



## PANDEMIC INFLUENZA PLAN INFECTION PREVENTION AND CONTROL CHAPTER

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## 1. INTRODUCTION

Influenza occurs across Canada each fall and winter and is referred to as “seasonal influenza”. Preparation for the arrival of the season’s first cases of influenza requires a concerted effort from many disciplines and jurisdictions inside and outside the healthcare organization’s boundaries. Comprehensive Infection Prevention and Control (IP&C), Occupational and Environmental Safety and Health (OESH), and Population and Public Health (PPH) programs are important in providing effective processes and activities to prevent or minimize transmission of influenza within their population.

Periodically, influenza may cause worldwide epidemics, or pandemics, with high rates of illness and death. An influenza pandemic can occur at any time with the potential to cause serious illness, death, and extensive social and economic disruption throughout the world. Experts agree influenza pandemics are inevitable, however, the timing and severity of any pandemic is unpredictable and occurs with little warning. As well, pandemics may differ in their severity and attack rates. Historically, pandemics infected large numbers of the population with high mortality rates. The 2009 pH1N1 however, was relatively mild in comparison. The transmissibility, attack rates, severity indicators, high risk groups and mortality may differ as a result of the epidemiology that emerges with the pandemic.

[The Canadian Pandemic Influenza Plan \(CPIP\)](#) assumes any influenza pandemic will first emerge outside of Canada; however, due to the volume and speed of global air travel, the virus will be present in Canada within weeks of its emergence in another part of the world. The pandemic virus may arrive in Canada at any time of year (i.e., potentially outside of the usual influenza season in Canada). The first peak of illness in Canada (i.e., beginning of the pandemic wave) could occur within weeks after the virus arrives in Canada. The first peak in mortality is expected to be approximately one month after the peak in illness.

The pandemic wave may sweep across Canada in one to two months affecting multiple locations simultaneously; the influenza pandemic may occur in two or more waves lasting six to eight weeks in any locality. Overall, the pandemic may last 12 to 18 months and more than one wave may occur within a 12-month period.

### 1.1. Scope/Purpose

Implementation of this plan would be directed by the Emergency and Continuity Management Program, in consultation with the Winnipeg Regional Health Authority (WRHA) IP&C Program, OESH Program, and PPH Program.

This plan provides guidance and information on IP&C procedures for WRHA staff for all pandemic influenza phases. These guidelines are to be incorporated with other IP&C guidelines and recommendations currently in place. This plan may evolve as information on the pandemic virus emerges.



## 1.2. Mode of Transmission of Influenza Virus

The influenza virus is spread primarily by droplets.

Both seasonal and pandemic influenza viruses are spread primarily by droplets. “Primarily” by droplets reflects that in certain circumstances, such as [aerosol-generating medical procedures \(AGMPs\)](#), droplets can turn into aerosolized particles. Influenza may also be transmitted by direct or indirect contact transmission.

Droplet transmission of influenza virus: Droplets generally travel up to 2 metres before they fall.

Influenza A and Influenza B viruses can survive on hard surfaces for up to 48 hours; soft surfaces for up to 12 hours; hands for 5 minutes <sup>[6.3]</sup>.

Influenza virus can be spread by direct contact with mucous membranes (i.e., the eyes, nose, and mouth) or from indirect contact via hands (or any other item) that has touched a virus-contaminated surface, which then comes into contact with someone’s eyes, nose or mouth.

## 1.3. Pandemic Influenza Phases

The World Health Organization (WHO) has developed a Pandemic Influenza Alert Classification system, and will identify which phase is occurring internationally and declare the beginning of a pandemic. The Public Health Agency of Canada (PHAC) will declare the beginning of the pandemic period in Canada.

World Health Organization Pandemic Phases <sup>[6.2]</sup>

Inter Pandemic	Phase 1 No viruses among animals have been reported to cause infections in humans
	Phase 2 An influenza virus among animals is known to have caused infection in humans
Pandemic Alert	Phase 3 An animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to- human transmission sufficient to sustain community-level outbreaks
	Phase 4 Verified human-to-human transmission of an influenza reassortant virus able to cause ‘community-level outbreaks’
	Phase 5 human-to-human spread of into at least two countries in one WHO region
Pandemic	Phase 6 Community level outbreaks in at least one other country in a different WHO region in addition to the criteria defined in Phase 5
Post Pandemic	Pandemic disease levels in most countries have dropped below peak observed levels, however, it is uncertain if additional waves will occur



#### 1.4. IP&C Considerations during Pandemic Influenza

Some IP&C strategies may be achievable only in the early pandemic period and not achievable as the pandemic spreads and resources (e.g., equipment, supplies, rooms, and human resources) become scarce.

IP&C resources may need to be prioritized to the acute care settings. Critically evaluate situations in which Personal Protective Equipment (PPE) is indicated. If a sufficient supply of PPE is not available, healthcare facilities may consider extending use or reuse of some disposable items only as an urgent and temporary solution, and only if the item has not been obviously soiled or damaged (e.g., creased or torn). IP&C and OESH must be involved in the decision to extend use of or reuse PPE.

Routine Practices and Additional Precautions to limit healthcare associated transmission include:

- Education of staff, patients/residents/clients (PRC) and visitors regarding transmission and prevention of influenza
  - Provide Pandemic Influenza information sheets
- Segregation or cohorting of PRC with pandemic influenza from those with other medical conditions
  - Provide clear directions to the pandemic influenza areas, assessment and admission areas, waiting rooms
- Restricting ill workers and visitors from the site
- Posting signage at all entrances informing people of Respiratory Etiquette, hand hygiene, and the need to immediately report symptoms of a respiratory infection
  - [Respiratory Etiquette](#) and [hand hygiene signs](#) are available on the [WRHA IP&C web page](#).

Before every interaction, each health care worker (HCW) has a responsibility to assess the infectious risk posed to him/herself, other PRC, visitors, and co-workers by a PRC, situation or procedure, and take appropriate measures based on a Point of Care Risk Assessment (PCRA). The PCRA is an evaluation of the risk factors related to the interaction between the HCW, the PRC and their environment to assess and analyze their potential for exposure to infectious agents and identifies risks for transmission. Control measures are based on the evaluation of the risk factors identified.

#### Key Points

- Separate PRCs with symptoms of influenza symptoms from non-influenza PRCs as rapidly as possible in all healthcare settings
- Manage PRCs with influenza symptoms separately until discharged
- Separate staff care for influenza and non- influenza PRCs whenever possible
- Separation of symptomatic PRCs is important in containment of influenza
- Careful consideration of flexible accommodation and staffing arrangements is required
- Maintain Additional Precautions for PRCs until discontinuation criteria are met



## 2. IP&C GUIDELINES

### 2.1. Inter-Pandemic and Pandemic Alert Periods (Phases 1-5) - All Treatment Areas

Follow Routine Practices and Enhanced Droplet/Contact Precautions for people with known/suspected influenza.

All staff shall practice Respiratory Etiquette ('Cover Your Cough') and encourage PRCs and visitors to do the same. To achieve this, provide:

- Alcohol based hand rub
- Medical mask
- Tissue
- Waste receptacle (e.g., garbage can/bag)
- Assistance to follow Respiratory Etiquette as needed.

In addition to Routine Practices, implement Enhanced Droplet/Contact Precautions for PRCs with known/suspected influenza.

### 2.2. Pandemic Period (Phase 6) - All Non- Influenza Treatment Areas

Undertake all necessary efforts to maintain "clean" or non-influenza care areas within healthcare facilities. Designate specific areas within each facility as influenza or non-influenza treatment areas.

Triage all PRCs before placement in non-influenza treatment areas.

