Respiratory illness in residential and aged care facilities
Guidelines and information kit
Updated March 2017
To receive this publication in an accessible format phone 1300 651 160, using the National Relay Service 13 36 77 if required, or email infectious.diseases@health.vic.gov.au

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Respiratory outbreak management actions
Introduction

These guidelines provide general information about influenza, its risk to health (particularly in the elderly) and recommendations for managing respiratory outbreaks in residential and aged care facilities.

When an outbreak of respiratory illness is present (suspected/confirmed) there are a number of actions required to reduce the risk of further transmission within the facility and to manage the outbreak effectively and efficiently.

The actions that should be undertaken immediately by the facility and its staff, particularly during the initial stages are listed here and will be explained in detail in the document.

These actions are:

• Determine if you do have an outbreak – Section 2.1
• Implementing infection prevention and control strategies in addition to standard precautions – Section 2.2
• Notification to the Department of Health and Human Services Victoria – Section 2.3
• Obtaining nose and throat swabs – Section 2.6 and Appendix 7
1. Background information

Older people living in residential aged care facilities are susceptible to outbreaks of respiratory illness. These outbreaks are commonly caused by influenza however other viruses such as parainfluenza, respiratory syncytial virus (RSV), adenoviruses, and rhinoviruses can also cause outbreaks of respiratory illness.

In Australia outbreaks commonly occur during the months of March through to September. It can be difficult to tell the difference between a respiratory illness caused by influenza and a respiratory illness caused by other viruses based on symptoms alone.

In general, influenza is worse than the common cold, and symptoms such as fever, body aches, extreme tiredness, and dry cough are more common and intense. In influenza outbreaks death rates up to 55% have been reported.

Influenza can be unpredictable and severity can vary from one season to the next depending on many things (for example, what influenza strains are circulating and vaccine coverage of the population).

In order to detect influenza outbreaks early, a case definition for influenza-like-illness is applied (see section 2.1). Furthermore, nose and throat swabs should be collected within the first 48 hours after onset of a respiratory illness to identify the cause of the infection.

The main strategies to prevent and manage influenza-like outbreaks in the residential aged care setting include:

- early influenza vaccination of residents and staff prior to influenza season commencement
- recognition of outbreaks
- the introduction of stringent infection prevention and control measures including the restriction of movement between affected and unaffected areas within the facility
- the use of antiviral medication if indicated
- minimizing contact between affected and unaffected persons during an outbreak.

1.1 Signs and symptoms

Signs and symptoms of a respiratory illness can be mild to severe. If a person has influenza it is different from a cold and usually comes on suddenly. People who have influenza or an influenza-like-illness often experience some or all of the following symptoms:

- fever or feeling feverish/chills
- cough
- sore throat
- shortness of breath
- runny or stuffy nose
- muscle or body aches
- headaches
- fatigue (tiredness).

Older people may also have the following symptoms:

- increased confusion
- worsening chronic conditions of the lungs
- loss of appetite.

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1 Fever is usually a dominant feature but may be absent in certain circumstances, i.e. elderly residents
1.2 Complications of influenza

Most people will recover in a few days to less than two weeks, but some people can develop complications (such as pneumonia) and this may be life-threatening and result in death.

Complications include:

- pneumonia
- bronchitis
- sinus and ear infections
- worsening of chronic health problems such as congestive heart failure, asthma and diabetes
- death

1.3 Transmission

Respiratory illnesses are mainly spread by droplet transmission. Respiratory droplets are large and do not remain suspended in the air.

Large droplets are produced when people cough and sneeze. When a person with a respiratory illness coughs or sneezes respiratory droplets can land in the mouth, nose or eyes — or possibly be inhaled into the lungs — of a person who is nearby.

Respiratory illnesses can be transmitted from respiratory droplets that land on surfaces or objects that people touch and then touch their own mouth, eyes or nose.

For these reasons, cough etiquette, hand hygiene and regular cleaning of surfaces are paramount to preventing the transmission of influenza.

1.4 Incubation period

The incubation period will vary depending on what agent is causing the respiratory illness. For example:

- the incubation period for influenza is on average 2 days (range 1-4), and
- the incubation period for respiratory illnesses caused by viruses such as parainfluenza, respiratory syncytial virus (RSV), adenoviruses and rhinoviruses can range from 1 to 10 days.

