secretions/body fluids
- Fit-tested N95 respirator
- Appropriately clean and disinfect any equipment that is shared before moving it from one resident to another
- Clean and disinfect surfaces that may have become contaminated with respiratory secretions using a hospital grade disinfectant

Remind residents and staff to be vigilant with their hand hygiene practice and respiratory etiquette (covering coughs and sneezes, disposing of used tissues immediately and cleaning their hands after contamination with respiratory secretions).

3. Laboratory Testing

Residents who present with ILI symptoms should have a nasopharyngeal (NP) swab obtained and specimens should be forwarded to the clinician's local community or hospital laboratory. Influenza A positive samples (and all other samples where Influenza A molecular testing is not available) will be forwarded for further testing at the Central Public Health Laboratory (Toronto) or the nearest Regional Public Health Laboratory (PHL). Samples from outbreaks at LTC facilities should be forwarded directly for testing at PHL.

Molecular testing for the 2009 Influenza A H1N1 virus is also at being performed at several hospital laboratories. Some of these laboratories are able to report confirmed cases of the novel influenza A H1N1. Further confirmation of these results at PHL is at the discretion of the laboratory director.

² Resident point of care is where three elements are present at the same time; the resident, the health care worker and care involving contact.

It is critical that clinical symptoms and risk factors be written on the test requisition in order to triage specimens. Specimens from asymptomatic patients will not be tested.

The NP swab should be placed into viral transport medium and transported at 4°C.

4. Treatment Recommendations

Treatment of the following groups with ILI with oseltamivir is currently recommended within 48 hours of the onset of symptoms:

- Fever and acute ILI or pneumonia requiring hospitalization
- ILI and at risk for complicated disease

NOTE: Residents of long-term care settings are considered to be at higher risk of complications.

Other patients with ILI do not require treatment.

Comment on the treatment of children

The use of oseltamivir in children under the age of 1 year has been studied in a very limited number of children. The Centers for Disease Control and Prevention (CDC) has recently received emergency approval in the United States for use in infants under 1 year of age with suggested dosing guidelines. The use of zanamivir in children under the age of 7 is not well studied and it is technically difficult to administer.

The Canadian Paediatric Society has recommended that the use of antivirals in children be confined to:

Children hospitalized with H1N1 influenza
Outpatient children with moderate illness and specified underlying chronic health conditions.
Details regarding the treatment of children are available at:

www.cps.ca/english/statements/ID/H1N1Mexico2009.htm