See [Section 2.3 Triage Assessment of Influenza Symptoms](#).

#### Overview

Staff will follow current IP&C practices, based on principles of Routine Practices and Additional Precautions.

Maintain a high index of suspicion is required to identify potentially infectious people.

Assess PRCs for influenza symptoms regularly to prioritize those requiring urgent attention and [Enhanced Droplet/Contact Precautions](#). Assess for influenza symptoms every 4-6 hours in acute care facilities, long term care facilities (LTCF), or other healthcare settings. <sup>[6.3]</sup>

#### 2.2.1. Hand Hygiene:

Follow hand hygiene procedures at all times in all health care settings. If the patient/resident sink must be used for hand hygiene, avoid contamination of hands from contaminated surfaces or objects.

Place alcohol-based hand rub and tissue boxes strategically.

Staff, PRCs, and visitors practice hand hygiene and respiratory etiquette to minimize influenza transmission.



### 2.2.2. Accommodation:

Physically separate PRCs with influenza symptoms from those without influenza symptoms if possible:

- Perform an influenza assessment using [Appendix 2: Influenza Assessment Tool](#)
- Place symptomatic PRCs on [Enhanced Droplet/Contact Precautions](#) in a single room, or cohort with another PRC with influenza
- Assess if PRCs need to be moved to a designated influenza area.

### 2.2.3. Contact Tracing of Roommates <sup>[6.3]</sup>

- In an outbreak, roommates include present roommates and any patient/resident who shared the room during the period of communicability
- In open units (e.g., intensive care units), roommates include patients/residents on either side of the newly infected patient, or any patient within 2 metres of the newly infected patient/resident
- Monitor roommates for signs and symptoms of influenza every four to six hours for one incubation period following last contact
- Start roommates on antiviral prophylaxis, unless medically contraindicated
- Encourage roommates to practice frequent hand hygiene
- Asymptomatic roommates are not required to wear masks
- Do not transfer contacts to another room or care area for the period of incubation (treat as a cohort for one incubation period)
- Continue unit monitoring beyond the source room for additional cases (i.e., assess all patients/residents on the unit for symptoms compatible with influenza every four to six hours for one incubation period).

## 2.3. Triage: Assessment of Influenza Symptoms

During an influenza pandemic, there will be a large number of people seeking assessment for Influenza-Like illness (ILI). Assessment guidelines have been developed to evaluate the needs of each person and to assist in the efficient triage of influenza PRCs in a crisis.

### 2.3.1. Acute Care and Long Term Care Settings

Prepare facilities for triaging, assessing, and managing a large number of people.

Whenever possible, staff working with symptomatic people should avoid working with people who are not symptomatic (staff cohort). This can be accomplished as follows:

- Assign the same staff to assist symptomatic people
- Keep symptomatic people in rooms until symptoms cease
- Limit movement of patients/residents to medically essential purposes
- Implement visitor restrictions
- Group activities should be cancelled. For exceptions, consult IP&C.



### 2.3.2. Screening

- Post Visual alerts at entrances to all healthcare settings asking people to report whether they have fever and any new or worsening respiratory symptoms, and
- At first contact, staff ask about fever, cough, and other symptoms included in the case definition: 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 patients/residents less than 5 years or greater than 65 years of age, fever may not be prominent

[See Appendix 2: Influenza Assessment Tool.](#)

### 2.3.3. Respiratory Hygiene

Instruct people reporting respiratory symptoms with fever and cough to:

- Clean their hands with an alcohol- based hand rub (or soap and water if immediately available)
- Put on a medical mask
- Maintain a separation from other people of 2 metres. If this is not possible in the waiting room setting, immediately place PRC in an exam room.

To control entry, post signs designating the area as an isolation 'unit' or 'area' at all entrances and exits. Posted signs must also alert everyone to the precautions to be adopted.

### 2.3.4. Engineering Controls

Every effort to separate people with pandemic influenza from those without should be made. Identify a designated self-contained area of the facility for the triage, treatment, and care of people with suspected/confirmed pandemic influenza. Close doors between influenza and non-influenza areas. All people will be required to put on a medical mask before entry into the isolation room/bed space. Ideally this area should:

- Be designated for those people presenting with influenza
- Include a reception/triage area separate from the rest of the facility
- Have a separate entrance/exit from the rest of the facility, if feasible
- Not be used as a thoroughfare by other people. This includes transfers, staff going for meal breaks, etc.





Provide clear directions to pandemic influenza assessment areas and admission areas.

There should be a nursing station with administrative and supply storage space as close to the entrance as possible.

Maintain a minimum of 4 metres between the administration area and care areas. Staff must perform a PCRA.

Limit the number of personnel to those necessary for PRC care and support.

#### 2.3.5. Ambulatory Care and Community Health Centres

Early recognition of people with symptoms compatible with influenza is imperative to determine flow and minimize contact between symptomatic and asymptomatic patients/clients. When a pandemic is declared, each site should open a triage area(s) for patient/client assessment.

Follow recommendations for triage described above in the Acute Care and Long-Term Care Settings. Additionally, implement a phone triage plan and alternate care plan, based on regional pandemic management directives. During telephone bookings, inquire whether symptoms are present as outlined in [Appendix 2: Influenza Assessment Tool](#).

Coordinate appointments for patients with respiratory symptoms to avoid exposure of patients without symptoms. Cancel non-urgent visits. Consider actively screening patients at the entrance to the clinic if telephone triage is not appropriate.

If possible, use a separate entrance for these people and immediately lead them to an examination room. Triage these people expeditiously, confine them until diagnosed. An assigned staff member screens patients/client immediately upon arrival at the clinic. Screen patients/clients for symptoms of or exposure to pandemic influenza.

#### 2.3.6. Self-Assessment and Initial Triage

Public education may help people perform their own personal assessment and thus reduce unnecessary strain on the healthcare system. Refer the public to [Appendix 5: Influenza Self-Assessment Tool](#) when possible. Health Links/Info Santé can assist with conducting initial telephone assessments. These assessments will serve to determine whether a person is unlikely to have influenza and can stay at home, or whether she/he needs to be seen by a clinician for further assessment. PPH provides public communication, prevention advice and outreach to vulnerable populations, shelters as well as other key stakeholders.

Some people will need to be assessed by staff in person. Educate triage regarding how to use algorithms to decide if/when patients can be sent





home with instruction and follow-up, managed in an ambulatory site, or admitted to an acute care hospital.

Follow [Adult and Pediatric Point of Entry Respiratory Infection Screening](#) for IP&C guidance of people with ILI.

### 2.3.7. Assessment Process

Organize the assessment area to minimize crowding, and provide a separation of 2 metres between people in assessment centres, waiting areas, and PRC care areas.

- Use single rooms for patients with symptoms compatible with influenza whenever possible
- Separate people by two metres when single rooms or physical barriers are not possible
- Utilize Respiratory Hygiene measures, including the use of masks, if tolerated
- Ensure assessment staff evaluate not only the PRC's symptoms but also symptoms of the person accompanying the PRC

#### Before Clinical Assessment:

Ensure patient is still wearing a medical mask.

Perform hand hygiene.

PPE are applied before entering the room/bed space:

- Gloves
- Gown
- Medical mask/N95 respirator
  - N95 respirators are only indicated during AGMPS. See Glossary for AGMP list.
- Face shield or safety glasses or goggles.

Personal air-purifying respirators (PAPRs) are not indicated.

See [PPE Donning](#)/ and [PPE Doffing](#) posters (available online, in this manual, or for order through HSC Print Shop) for additional information.