1.5 People at increased risk

People at increased risk include:

- people 65 years of age and over (the human immune defences become weaker with advancing age)
- all Aboriginal and Torres Strait Islander people
- people with chronic or other medical conditions including:
  - asthma, a lung disease that is caused by chronic inflammation of the airways
  - neurological and neurodevelopmental conditions including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury
  - chronic lung disease (such as chronic obstructive pulmonary disease)
  - heart disease (such as congestive heart failure and coronary artery disease)
  - blood disorders (such as sickle cell disease)
  - endocrine disorders (such as diabetes mellitus)
  - kidney disorders
  - liver disorders
– weakened immune system due to diseases (such as HIV and cancer) or medications such as chemotherapy, long term steroids or immune based therapy for conditions such as rheumatoid arthritis).

– morbid obesity.

1.6 Period of communicability

In general people with a respiratory illness can be infectious shortly before signs and symptoms commence and for up to 5 to 7 days after becoming sick.

In some people, such as those who are severely immunocompromised, the period of communicability may be longer (up to 7 to 10 days).

1.7 Influenza vaccination

The single best way to prevent influenza in the residential care setting is for residents and staff to be vaccinated annually. Vaccination of high risk persons is especially important to decrease their risk of severe influenza illness.

Vaccination of health care workers (HCWs) and other staff who have contact with people in residential aged care settings is important to prevent the spread of influenza to residents who may develop more severe disease or complications.

In Australia seasonal influenza vaccination commences in March of each year. There are no vaccines for influenza-like illnesses caused by non-influenza viruses.

Residential aged care facilities should:

• start to make plans for their residents to be vaccinated before each year’s influenza season (ideally March/April)
• organise a regular staff vaccination program before each year’s influenza season (ideally March/April)
• maintain an annual register of residents and staff who are vaccinated.
2. Management of a respiratory outbreak

2.1 Determine if you have an outbreak

An outbreak should be declared when there are three or more people (residents and/or staff) with an onset of an influenza-like illness within a 72 hour period that are linked to one another. These people may have been in the same ward/unit/room or an area where they had contact with one another and there was an opportunity for the spread of infection.

The following case definition should be used to determine if there is an outbreak:

Figure 1. Case definitions for influenza-like illnesses updated March 2017)

A. Case of influenza-like-illness

- Sudden onset of symptoms
- At least one of the following respiratory symptoms:
  - Cough (new or worsening)
  - Sore throat
  - Shortness of breath
- At least one of the following systemic symptoms:
  - Fever or feverishness
  - Malaise
  - Headache
  - Myalgia (sore muscles)

B. Confirmed case of influenza

Case of influenza-like-illness with a positive laboratory test result for influenza


2.2 Implementing infection prevention and control measures

In addition to standard precautions that are already in place in the facility, droplet precautions will need to be implemented.

2.2.1 Standard precautions

Standard precautions include a group of infection prevention practices that apply to all residents, regardless of suspected or confirmed infection status, in all healthcare settings. Standard precautions include hand hygiene and the use of gloves, gown, mask and eye protection depending on the anticipated exposure or contact, respiratory hygiene/cough etiquette (see Appendix 4) and regular cleaning of the environment and resident care equipment.

2.2.2 Hand hygiene (Appendix 3)

Hand washing and thorough drying is essential in preventing the transmission of microorganisms between residents and staff and contaminating furnishings and equipment. Hands should be washed with warm water and liquid soap before and after caring for a resident:

- even when visibly clean
- when soiled with body fluids and/or substances
- have been in contact with contaminated surfaces
- whether or not gloves are worn.
2.2.3 Alcohol-based Hand Rub Solutions (ABHRS)

ABHRS can be used when performing clean procedures/tasks such as bed-making.

2.2.4 Use of Personal Protective Equipment (PPE)

Use the appropriate PPE when caring for residents according to standard and droplet precautions. Appropriate PPE should be used whenever any aerosol producing procedures are undertaken such as when obtaining a respiratory specimens from a resident.

2.2.5 Single use face masks (Appendix 5)

- Single use face masks should be worn when exposure to respiratory droplets or aerosols is likely. All staff and visitors entering the room of a resident with a respiratory illness should wear a single use face mask for any close contact, that is, when coming within less than a metre or approximately 3 feet.
- The mask should be put on when entering the room.
- Remove the mask after leaving the room handling only by the tapes and place in a clinical (yellow) waste bin.
- Never reuse masks.

2.2.6 Gloves and gowns

Gloves and gowns should be used as per standard precautions and when taking respiratory specimens. Gloves and gowns should be removed in a manner which prevents contamination of the hands or surfaces or the HCWs clothing, then placed in the appropriate waste bins. Hands should be washed and dried after removing gown and/or gloves.

2.2.7 Eye protection

Eyes should be protected particularly during aerosol-producing procedures such as the taking of respiratory specimens. Goggles or single use face masks with shields should be used. Goggles or other protective eyewear must be cleaned after use. Protective eyewear should be individual use only.

2.2.8 Droplet precautions

Droplet precautions are required in addition to standard precautions to reduce the risk of transmission of respiratory viruses between staff, residents and visitors. They include the use of single use face masks as described above and the following:

2.2.9 Isolation

All residents with a respiratory illness should be isolated and cared for in a single room where practicable.

2.2.10 Cohorting

- If single rooms are limited, residents who have a respiratory illness with similar signs and symptoms can be cohorted (grouped or roomed together) if possible.
- When a single room is not available, and cohorting is not possible, a resident with a respiratory illness may be cared for in a room with a roommate/s with the beds being separated by at least 1 metre (≥3 feet).
- The curtain should be drawn between resident beds.
- Staff must change their PPE and perform hand hygiene before moving from one resident to another.
2.2.11 Droplet precaution sign (Appendix 2)

Place a droplet precaution sign outside the resident’s room to remind staff and visitors about the requirement for strict infection control procedures.

- All staff and visitors entering the room of a person with a respiratory illness should wear a single use face mask for close contact — 1 metre (≥3 feet).

2.2.12 Staff

Once isolation measures are in place HCWs should not move between wings of the facility caring for other residents and should be allocated the care of residents in the isolated wing to further reduce the risk of transmission.

For suspected or confirmed cases of respiratory illness in residents caused by influenza it is preferable that only staff who have been vaccinated for influenza care for these residents.

Unvaccinated staff who have been working in the outbreak affected area should not be moved as they may be incubating infection. They should be offered immediate influenza vaccination. Please note that vaccination may not prevent illness if already incubating. A protective immune response takes approximately two weeks to develop. **During a confirmed influenza outbreak unvaccinated staff are recommended to attend work only if they are asymptomatic and wearing a single use face mask, or asymptomatic and taking appropriate antiviral prophylaxis to minimise the risk of potentially exposing vulnerable residents.**

All staff members should self-monitor for signs and symptoms of respiratory illness and self-exclude if unwell.

Staff with respiratory illnesses should be excluded from work for the period during which they are infectious (generally 5 days after the onset of the acute illness).

2.2.13 Resident movement during an outbreak

- Limit resident movement outside the isolation room to medically necessary/essential procedures or activities.
- Residents with a respiratory illness who must be transported outside of the room should wear a mask if tolerated and follow Respiratory Hygiene/Cough Etiquette (Appendix 4).
- Communicate the respiratory illness status of the resident to other healthcare facilities before transfer so that appropriate infection prevention and control precautions can be implemented at the accepting facility.

2.2.14 New admissions

An ongoing outbreak does not necessarily mean the facility has to go into complete “lock down”. This seems to be a common misconception. However, generally **admissions of new residents to the affected unit** during the outbreak are not permitted. If new admissions are unavoidable, new residents and their families must be informed about the current outbreak and adequate outbreak control measures must be in place.

2.2.15 Re-admission of cases

The re-admission of residents who met the case definition is permitted provided appropriate accommodation including any infection control requirements can be met.

2.2.16 Re-admission of non-cases

The re-admission of residents that have not been on the respiratory outbreak case lists (i.e. are not a known case) should be avoided during the outbreak period if possible. If non-cases are re-admitted, the
resident and their family must be informed about the current outbreak and adequate outbreak control measures must be in place. Families may wish to make alternative arrangements.

2.2.17 Transfers
If transfer to hospital is required, the ambulance service and receiving hospital must be notified of the outbreak/suspected outbreak verbally and through using a resident transfer advice form (Appendix 9).

2.2.18 Non-infected residents
In some circumstances, it may be feasible to transfer residents who are not symptomatic, to other settings (for example, family care). The family should be aware that the resident may have been exposed and is at risk of developing disease.