#### During Clinical Assessment:

Assess PRCs in accordance with Appendices [1: Triage and Assessment Strategies](#), Appendices 2: [Influenza Assessment Tool](#), and [Adult & Pediatric Point of Entry Respiratory Infection Screening](#).

#### After Clinical Assessment:

Remove PPE, See [PPE Donning](#)/ and [PPE Doffing](#) posters (available online, in this manual, or for order through HSC Print Shop) for additional information.



### 2.3.8. Assessment Criteria for Persons Accompanying PRC

If the person accompanying the PRC has symptoms compatible with influenza:

- Consider PRC exposed to influenza
- Monitor for symptoms compatible with influenza
- Inform the accompanying person with symptoms compatible with influenza they may stay with this PRC
- Inform the accompanying person with symptoms compatible with influenza if they leave the PRC's bedside, they should leave the PRC area and the facility<sup>[6.3]</sup>.

## 3. PANDEMIC PERIOD – PANDEMIC DESIGNATED AREAS

### 3.1. Acute Care

Liaise with Population Public Health (PPH) and Community Care and Long-Term Care (LTC) to keep people out of facility when at all feasible.

Place signage at specific locations (e.g., entrances) indicating the location of masks and ABHR.

Frequent hand hygiene and respiratory hygiene by patients, HCWs, visitors, contractors, etc. is required. Place ABHRs at points of care and at entrances to and exits from healthcare settings and patient-care units.

Perform a PCRA before every patient encounter.

Use Personal Protective Equipment, including (if appropriate):

- Masks/Respirators
- Face Shields/eye protection
- Gloves
- Gowns.

Manage housekeeping, laundry and waste appropriately.

Implement engineering and administrative controls to enable rapid and sustainable separation of infected sources from susceptible hosts using:

- Separate assessment and care areas
- Single rooms
- Two metre distance
- Curtains
- Partitions.

Post signs at all entrances informing people regarding Respiratory Etiquette, hand hygiene, and the need for immediate reporting of symptoms of a respiratory infection

- Provide training in the performance of respiratory hygiene and hand hygiene. [Respiratory Etiquette](#) and [hand hygiene](#) are available on the [WRHA IP&C web page](#)
- Provide clear directions to the pandemic influenza areas, assessment and admission areas



- Provide Pandemic Influenza information sheets
- Provide guidance in the performance of Influenza Self Assessments according to [Appendix 5: Influenza Self-Assessment Tool](#).

### 3.1.1. Accommodations/Cohorting

See [Section 2.3: Triage: Assessment of Influenza Symptoms](#)

See [Influenza Assessment Tool, Appendix 2](#).

Every effort should be made to segregate persons with suspected or confirmed influenza from those who do not have signs and symptoms of respiratory illness.

Ensure clear directions to pandemic influenza assessment areas and admission areas.

Single room preferred. In a shared room, maintain a distance of 2 metres between patients.

- Cohort patients if necessary. Assign patients with confirmed pandemic influenza to the same room. If laboratory testing to confirm the virus is limited, cohort cases based on symptoms consistent with the pandemic influenza. See the Influenza Case Definition in the [Glossary](#)
- Doors to patient rooms may remain open, with the exception of AGMPs. See the list of AGMPs in the [Glossary](#)
  - Airborne infection isolation rooms (AIIR) are to be used for patients with known or suspected infections spread by the airborne route (e.g., TB, measles, varicella, disseminated zoster), and for AGMPs on people with ILI if available. See [Airborne Isolation Room \(AIIR\) Prioritization](#) for additional information

Patients who have recovered from influenza are considered immune. They may be discharged as soon as medically safe to do so or may be moved into a “non-influenza” cohort area after the period of communicability of the pandemic strain has passed.

As the pandemic progresses, the ‘suspect/exposed cohort’ and the ‘confirmed influenza cohort’ may require a merge. Consult IP&C before making this decision.

See [Appendix 4: Interim Measures to Optimize Bed Availability in Acute Care Facilities](#) during Pandemic Influenza for additional information.

Maintain cohorting principles until the pandemic has been declared over and direction has been received from the WRHA Emergency and Continuity Management Program.



### 3.1.2. Admission/Discharge

Organize the admission process to minimize crowding and provide a separation of two metres between infectious agents, infected sources, and susceptible hosts.

Use physical barriers (e.g., glass, acrylic partitions) where ever feasible, to minimize exposure of assessment, reception, and admission personnel to patients with ILI symptoms.

When physical barriers are not possible, maintain two metres between non-infected personnel and patients with ILI symptoms.

Maintain separation of influenza and non-influenza cohorts for the duration of the pandemic (i.e., locally).

Limit admission of influenza patients to those with complications that cannot be cared for outside the hospital setting.

If a patient is discharged while still possibly infectious, educate the patient and family members about hand hygiene, respiratory etiquette, and additional IP&C measures, according to current recommendations.

### 3.1.3. Aerosol-Generating Medical Procedures (AGMPs)

Perform a PCRA to evaluate the risk factors related to the interaction between the HCW, the patient and the patient's environment to assess and analyze their potential for exposure to infectious agents and identifies risks for transmission. Appropriate administrative controls, environment controls, and PPE are based on the evaluation of the risk factors identified. See [Point of Care Risk Assessment PCRA](#).

Conduct AGMPs in a controlled setting whenever possible. This requires early recognition of patients who may require high-risk interventions (e.g., intubation, bronchoscopy) in order to avoid emergency situations. A controlled setting includes:

- Administrative Controls
  - Most experienced personnel perform the procedure
  - Number of people present during AGMPs should be limited to only those essential to patient care and support
  - Conduct procedures in a non-emergent manner (e.g., elective intubation)
  - Sedate patient if intubation is required
  - Ensure adequate equipment is in the room/bed space before procedure
- Engineering Controls
  - Close doors and windows
- Environmental Controls
  - Discard contaminated disposable equipment



- Clean/disinfect contaminated reusable equipment before removing it from the room/bed space.

Perform these procedures in an AIIR when feasible. If this is not possible, perform the procedures in a single room. If a single room is not available, use a minimum of 2 metres separation with curtains. Do not delay urgent procedures transferring people to an AIIR or a single room.<sup>[6.3]</sup>

- Ensure the doors to the room are closed
- All non-essential people should leave the room
- Draw curtains in multi-bed rooms
  - Patients in multi-bed rooms are not required to wear N95 respirators
  - Maintain a 2 metre spatial separation.

An AGMP is any procedure conducted on a patient that can induce production of aerosols of various sizes, including droplet nuclei. AGMPs should be performed on patients only when medically necessary.

Examples include:

- Intubation and related procedures (e.g., manual ventilation, extubating, open endotracheal suctioning)
- Cardiopulmonary resuscitation
- Bronchoscopy
- Sputum induction
- Nebulized therapy
- Autopsy
- Non-invasive positive pressure ventilation (CPAP, BiPAP).

An N95 respirator, eye protection, gloves, and a long-sleeved gown are worn by all persons in the room where an AGMP is being performed:

- Put on all PPE before entering the room/bed space
- N95 Respirator shall be:
  - Fit tested for HCWs
  - Seal-checked before each use, as follows:
    - cover respirator with both hands
    - perform either an inhalation test (if respirator collapses slightly there is an adequate seal) or an exhalation test (if no air escapes respirator, there is an adequate seal)
  - Changed if contaminated/wet

Respirators shall never dangle around the neck. Disposable respirators shall never be reused.

#### 3.1.4. Duration of Additional Precautions

Discontinue Additional Precautions as directed by Infectious Diseases/ IP&C based on current WRHA IP&C Program recommendations.



### 3.1.5. Environmental Control (Housekeeping, Laundry and Waste) <sup>[6.3]</sup>

Remove clutter and entertainment items such as magazines, books and toys in waiting areas to prevent cross contamination and allow for ease of cleaning.