2.2.19 Visitors
• Keep visitors to a minimum where possible.
• Restrict visitors with a respiratory illness if possible.
• Instruct and supervise visitors on the use of PPE (donning and removing masks) and hand hygiene.

2.2.20 Cleaning and disinfection of equipment and the environment (Appendix 6)
Please refer to Appendix 6 for detailed information on cleaning. Cleaning and disinfection of all resident-care areas is important for frequently touched surfaces, especially those closest to the resident, that are most likely to be contaminated (for example, bedrails, bedside tables, commodes, doorknobs, sinks, surfaces and equipment in close proximity to the resident).

The frequency or intensity of cleaning should be increased in the isolated areas of the facility to reduce the potential for transmission (at least twice daily). Other areas of the facility should also have their frequency of cleaning increased (for example, from once to twice daily).

Provide dedicated resident care equipment. If resident care equipment must be shared the items must be cleaned and disinfected between each resident use.

2.2.21 Linen and eating utensils
• Linen should be laundered as per AS4146 laundry practice using hot water and detergent and dried on a hot setting in a dryer. There is no need to separate the linen of ill residents from that of other residents.
• Crockery and cutlery should be washed in a dishwasher or if not available by hand using hot water and detergent, rinsed in hot water and dried. Separation of cutlery and crockery is not required.

2.2.22 Ceasing droplet precautions
Generally, people with influenza are considered infectious for 5 days. Droplet precautions should therefore continue for at least 5 days. The decision to cease droplet precautions should be made on a case-by-case basis and the resident should ideally be symptom free before precautions are stopped.

2.3. Notifying the Department of Health and Human Services
If you suspect an outbreak may be occurring, notify Communicable Disease Prevention and Control (CDPC) at the Department of Health and Human Services on telephone 1300 651 160 as soon as possible. A public health officer will provide you with advice and guidance on how to proceed.

If any deaths or hospitalisations occur during an outbreak, CDPC must be notified within 24 hours (Mon-Sunday 9am - 5pm). On initial notification of an outbreak you will be asked to provide the following information over the phone:
- total number of residents and/or staff who have a respiratory illness
Respiratory illness in RACF
± updated March 2017

- date of onset of illness of each person
- symptoms of each person
- number of people admitted to hospital with influenza-like symptoms
- number of people with influenza-like symptoms who have died
- total number of staff that work in the facility and in the affected area
- total number of residents in the facility and in the affected area
- whether respiratory specimens (nose and throat swabs) have been collected.

- CDPC will advise and assist with the following:
  - confirming the presence of an outbreak
  - identifying the control measures that need to be in place
  - testing of the initial respiratory specimens either at the Victorian Infectious Diseases Reference Laboratory (VIDRL) if necessary or your primary laboratory.

2.4. Advising visiting General Practitioners

Unwell residents require medical review by their visiting General Practitioners (GPs) regardless if an outbreak is present or not. If a respiratory outbreak is present, all visiting GPs should be informed at the start of the outbreak. CDPC will provide the facility with a letter to be sent to the relevant visiting GPs. This will facilitate swabs being obtained and early treatment for symptomatic residents and consideration of prophylaxis.

2.5. Establish an outbreak management team

It is the facility’s responsibility to self-manage the outbreak. If possible, an outbreak management team should be established. Even a relatively small respiratory outbreak can be very disruptive, and the risk of complications in residents and transmission amongst residents and staff is high. It is helpful in times of stress and disruption that people’s roles are clearly defined.

**The Outbreak Management Team may include the following people:**

- a chairperson (for example, Director of Nursing or Medical Director)
- an outbreak coordinator (for example, Infection Control Consultant or delegate)
- media spokesperson if indicated (usually DoN/manager)
- visiting general practitioners (GPs).

**The Outbreak Management Team should initially meet on a daily basis to:**

- direct and oversee the management of the outbreak
- review and confirm the role of visiting GPs
- confirm who is responsible for the ongoing monitoring of the outbreak
- designate responsibility for the daily updating of the respiratory outbreak case list to be sent to CDPC (Appendix 8)
- ensure CDPC is notified within 24 hours of any hospitalisations and deaths by phone (Mon-Sun, 9 am -5 pm)
- determine the process for reviewing laboratory results and prevention and control measures with the Communicable Disease Prevention and Control Section staff
- confirm how and when daily communications will take place
- ensure that telephone contact numbers are available to facility staff for CDPC (including out-of-hours — in particular for reporting hospitalisation and deaths that may occur)
- determine the processes for following up results and ensuring that the visiting GPs and CDPC are informed and aware of the results (positive or negative)
- review and implement staffing contingency plans.
For confirmed influenza outbreaks:

- organise treatment for ill residents with antiviral medications in consultation with their GPs
- review the vaccination status of staff and residents
- determine if additional influenza vaccinations are required for unvaccinated residents/staff
- antiviral prophylaxis may be recommended in some cases for well residents regardless of vaccination status and unvaccinated staff
- prepare and implement a communication plan for:
  - local GPs
  - local hospitals and community healthcare workers
  - residents, family and visitors
  - prepare signage for the facility (Appendix 7)
- determine education needs for staff
- confirm the implementation of the staff exclusion policy for staff with respiratory illnesses

2.6. Complete the respiratory outbreak case list

Complete the respiratory outbreak case list (Appendix 8).

Update the respiratory outbreak case list with new cases on a daily basis in order to monitor progress of outbreak. Fax the case list to CDPC on fax number 1300 651 170 twice weekly.

2.7. Collection of nose and throat swabs (Appendix 7)

Arrange collection of respiratory specimens (nose and throat swabs) as outlined in Appendix 7. If possible collect respiratory specimens from four to six people with acute symptoms only (ideally within 48 hours of onset of symptoms). Provide CDPC and resident’s GPs with the swab results as soon as they are available (influenza positive and negative).

2.6.1 Specimen labelling, storage and transport

Please refer to Appendix 7.

Liaise with CDPC regarding the laboratory that will be used to ensure there is efficient/timely transfer/testing/access to results.

2.8. Vaccination during an influenza outbreak

During a suspected or confirmed influenza outbreak:

- influenza vaccine should be offered to all residents and staff who are unvaccinated
- influenza vaccine is recommended for unvaccinated visitors/family members for the protection of residents and the containment of the outbreak.

Following vaccination it will take approximately two weeks to develop a protective immune response.

2.9. Guidelines for antiviral medications during an influenza outbreak

Seek advice from CDPC and the GP of the case(s). Prescribing antiviral medications and treating the residents is the responsibility of the GP. CDPC assists by providing a letter for GPs recommending treatment of confirmed cases (see section 2.4). Prophylaxis may be recommended in some cases if feasible.

2.10. Declaring the outbreak over

As a general rule, respiratory illness outbreak including those caused by influenza can be declared over if no new cases have occurred in 8 days from the onset of symptoms of the last resident case.
# 3. Action summary checklist

**Action summary chart for managing a respiratory outbreak**

**Outbreak Definition:** 3 or more cases of newly acquired influenza-like illness within 72 hours with sudden onset of symptoms and at least one respiratory symptom (cough, sore throat, shortness of breath) PLUS at least one systemic symptom (fever, malaise, headache, myalgia)