Use hospital-grade disinfectants for environmental cleaning.

Meticulously clean and disinfect environmental surfaces daily.

Clean and disinfect frequently touched surfaces (e.g., medical devices/knobs) with disinfectant wipes or hospital grade disinfectant at least twice daily AND when visibly contaminated.

Contaminated linen does NOT require special handling.

Waste does NOT require special handling.

Dishes do NOT require special handling.

Physical setting:

- Ensure accessibility and availability of supplies
  - Tissues and waste receptacles for used tissue disposal
  - Alcohol-based hand rub and/or hand washing supplies (soap, water, paper towels)
  - Medical masks for persons who are coughing.

### 3.1.6. Equipment Cleaning and Disinfection

Clean and disinfect non-critical medical devices and medical equipment (e.g., oximeters, intravenous infusion pumps, armrests, examining tables, stretchers) before use by a patient AND in between patients.

See WRHA IP&C [Cleaning and Disinfection of Non-Critical Reusable Equipment/Items for Patients in Hospital Operational Directive](#).

### 3.1.7. Laboratory Best Practices

To take a nasopharyngeal swab:

- Ensure the correct viral swab kit is used; check the expiry date
- Ensure both the specimen and the requisition are clearly labeled with the patient's name and another unique identifier, such as date of birth and healthcare number
- Note the exposure history and clinical symptoms on the lab requisition; this facilitates surveillance.

For more detailed information, See

<https://healthproviders.sharedhealthmb.ca/files/respiratory-virus-specimen-collection.pdf>.

### 3.1.8. Signage and Information Sheets

Post signs at all entrances informing people regarding Respiratory Etiquette, hand hygiene, and the need for immediate reporting of symptoms of a respiratory infection. Provide clear directions to the pandemic influenza areas, assessment and admission areas.

Provide Pandemic Influenza information sheets.



### 3.1.9. Staff

In the pandemic period, HCWs should perform and interpret a daily [Appendix 5: Influenza Self-Assessment Tool](#) to determine influenza status and ability to work.

HCW who develops ILI symptoms while on duty should report the occurrence and should be relieved of his/her duties.

HCW considered fit-for-work: is asymptomatic as per self-assessment for ILI.

HCW who is considered unfit-for-work: should, at a minimum, not report to work for at least one period of communicability after the onset of symptoms.

HCWs considered fit-for-work with restrictions: in a severe or prolonged pandemic where personnel shortages compromise patient safety; HCWs with mild influenza symptoms who feel well enough to work may be allowed to return to work. Consider assigning these personnel to influenza cohort areas.

OESH should provide education to HCWs on all shifts, in all departments. This includes providing an explanation of why and how to perform the daily Influenza Self-Assessment.

HCWs who self-identify they are at high risk of complications related to influenza, including pregnant HCWs, should be offered an assessment by OESH. OESH shall provide these HCWs with education including information pertaining to the severe outcomes of influenza and reinforcement of protective measures such as PCRA, appropriate use of PPE, access to treatment and use of antiviral medication. <sup>[6.3]</sup>

HCWs should be aware of appropriate use of PPE; see [Point of Care Risk Assessment PCRA](#).

Intensify pandemic influenza education and skills training when an influenza pandemic is imminent.

### 3.1.10. Transport/Transfer

Notify the receiving area, in advance, regarding required precautions.

Limit transport of patients outside the pandemic-designated area for medically essential purposes only:

- Cover open wounds
- Patient performs hand hygiene when leaving the room and wears clean clothes, housecoat, or cover gown, and medical mask





- Use a transport stretcher or wheel chair if possible, instead of the patient's own bed or wheel chair, because of the bio burden
- If the patient's own bed or wheel chair is used for transport, cover it with a clean sheet and wipe the steering handles and side rails with disinfectant and allow required wet contact time before removing it from the room. Disinfected handles are considered clean during transport
- Transport personnel shall perform hand hygiene and put on clean gloves, gown, medical mask and eye protection upon leaving the patient room
- Take care not to contaminate the environment with soiled gloves during transport
- If gloves come in direct contact with the patient or contaminated patient equipment during transport, they are contaminated and are NOT used to press elevator buttons
- Place the chart in a protective cover (e.g., plastic bag). NOTE: outside of the protective cover is contaminated – DO NOT place on environmental surfaces
- Contact the site/service Infection Control Professional or designate if additional Infection Prevention and Control guidance is required for transport
- Transporting the patient with no artificial airway
- Patient should wear a medical mask if tolerated
- Clear hallway/elevator during transport if patient unable to tolerate a medical mask. <sup>[6.4]</sup>

#### Transporting Infants:

- Ideally, transport infants in an incubator

#### **Transporting the patient with an artificial airway** <sup>[6.3]</sup>

- Resolve any air leaks before transport
- Inflate/maintain inflation of endotracheal tube (ETT) cuff (if present) for the duration of the transport to minimize contamination
- If an air leak occurs during transport and is not readily resolved, consider extubation and a tube exchange
- Exhaled gases must be N100 filtered
- Consult Respiratory Therapy if additional airway management guidance is required for transport.

#### 3.1.11. Visitors (including children and support workers)

**All Visitors:** Minimize the number of visitors.



### **Visitors and Influenza Assessment**

- Direct all visitors to perform an influenza self-assessment according to [Appendix 5: Influenza Self-Assessment Tool](#) before entering the facility
- Consider electronically posting the influenza self-assessment guide on the organization's web site so visitors can self-assess before arriving at the facility

### **Visitor Education**

- Teach all visitors how to:
  - put on and take off a mask
  - perform hand hygiene
  - follow respiratory hygiene.

**Visitor Restrictions:** Restrict all visitors to visiting one patient per visit.

**Visitor PPE:** Offer visitors the same PPE as HCWs.

### **Visitors with NO Influenza Symptoms Visiting a Patients with ILI Symptoms**

- Explain the risks of visiting to those who have not had pandemic influenza and have not been immunized at least 2 weeks before visit
  - Ask such visitors to consider NOT visiting if they are at high risk of influenza complications (e.g., cardiopulmonary disease, immune suppressed, pregnant, etc.).

### **Visitors with Influenza Symptoms**

- Visitors with ILI symptoms shall NOT enter the facility unless they meet ALL of the following:
  - A close family member or will provide care, including essential emotional support as specified by the patient or alternate decision maker.
  - Agree to and have been taught how to:
    - put on and take off a mask
    - perform hand hygiene
    - follow respiratory hygiene
  - Agree to avoid an open unit with vulnerable patients (e.g., Neonatal Intensive Care Unit)
  - Agree to restrict their visit to a single patient
  - Agree to avoid all other area of the facility (e.g., public areas, waiting areas, lounges, etc.)
  - Children must be supervised by an adult who ensures they follow the restrictions above
- Provide equipment and direction for the ill visitor to:
  - Put on a mask upon entering the facility



- Remove the mask and place in the garbage upon leaving the healthcare
- Perform hand hygiene upon entering the facility and before entering the room
- Follow respiratory hygiene
- Staff monitor patients for ILI symptoms for one incubation period after the last visitor of all ill visitors

**Note: Visitor restrictions may change on a case-by-case basis.**

### 3.2. Long Term Care

The IP&C goal of the pandemic influenza plan in LTCFs is to keep the facility (or major areas of the facility) completely free of influenza.

During a pandemic wave, it is likely acute care facilities will only have the capacity to admit LTC residents who require a higher level of care than can be provided within the LTCF. As a result, LTCFs should prepare to care for residents with influenza on-site.

#### 3.2.1. Accommodation/Cohorting

See [Appendix 2: Influenza Assessment Tool](#).

Every effort should be made to segregate persons with suspected or confirmed influenza from those who do not have signs and symptoms of respiratory illness.

Ensure clear directions to pandemic influenza assessment areas and admission areas. Single room preferred. In a shared room, maintain a distance of 2 metres between residents.

- Cohort residents if necessary. Assign residents with confirmed pandemic influenza to the same room. If laboratory testing to confirm the virus is limited, cohort cases based on symptoms. See the Influenza Case Definition in the [Glossary](#)
- Doors to resident rooms may remain open, with the exception of AGMPs. See the list of AGMPs in the [Glossary](#)
- AIIRs are to be used for residents with known or suspected infections spread by the airborne route (e.g., TB, measles, varicella, disseminated zoster), and for AGMPs on people with ILI if available. See [Airborne Isolation Room \(AIIR\) Prioritization](#) for additional information. AIIR availability may be limited

Residents who have recovered from influenza are considered immune. They may be moved into a “non-influenza” cohort area after the period of communicability of the pandemic strain has passed.

As the pandemic progresses, the ‘suspect/exposed cohort’ and the ‘confirmed influenza cohort’ may require a merge. Consult IP&C before making this decision.



Maintain cohort principles until the pandemic have been declared over and direction received from the WRHA.

#### Activities Outside the LTC Facility <sup>[6.3]</sup>

Consider residents who return from medical appointments or procedures performed outside the LTCF; other community activities (e.g., funerals); or home visits exposed to influenza. Monitor them every 4 to 6 hours for one incubation period <sup>[6.3]</sup>. See [Appendix 5: Influenza Self-Assessment Tool](#). Consider implementing the following:

- Cancel organized community social activities (e.g., taking residents to shopping malls) for the duration of the pandemic wave
- Discourage family home visits, especially to homes where family member has ILI symptoms
- Postpone all outside appointments, unless medically necessary.

#### 3.2.2. Admission/Re-admission/Discharge

Consider new admissions, as well as residents who return from medical appointments or procedures performed outside the LTCF facility, other community activities (e.g., funerals), or home visits exposed to pandemic influenza. Reassess them every 4-6 hours for symptoms compatible with influenza <sup>[6.3]</sup> using [Appendix 2: Influenza Assessment Tool](#).

Consider:

- Opening an Admission Area for ALL new residents
- Keeping newly admitted residents WITHOUT ILI symptoms in the Influenza Admission Area for one incubation period before transfer to the Resident Care Area

Organize the Admission Area to minimize crowding and provide a separation of two metres between infectious agents, infected sources, and susceptible hosts. Wherever possible use single rooms.

Assess residents in the Admission Area for ILI symptoms every 4-6 hours for one incubation period <sup>[6.3]</sup> using [Appendix 2: Influenza Assessment Tool](#).

- HCWs in the Admission Area perform PCRA. See [Point of Care Risk Assessment PCRA](#) before every contact with every resident.

Implement Pandemic Influenza Precautions as soon as a resident in the Admission Area is identified with ILI symptoms; consider antiviral prophylaxis of roommates.

- Appoint at least one HCW on every shift with the authority to implement Pandemic Influenza Precautions for initiation without delay
- Treat symptomatic residents with antiviral medications as appropriate
- Identify and transfer any resident who develops ILI symptoms to the Influenza Isolation Area



- If transfer is delayed, HCWs should have the authority to confine the resident to his or her room, implement Pandemic Influenza Precautions and ensure adequate separation from non-influenza residents (e.g., move to a single room or at least two metres, partitions, curtains)

If the LTCF is unable to establish a separate Admission Area, manage new residents who do not have ILI symptoms safely within the Resident Care Area:

- Place resident in a single room if possible
- If a single room is not available, place resident in a room where a two metre separation can be maintained between residents
- Monitor resident and all roommates for signs of influenza every four to six hours for one incubation period
- Ensure resident is able and willing to follow respiratory hygiene and hand hygiene
- Instruct resident not to leave his/her bed space for one incubation period, except for medically necessary procedures
- Utilize Pandemic Influenza Precautions for one incubation period for all resident care.

Admission to the Influenza Admission Area is NOT necessary for the following resident:

- New admission from the community with proof of recovery from laboratory confirmed influenza during the pandemic influenza period
- Based on the emerging epidemiology and vaccine effectiveness, was immunized against the influenza pandemic strain more than two weeks before this admission.

Admit/re-admit without restrictions:

- Persons from acute care or the community who have recovered from pandemic influenza
- Persons who have been immunized against the pandemic influenza strain at least 2 weeks earlier.

If a resident is discharged while still possibly infectious, educate the resident and family members about hand hygiene, respiratory etiquette, and additional IP&C measures, according to current recommendations.

### 3.2.3. Aerosol-Generating Medical Procedures (AGMPs)

Perform a PCRA to evaluate the risk factors related to the interaction between the HCW, the resident and the resident's environment to assess and analyze their potential for exposure to infectious agents and identifies risks for transmission.



Appropriate administrative controls, environment controls, and PPE are based on the evaluation of the risk factors identified. See [Point of Care Risk Assessment PCRA](#).

Conduct AGMPs in a controlled setting whenever possible. This requires early recognition of residents who may require high-risk interventions (e.g., intubation, bronchoscopy) in order to avoid emergency situations. A controlled setting includes:

- Administrative Controls
  - The most experienced personnel perform the procedure
  - The number of people present during AGMPs should be limited to only those essential to resident care and support
  - Conduct procedures in a non-emergent manner (e.g., elective intubation)
  - Sedate resident if intubation is required
  - Ensure adequate equipment is in the room/bed space before procedure
- Engineering Controls
  - Close doors and windows
- Environmental Controls
  - Discard contaminated disposable equipment
  - Clean/disinfect contaminated reusable equipment before removing it from the room/bed space.

Perform these procedures in an AIIR when feasible. If this is not possible, perform procedures in a single room. If a single room is not available, use a minimum of 2 metre separation with curtains or partitions. Do not delay urgent procedures transferring people to an AIIR or a single room <sup>[6.3]</sup>:

- Ensure the doors to the room are closed
- All non-essential people should leave the room
- Draw curtains in multi-bed rooms
  - Residents in multi-bed room are not required to wear N95 respirators
  - Maintain a 2 metre spatial separation.

An AGMP is any procedure conducted on a resident that can induce production of aerosols of various sizes, including droplet nuclei. AGMPs should be performed on residents only when medically necessary.

Examples include:

- Intubation and related procedures (e.g., manual ventilation, extubating, open endotracheal suctioning)
- Cardiopulmonary resuscitation
- Bronchoscopy
- Sputum induction
- Nebulized therapy
- Autopsy



- Non-invasive positive pressure ventilation (CPAP, BiPAP).

An N95 respirator, eye protection, gloves, and a long-sleeved gown are worn by all persons in the room where an AGMP is being performed.

- Put on all PPE before entering the room/bed space
- N95 Respirator shall be:
  - Fit tested for HCWs
  - Seal checked before each use, as follows:
    - cover respirator with both hands
    - perform either an inhalation test (if respirator collapses slightly there is an adequate seal) or an exhalation test (if no air escapes respirator, there is an adequate seal)
  - Changed if contaminated/wet
  - Respirators shall never dangle around the neck. Disposable respirators shall never be reused.

#### 3.2.4. Duration of Additional Precautions

Discontinue Additional Precautions as directed by Infectious Diseases/ IP&C, based on current WRHA IP&C Program recommendations.