<table>
<thead>
<tr>
<th>Task</th>
<th>Reference</th>
<th>Tick</th>
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<tbody>
<tr>
<td>• Notify the Department of Health and Human Services (DHHS) of the outbreak on telephone: <strong>1300 65 11 60</strong></td>
<td>Page 12-13</td>
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<tr>
<td>• Advise resident’s GP of the outbreak and provide GPs with the letter from DHHS</td>
<td>Appendix 8</td>
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<tr>
<td>→ Unwell residents should be reviewed by their GPs</td>
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<tr>
<td>• Notify DHHS by phone within 24 hours of deaths or hospitalisations (9 am to 5 pm Mon-Sun) and record these on the case list</td>
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<td>• Fax the initial case list of unwell residents/staff to DHHS (update daily with new cases) on fax number <strong>1300 65 11 70</strong>. Fax updated case lists to DHHS twice weekly.</td>
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<tr>
<td>• Isolate/cohort ill residents in one area</td>
<td>Page 10</td>
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<tr>
<td>• Restrict ill residents to their room</td>
<td>Appendix 1</td>
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<tr>
<td>• Implement enhanced infection and prevention control procedures</td>
<td>Appendix 2</td>
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<tr>
<td>→ Instruct cleaning staff regarding extra cleaning</td>
<td>Page 12</td>
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<tr>
<td>• Post signs on facility entrance door</td>
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<tr>
<td>• Post sign on residents room door</td>
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<td>→ Restrict unwell visitors and keep visitors to a minimum if possible</td>
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<tr>
<td>• Collect nose and throat swabs for respiratory multiplex PCR from four to six cases with acute symptoms (ideally within 48 hours of onset of symptoms)</td>
<td>Appendix 7</td>
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<tr>
<td>• Liaise with DHHS about sending the swabs to the laboratory (local pathology provider or VIDRL)</td>
<td>Appendix 8</td>
<td></td>
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<tr>
<td>• Record on the case list residents who have swabs taken and fax to DHHS on <strong>1300 651 170</strong></td>
<td></td>
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<tr>
<td>• Provide CDPC and residents’ GPs with the swab results as soon as they are available (influenza positive and negative)</td>
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<tr>
<td>• Only vaccinated staff should care for residents with respiratory illness where possible. <strong>Unvaccinated staff</strong> who have been exposed to ill people should not be moved into other areas and should wear a mask whilst at work or take antiviral prophylaxis</td>
<td>Page 11</td>
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<tr>
<td>• Symptomatic staff should be excluded from work</td>
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<tr>
<td>• Offer influenza vaccinations for all well unvaccinated staff and residents</td>
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<tr>
<td>• Suspend transfers out of the facility if at all possible</td>
<td>Page 12</td>
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</tr>
<tr>
<td>→ If transfer necessary send with notice to facility</td>
<td>Appendix 9</td>
<td></td>
</tr>
<tr>
<td>• Do not accept new residents unless no alternative</td>
<td>Page 11</td>
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<tr>
<td>• If influenza is confirmed, discuss prescription of antiviral treatment and prophylaxis for ill residents with their GPs.</td>
<td>Page 14</td>
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</tbody>
</table>
• **Outbreak can be declared over** if no new cases have occurred in 8 days from the onset of symptoms of the last resident case.
Appendix 1 – Front door sign for visitors
Attention all visitors

There have been a number of cases of influenza-like illness at this facility. We are trying to prevent this illness from spreading.

Visitors are advised that there is a risk of acquiring this influenza-like illness by visiting this facility at this time. If you have recently been ill, have symptoms of any respiratory illness (fever, sore throat, cough, muscle and joint pains, tiredness/exhaustion) or have been in contact with someone who is ill we strongly advise you do not enter this facility.

Please follow the recommended infection control precautions on the signs when visiting.

Thank you for your cooperation.
Appendix 2 – Droplet precautions sign for resident’s room
Droplet precautions
Put on a SINGLE USE FACE MASK before entering the room

Follow standard precautions at all times:
- Wash your hands thoroughly
- Gloves must be worn when touching body fluids/substances and contaminated items or surfaces
- Wear a gown or apron during care activities where your clothing may come into contact with body fluids and substances

Thank you for your cooperation
Appendix 3 – Hand hygiene
Hand hygiene

Duration of the entire procedure: 40-60 seconds

1. Wet hands with water;
2. Apply enough soap to cover all hand surfaces;
3. Rub hands palm to palm;
4. Right palm over left dorsum with interlaced fingers and vice versa;
5. Palm to palm with fingers interlaced;
6. Backs of fingers to opposing palms with fingers interlocked;
7. Rotational rubbing of left thumb clasped in right palm and vice versa;
8. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;
9. Rinse hands with water;
10. Dry hands thoroughly with a single use towel;
11. Use towel to turn off faucet;

Ideally, hands should be washed thoroughly:
• before touching a resident
• before a procedure
• after a procedure or body fluid exposure risk
• after touching a resident
• after touching a resident’s surroundings.

Based on the 'How to Handwash', URL: http://www.who.int/gpsc/5may/How_To_HandWash_Poster.pdf © World Health Organization 2009. All rights reserved.
Appendix 4 – Respiratory etiquette sign
Protect yourself and your family
Cover your cough and sneeze

1. Cover your mouth and nose with a tissue when you cough or sneeze.

2. Put your used tissue in the rubbish bin.

3. Wash your hands with soap and running water. Dry your hands thoroughly with a disposable paper towel.

Stay germ free and healthy
Appendix 5 – Donning and removing a surgical mask

1. How to don a mask

- Place over nose, mouth and chin
- Fit flexible nose piece over nose bridge
- Secure on head with ties or elastic
- Adjust to fit

2. How to remove a mask

- Untie the bottom, then top tie
- Remove from face
- Discard handling the ties only
Appendix 6 - Environmental cleaning

Influenza virus is inactivated by 70% alcohol and by chlorine, therefore cleaning of environmental surfaces with a neutral detergent followed by a disinfectant solution, is recommended during an outbreak.