#### 3.2.5. Environmental Control (Housekeeping, Laundry and Waste)<sup>[6.3]</sup>

Remove clutter and entertainment items such as magazines, books and toys in waiting areas to prevent cross contamination and allow for ease of cleaning.

Use hospital-grade disinfectants for environmental cleaning.  
Meticulously clean and disinfect environmental surfaces daily.

Clean and disinfect frequently touched surfaces (e.g., medical devices/knobs) with disinfectant wipes or hospital grade disinfectant at least twice daily AND when visibly contaminated.

Contaminated linen does NOT require special handling. Waste does NOT require special handling.  
Dishes do NOT require special handling.

Physical setting:

- Ensure the accessibility and availability of supplies
  - Tissues and waste receptacles for used tissue disposal
  - Alcohol-based hand rub and/or hand washing supplies (soap, water, paper towels).

#### 3.2.6. Equipment Cleaning and Disinfection

- Clean and disinfect non-critical medical devices and equipment (e.g., oximeters, intravenous infusion pumps, armrests, examining tables, stretchers) before resident use AND between residents.





See [WRHA IP&C Cleaning, Disinfection or Reprocessing of Non-Critical Reusable Resident Equipment/Items](#) Operational Directive.

### 3.2.7. Laboratory Best Practices

To take a nasopharyngeal swab:

- Ensure the correct viral swab kit is used; check the expiry date
- Ensure both the specimen and the requisition are clearly labeled with the resident's name and another unique identifier, such as date of birth and healthcare number
- Note the exposure history and clinical symptoms on the lab requisition; this facilitates surveillance

For more detailed information, See

<https://healthproviders.sharedhealthmb.ca/files/respiratory-virus-specimen-collection.pdf>

### 3.2.8. Signage and Information sheets

Post signs at all entrances informing people regarding [Respiratory Etiquette, hand hygiene](#), and the need for immediate reporting of symptoms of a respiratory infection. Provide clear directions to the pandemic influenza areas, assessment and admission areas.

Provide Pandemic Influenza information sheets.

### 3.2.9. Staff

During the pandemic period, HCWs should perform and interpret a daily influenza self- assessment according to [Appendix 5: Influenza Self-Assessment Tool](#) to determine their influenza status and thus their ability to work.

- HCW who develops ILI symptoms while on duty should report the occurrence and should be relieved of his/her duties
- HCW considered fit-for-work: is asymptomatic as per self-assessment for ILI
- HCW who is considered unfit-for-work: should, at a minimum, not report to work for at least one period of communicability after the onset of symptoms
- HCW considered fit-for-work with restrictions: in a severe or prolonged pandemic where personnel shortages compromise resident safety. HCWs with mild influenza symptoms who feel well enough to work may be allowed to return to work. Consider assigning these personnel to influenza cohort areas
- HCWs who self-identify they are at high risk of complications related to influenza, including pregnant HCWs, should be offered an assessment by OESH.



OESH should provide education to HCWs on all shifts, in all departments. This includes providing an explanation of why and how to perform the daily Influenza Self-Assessment.

### 3.2.10. Transport/Transfer

Notify the receiving area, in advance, regarding required precautions.

Limit transport to medically essential purposes only:

- Cover open wounds
- Resident performs hand hygiene when leaving the room and wears clean clothes, housecoat, or cover gown, and medical mask
- Use a transport stretcher or wheel chair if possible, instead of the resident's own bed or wheel chair, because of the bio burden
- If the resident's own bed or wheel chair is used for transport, cover it with a clean sheet and wipe the steering handles and side rails with disinfectant and allow required wet contact time before removing it from the room. Disinfected handles are considered clean during transport
- Transport personnel shall perform hand hygiene and put on clean gloves, gown, medical mask and eye protection upon leaving the resident room
- Take care not to contaminate the environment with soiled gloves during transport
- If gloves come in direct contact with the resident or contaminated equipment during transport, they are contaminated and are NOT used to press elevator buttons
- Place the chart in a protective cover (e.g., plastic bag). NOTE: outside of the protective cover is contaminated – DO NOT place on environmental surfaces.

#### **Transporting the resident with no artificial airway**

- Resident should wear a medical mask if tolerated
- Clear hallway/elevator during transport if resident unable to tolerate a medical mask. <sup>[6.4]</sup>

#### **Transporting the resident with an artificial airway**

- Ideally, transport infants in an incubator
- Resolve any air leaks before transport
- Inflate/maintain inflation of endotracheal tube (ETT) cuff (if present) for the duration of the transport, to minimize contamination
- If an air leak occurs during transport and is not readily resolved, consider extubation and a tube exchange
- Exhaled gases must be N100 filtered
- Consult Respiratory Therapy if additional airway management guidance is required for transport



### 3.2.11. Visitors (including children and support workers)

**All Visitors:** Minimize the number of visitors.

#### **Visitors and Influenza Assessment**

- Direct all visitors to perform an influenza self-assessment according to [Appendix 5: Influenza Self-Assessment Tool](#) before entering the facility
- Consider electronically posting the influenza self-assessment guide on the organization's web site so visitors can self-assess before arriving at the facility

#### **Visitor Education**

- Teach all visitors how to:
  - put on and take off a mask
  - perform hand hygiene
  - follow respiratory hygiene

**Visitor Restrictions:** Restrict all visitors to visiting one resident per visit.

**Visitor PPE:** Offer visitors the same PPE as HCWs.

#### **Visitors with NO Influenza Symptoms Visiting a Residents with ILI Symptoms**

- Explain the risks of visiting to those who have not had pandemic influenza and have not been immunized at least 2 weeks before the visit.
  - Ask such visitors to consider NOT visiting if they are at high risk of influenza complications (e.g., cardiopulmonary disease, immune suppressed, pregnant, etc.)

#### **Visitors with Influenza Symptoms**

- Visitors with ILI symptoms shall NOT enter the facility unless they meet ALL of the following:
  - A close family member or will provide care, including essential emotional support as specified by the resident or alternate decision maker.
  - Agree to and have been taught how to:
    - put on and take off a mask
    - perform hand hygiene
    - follow respiratory hygiene
  - Agree to avoid open areas in the facility, e.g., dining areas
  - Agree to restrict their visit to a single resident
  - Agree to avoid all other area of the facility (e.g., public areas, waiting areas, lounges, etc.)



- Children must be supervised by an adult who ensures they follow the restrictions above
- Provide equipment and direction for the ill visitor to:
  - Put on a mask upon entering the facility
  - Remove the mask and place in the garbage upon leaving the healthcare
  - Perform hand hygiene upon entering the facility and before entering the room
  - Follow respiratory hygiene
- Staff monitors residents for ILI symptoms for one incubation period after the last visitor of all ill visitors

**Note: Visitor restrictions may change on a case-by-case basis.**

### **3.3. Ambulatory Care, Community Health Centres, Physician's Offices, Primary Health Care, and Walk-in Clinics**

Outpatient clinics and healthcare centres present unique challenges due to patient mix, acuity, practice environment, and other factors. Some settings serve both in-patient and ambulatory patients.

The goal of the plan for ambulatory clinics is to reduce or limit the time (i.e., waiting, receiving care) an infected source (i.e., person with symptoms compatible with influenza) is in contact with a susceptible host (e.g., staff and other people without influenza). Health Links/Info Santé can assist with conducting initial telephone assessments. These assessments will serve to determine whether a person is unlikely to have influenza and can stay at home, or whether she/he needs to be seen by a clinician for further assessment. PPH provides public communication, prevention advice and outreach to vulnerable populations, shelters as well as other key stakeholders.

#### **3.3.1. Accommodation/Cohorting**

See section 2.3: [Triage: Assessment of Influenza Symptoms](#). See [Appendix 2: Influenza Assessment Tool](#).

Cancel or re-schedule non-urgent visits to the ambulatory care facility, as appropriate.

Every effort should be made to segregate persons with suspected or confirmed influenza from those who do not have signs and symptoms of respiratory illness. Minimize time spent in waiting rooms

- Place symptomatic people in an area a minimum of 2 metres from non- symptomatic people

OR

- Separate symptomatic and non- symptomatic people with physical barriers such as curtains or partitions.



Assign people with symptoms compatible with pandemic influenza to an influenza designated area. Ensure clear directions to pandemic influenza assessment areas.

- Separate people with suspected or confirmed influenza as quickly as possible from those without signs and symptoms of respiratory illness
- A single examination/treatment room is preferred. The door to the exam room may remain open, UNLESS an AGMP is being performed. See the list of AGMPs in the [Glossary](#)
- AIIR availability may be limited. Prioritize these rooms, if available, for people with known or suspected infections spread by the airborne route (e.g., TB, measles, varicella, disseminated zoster)
- Cohort people if necessary. Assign people with confirmed pandemic influenza to the same room. If laboratory testing to confirm the virus is limited, cohort cases based on symptoms consistent with the pandemic influenza. See the [Influenza Case Definition](#)
  - As the pandemic progresses, the 'suspect/exposed cohort' and the 'confirmed influenza cohort' may require a merge
  - People who have recovered from influenza are considered immune. They may be moved into the 'non-influenza' cohort area after the period of communicability of the pandemic strain has passed
  - Maintain cohort principles until pandemic has been declared over and direction received from the WRHA IP&C Program.

Provide instructions and equipment for hand hygiene and respiratory hygiene for people with symptoms compatible with influenza (e.g., mask, tissues, and alcohol-based hand rub station).

### 3.3.2. Appointment Scheduling/Patient Referrals

- Evaluate appointments and, if possible prioritize, ambulatory care visits to those for whom hospitalization (for influenza or other medical conditions) may be prevented
- Initiate any alternate care plans as determined by regional pandemic management directives
- Implement a telephone triage plan to screen people for symptoms compatible with influenza before arrival at the clinic
- During telephone bookings, staff should inquire whether symptoms are present (as outlined in the [Influenza Case Definition](#))
- If telephone triage is not appropriate or feasible, consider screening at the entrance to the clinic
  - Screen for symptoms compatible with influenza before arriving at clinic/treatment appointments
  - In shared settings, maintain a distance of 2 metres between people



- In settings where people arrive for scheduled appointments, advise them to
  - Call his/her care provider in advance of a scheduled visit to advise them of any respiratory symptoms
  - Tell the receptionist or nurse of his/her symptoms before, or immediately upon arrival to the clinic
  - Reschedule non-urgent visits, if medically appropriate, by phone or by signage at the entrance to the building/clinic area
- When people with symptoms compatible with influenza are identified
  - Cancel/postpone/reschedule their appointments, if medically appropriate, until the period of communicability has passed and symptoms resolved
  - Direct people who need medical assessment for symptoms compatible with influenza to local centres when appropriate
  - Schedule appointments for people with respiratory symptoms to avoid exposure of non-symptomatic people. Maintain a distance of 2 metres between people
- Ensure assessment staff evaluates not only the patients' symptoms but also the symptoms of the person/s accompanying them to the appointment.
- Implement a process for prescription renewal that does not require the person to visit the clinic/office (e.g., telephone renewal)

### 3.3.3. Aerosol-Generating Medical Procedures (AGMPs)

An AGMP is any procedure conducted on a patient that can induce production of aerosols of various sizes, including droplet nuclei. AGMPs should be performed on patients only when medically necessary.

Examples include:

- Intubation and related procedures (e.g., manual ventilation, extubating, open endotracheal suctioning)
- Cardiopulmonary resuscitation
- Bronchoscopy
- Sputum induction
- Nebulized therapy
- Autopsy
- Non-invasive positive pressure ventilation (CPAP, BiPAP).

Perform a PCRA to evaluate the risk factors related to the interaction between the HCW, the patient and the patient's environment to assess and analyze their potential for exposure to infectious agents and identifies risks for transmission. Appropriate administrative controls, environment controls, and PPE are based on the evaluation of the risk factors identified. See [Point of Care Risk Assessment \(PCRA\)](#).

Conduct AGMPs in a controlled setting whenever possible. This requires early recognition of persons who may require high-risk



interventions (e.g., intubation, bronchoscopy) in order to avoid emergency situations. A controlled setting includes:

- Administrative Controls
  - The most experienced personnel perform the procedure
  - The number of people present during AGMPs should be limited to only those essential to patient care and support
  - Conduct procedures in a non-emergent manner (e.g., elective intubation)
  - Sedate patient if intubation is required
  - Ensure adequate equipment is in the room/bed space before procedure
- Engineering Controls
  - Close doors and windows with post-procedure air clearance
- Environmental Controls
  - Discard contaminated disposable equipment
  - Clean/disinfect contaminated reusable equipment before removing it from the room/bed space

Perform these procedures in an AIIR when feasible. If this is not possible, perform the procedures in a single room. If a single room is not available, use a minimum of 2 metres separation with curtains. Do not delay urgent procedures transferring people to an AIIR or a single room: <sup>[6.3]</sup>

- Ensure the doors to the room are closed
- All non-essential people should leave the room
- Draw curtains in multi-space rooms
  - Patients in multi-space rooms are not required to wear N95 respirators
  - Maintain a 2-meter spatial separation.

An N95 respirator, eye protection, gloves, and a long-sleeved gown are worn by all persons in the room where an AGMP is being performed:

- Put on all PPE before entering the room/bed space
- N95 Respirator shall be:
  - Fit tested for HCWs
    - Seal-checked before each use, as follows:
  - Cover respirator with both hands
  - Perform either an inhalation test (if respirator collapses slightly there is an adequate seal) or an exhalation test (if no air escapes respirator, there is an adequate seal)
- Changed if contaminated/wet

Respirators shall never dangle around the neck. Disposable respirators shall never be reused.





#### 3.3.4. Duration of Additional Precautions

Discontinue Additional Precautions as directed by Infectious Diseases/ IP&C, based on the current WRHA IP&C Program recommendations.

#### 3.3.5. Environmental Control (Housekeeping, Laundry and Waste) <sup>[6.3]</sup>

Remove clutter and entertainment items such as magazines, books and toys in waiting areas to prevent cross contamination and allow for ease of cleaning.

Use hospital-grade disinfectants for environmental cleaning.

Meticulously clean and disinfect environmental surfaces daily.

Clean and disinfect frequently touched surfaces (e.g., medical devices/knobs) with disinfectant wipes or hospital grade disinfectant at least twice daily AND when visibly contaminated.

Contaminated linen does NOT require special handling.

Waste does NOT require special handling.

Dishes do NOT require special handling.

Physical setting:

- Ensure the accessibility and availability of supplies:
  - Tissues and waste receptacles for used tissue disposal
  - Alcohol-based hand rub and/or hand washing supplies (soap, water, paper towels)
  - Medical masks for persons who are coughing.

#### 3.3.6. Equipment Cleaning and Disinfection

Clean and disinfect non-critical medical devices and medical equipment (e.g., oximeters, intravenous infusion pumps, armrests, examining tables, stretchers) before use by a patient AND in between patients.

See WRHA [IP&C Cleaning and Disinfection of Non-Critical Reusable Equipment/Items in Community Health Settings](#).

#### 3.3.7. Laboratory Best Practices

To take a nasopharyngeal swab:

- Ensure the correct viral swab kit is used; check the expiry date
- Ensure both the specimen and the requisition are clearly labeled with the patient's name and another unique identifier, such as date of birth and healthcare number
- Note the exposure history and clinical symptoms on the lab requisition; this facilitates surveillance.