Step 1: Cleaning
- Use warm water with a neutral detergent. Refer to Material Safety Data Sheet and product labels if not sure. Rinse and dry.

Step 2: Disinfect
- This is an additional step to cleaning and does not replace cleaning. Use either chlorine disinfectant or alternatively, alcohol. See instructions below.
  All horizontal surfaces plus/and including the following:
  - Bedside table
  - Over bed table
  - Chairs
  - Commodes
  - Doorknobs
  - Toilet flushers
  - Taps
  - Handrails
  - Basins
  - Walking frames

Note—Floor just requires cleaning with warm water and neutral detergent. Clothes and bed linen can be laundered as usual.

Step 3: If using chlorine solution
- If using chlorine solution leave on for 10 minutes then rinse off with hot water and dry.
- No need to rinse off alcohol.

Chlorine concentrations required for disinfection

Chlorine solutions must be freshly made up and used within 24 hours, as chlorine deteriorates over time. To make the concentration required dilute household bleach (with 4% available chlorine) as follows:

<table>
<thead>
<tr>
<th>Volume of hot water to which chlorine is added</th>
<th>For concentration of 200 ppm add:</th>
</tr>
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<tbody>
<tr>
<td>1 litres</td>
<td>5ml</td>
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<tr>
<td>5 litres</td>
<td>25 ml</td>
</tr>
</tbody>
</table>

Important safety notes when using chlorine as disinfectant:
- Follow safety and handling instructions on all bleach (chlorine) containers
- It is safer to add chlorine to the water-do not add water to chlorine
- Always use warm water to make up chlorine solutions
- Use gloves when preparing and handling chlorine solutions
• Use chlorine carefully as it bleaches fabrics and may irritate the skin, nose and lungs
• Chlorine is corrosive to metals. Rinse off.
• Use in well ventilated areas
• Do not mix with strong acids to avoid release of chlorine gas

Alternative disinfectant to chlorine

<table>
<thead>
<tr>
<th>Disinfectant</th>
<th>Recommendation</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (70%):</td>
<td>Use on smooth metal surfaces, table tops and other surfaces on which bleach cannot be used.</td>
<td>Flammable, Toxic, Use in well ventilated area, Avoid inhalation, Keep away from heat sources, electrical equipment, flames, hot surfaces</td>
</tr>
<tr>
<td>Isopropyl, Ethyl alcohol</td>
<td>Do not rinse off, Do not dilute</td>
<td></td>
</tr>
</tbody>
</table>


Appendix 7 - Collection of nose and throat swabs

Take nose (both left and right nostrils) and throat swabs from residents with acute symptoms (onset within the preceding 48 hours) of a respiratory illness. Ideally collect swabs from four to six residents. We recommend the treating doctor requests a respiratory multiplex PCR to be done by the laboratory (this will include Influenza A/B and other respiratory viruses).

Confirm with DHHS where the swabs will be tested.

Please note if swabs are to be processed by VIDRL there is no need to use the transport medium. VIDRL require only 2 dry swabs, one can be used for both nostrils and one for the throat swab. If using the facility’s primary laboratory provider, please check with the laboratory provider if viral transport medium is required.

Equipment:
- swabs x 3 (dry)
- viral transport medium container (if not using VIDLR)
- personal protective equipment
  - single use face mask
  - protective eyewear
  - gloves

Procedure
Take swabs from the resident’s nose and throat as follows and place in the same viral transport medium container.

1. Don mask, protective eyewear and gloves

Nose swabs
- Tilt the resident’s head back gently with one hand and steady the resident’s chin.
- With the other hand, insert the swab into the resident’s right side of the nose.
- Rub vigorously against the internal surface of the nose to ensure the swab contains cells as well as mucus from the nose.
- Withdraw the swab from the nose.
- Remove the cap from the tube of viral transport medium specimen container.
- Break off (or cut with scissors) the end of the swab’s stick, ensuring that the entire swab can be sealed within the specimen container.
- Loosely recap the specimen container.
- Discard the remaining end of the swab.
- Repeat the procedure with a new swab in the resident’s left side of the nose (if using VIDRL use same swab for both nostrils)
- Place the swab in the same viral transport medium specimen container with the other swab.
Throat swab

- Ask the resident to open his/her mouth and stick out their tongue.
- Use a wooden spatula to press the tongue downward to the floor of the mouth.
- Firmly swab both of the tonsillar arches and the posterior naso-oropharynx, without touching the sides of the mouth.
- The swab should be thoroughly wet with throat secretions.
- Place the swab in the same viral transport medium specimen container with the nose swab(s).

2. Remove gloves, protective eyewear and mask

3. Wash hands

Specimen labelling, storage and transport

- Label the specimen
- Place the specimen in a biohazard bag
- Complete the request form (request a multiplex respiratory PCR)
- Refrigerate the specimen until it is sent to the laboratory. Do not freeze the specimen
- Transport to the laboratory in a small insulated bag/box (with ice bricks)
- Specimens should preferably be sent to the laboratory on the day of collection or the following day
- DHHS will liaise with the facility to determine the most efficient option for processing swabs. This could be a primary laboratory or relevant public health laboratory (VIDRL). Telephone the Communicable Disease Prevention and Control Section on 1300 65 11 60.
Appendix 8 – Respiratory outbreak case list
# Respiratory outbreak case list

Please return completed forms to 1300 651 170 twice weekly to: 
(Public Health Officer’s name) 

<table>
<thead>
<tr>
<th>Institution name:</th>
<th>Outbreak name:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Case identification</th>
<th>Symptoms</th>
<th>Swab</th>
<th>Hospitalisation</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last name, First name</td>
<td>Residence</td>
<td>Staff</td>
<td>Birth date (dd/mm/yyyy)</td>
<td>Onset date (dd/mm/yyyy)</td>
</tr>
<tr>
<td>---------------------</td>
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</tbody>
</table>

**Further comments:**

*Y-Yes or N-No
Appendix 9 – Health care facility transfer advice form
Health care facility transfer advice form

To:______________________________________________________________

Please be advised that__________________________________________ is being transferred
from a facility where there is a cluster/outbreak of a respiratory illness:

☐ suspected
☐ confirmed

Please ensure that appropriate infection control precautions are taken upon receipt of this resident.

At the time of transfer:

☐ The resident has a respiratory illness
☐ The resident does not have a respiratory illness

Influenza vaccination:

☐ This resident has been vaccinated with the current influenza vaccine on date_____/_____/______
☐ This resident has NOT been vaccinated with the current influenza vaccine because of:
  ☐ Allergy
  ☐ Medication conflict
  ☐ Conscientious objection
  ☐ Other, specify: ________________________________________________________________

Medication for influenza:

☐ The resident is taking the antiviral medication called: ________________________________
  Start date: _____/_____/______  Dose of the medication: ______________________
☐ The resident is not taking antiviral medication

For further information contact:

Name: _______________________________________________________________________

Facility: _____________________________________________________________________

Telephone: ___________________________________________________________________
Appendix 10 – Action summary flow chart
Respiratory outbreak management actions

**Notification**
- Count ill residents and staff
- Call 1300651160 immediately

**Monitoring**
- Involve residents' GPs
- Swabs (from 4-6 residents in total) taken within 48 hours of onset
- Call 1300651160 immediately if admissions to hospital or deaths
- Update respiratory outbreak case list daily

**Precautions**
- Hand and respiratory hygiene
- Display signs
- Twice daily cleaning
- Only vaccinated staff should work with ill residents where possible

**Infection control measures**
- Isolation of sick residents (cohort or single rooms)
- Personal protective equipment (PPE)
- Ill staff cannot return until 5 days after onset of illness

**Movement of patients**
- Avoid transfers out and new admissions
- If transfers are required, use Health care facility transfer advice form

**Therapeutic measures**
- Antiviral treatment for confirmed cases
- Possible antiviral prophylaxis for contacts
- Offer vaccination to well residents and staff

**Minimise visitors**
- Ensure visitors apply respiratory and hand hygiene measures
- Visit one patient only
- Restrict ill visitors

**Infection control**
- Isolation of sick residents (cohort or single rooms)
- Personal protective equipment (PPE)
- Ill staff cannot return until 5 days after onset of illness

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