For more detailed information, See

<https://healthproviders.sharedhealthmb.ca/files/respiratory-virus-specimen-collection.pdf>



### 3.3.8. Signage and Information Sheets

Post signs at all entrances informing people regarding [Respiratory Etiquette, hand hygiene](#), and the need for immediate reporting of symptoms of a respiratory infection. Provide clear directions to the pandemic influenza areas, assessment and admission areas.

### 3.3.9. Staff

During the pandemic period, HCWs should perform and interpret a daily influenza self-assessment to determine their influenza status and thus their ability to work.

- HCW who develops ILI symptoms while on duty should report the occurrence and should be relieved of his/her duties.
- HCW considered fit-for-work: is asymptomatic as per self-assessment for ILI
- HCW who is considered unfit-for-work: should, at a minimum, not report to work for at least one period of communicability after the onset of symptoms
- HCWs considered fit-for-work with restrictions: in a severe or prolonged pandemic where personnel shortages compromise patient safety; HCWs with mild influenza symptoms who feel well enough to work may be allowed to return to work. Consider assigning these personnel to influenza cohort areas.

OESH should provide education to HCWs on all shifts, in all departments. This includes providing an explanation of why and how to perform the daily Influenza Self-Assessment.

HCWs that self-identify they are at high risk of complications related to influenza, including pregnant HCWs should be offered an assessment by OESH. OESH shall provide these HCWs with education including information pertaining to the severe outcomes of influenza and reinforcement of protective measures such as PCRA, appropriate use of PPE, access to treatment and use of antiviral medication <sup>[6.3]</sup>.

HCWs should be aware of appropriate use of PPE. See [Point of Care Risk Assessment \(PCRA\)](#).

Intensify pandemic influenza education and skills training when an influenza pandemic is imminent.

### 3.3.10. Transport/Transfer

Ambulatory Care:

Notify the receiving area, in advance, regarding required precautions. Limit transport to medically essential purposes only:

- Cover open wounds



- Patient/client performs hand hygiene when leaving the room and wears clean clothes, housecoat, or cover gown, and medical mask
- Use a transport stretcher or wheel chair if possible, instead of the patient's/client's own bed or wheel chair, because of the bio burden on the patient/client bed/bedding/wheelchair
- If the patient's/client's own wheel chair is used for transport, cover it with a clean sheet and wipe the steering handles and side rails with disinfectant and allow required wet contact time before removing it from the room. Disinfected handles are considered clean during transport
- Staff shall perform hand hygiene and put on clean gloves, gown, medical mask and eye protection upon leaving the room
- Take care not to contaminate the environment with soiled gloves during transport
- If gloves come in direct contact with the patient or contaminated equipment during transport, they are contaminated and are NOT used to press elevator buttons
- Place the chart in a protective cover (e.g., plastic bag). NOTE: outside of the protective cover is contaminated – DO NOT place on environmental surfaces
- Contact the site/service Infection Control Professional or designate if additional Infection Prevention and Control guidance is required for transport.

#### **Transporting the Patient/Client with no Artificial Airway**

- Patient/client should wear a medical mask if tolerated
- Clear hallway/elevator during transport if patient/client unable to tolerate a medical mask <sup>[6.4]</sup>

#### **Transporting the Patient/Client with an Artificial Airway**

- Ideally, transport infants in an incubator
- Resolve any air leaks before transport
- Inflate/maintain inflation of endotracheal tube (ETT) cuff (if present) for the duration of the transport, to minimize contamination
- If an air leak occurs during transport and is not readily resolved, consider extubation and a tube exchange
- Exhaled gases must be N100 filtered
- Consult Respiratory Therapy if additional airway management guidance is required for transport

Community Health Centres, Physician's Offices, Primary Health Care, and Walk-in Clinics:

Notify the receiving area, in advance, regarding required precautions. Only transfer patients/clients with influenza under previously established guidelines of the receiving facility.



Patients/clients must perform hand hygiene and wear a medical mask for transport; patient/client does not wear a gown or gloves.

HCWs should perform a PCRA during and after the transport.

If the patient/client is using public transport (e.g., bus, taxi, ride share etc) encourage them to wear a mask during trip.

### 3.3.11. Visitors (including children and support workers)

**All Visitors:** Minimize the number of people who accompany the patient/resident/client.

#### **Visitors and Influenza Assessment**

- Direct all visitors/support persons to perform an influenza self-assessment according to [Appendix 5: Influenza Self-Assessment Tool](#) before entering the healthcare setting
- Consider electronically posting the influenza self-assessment guide on the organization's web site so people can self-assess before arriving

#### **Visitor Education**

- Teach all visitors/support persons how to:
  - put on and take off a mask
  - perform hand hygiene
  - follow respiratory hygiene

**Visitor PPE:** Offer visitors/support persons the same PPE as HCWs.

#### **Visitors with NO Influenza Symptoms Visiting a Patient/Resident/Client with ILI Symptoms**

- Explain the risks of accompanying to those who have not had pandemic influenza and have not been immunized at least 2 weeks before the visit
  - Ask such people to consider NOT accompanying if they are at high risk of influenza complications (e.g., cardiopulmonary disease, immune suppressed, pregnant, etc.)

#### **Visitors with Influenza Symptoms**

- People with ILI symptoms shall NOT accompany the person unless they meet ALL of the following:
  - A support person or close family member or will provide care, including essential emotional support as specified by the patient/resident/client or alternate decision maker
  - Agree to and have been taught how to:
    - put on and take off a mask
    - perform hand hygiene
    - follow respiratory hygiene



- Agree to avoid areas with vulnerable patients as specified by site HCWs
- Agree to avoid all areas not essential to the visit (e.g., public areas, waiting areas, lounges, etc.).
- Provide equipment and direction for the ill visitor to:
  - Put on a mask upon entering the facility
  - Remove the mask and place in the garbage upon leaving the healthcare
  - Perform hand hygiene upon entering the facility and before entering the room
  - Follow respiratory hygiene
- Staff monitor patients for ILI symptoms for one incubation period after the last visitor of all ill visitor/support person.

**Note: Visitor restrictions may change on a case-by-case basis.**

### 3.4. Home Visits

#### 3.4.1. Home Visit Considerations

##### 3.4.1.1. Accommodations

- Minimize contact with client with suspected or confirmed pandemic influenza
- Advise client(s) or other household members with ILI symptoms, to rest and recover in a room/area of the home away from individuals that have no ILI symptoms
- Use separate washroom if possible
- If client in a room with a door, doors rooms may remain open; with the exception of AGMPs.
- Encourage clients to open their window for natural ventilation.

##### 3.4.1.2. Screening/PCRA

- Evaluate client appointments and where possible prioritize home care visits to those clients for whom hospitalization may be prevented
- Implement a telephone screening plan to screen clients before HCWs arrive at the home. If unable to do telephone screening, create a screening/PCRA plan that can be safely upon arrival (e.g., don mask and eye/face protection prior to entering the home, maintain 2 metres distance from all members of the household while screening). If clients/family members with symptoms compatible with influenza are identified:
  - Cancel or postpone the home visit appointment if medically appropriate, until the period of communicability has passed
  - Direct clients with influenza like symptoms to local centres when appropriate



- Ensure a separation of 2 metres is maintained between the infected source (e.g., client, accompanying person) and the HCW and other staff when possible
- HCWs and other staff should utilize Pandemic Influenza Precautions when within two metres of a client with symptoms compatible with influenza
- If feasible consider assigning HCWs and other staff to visits with clients with symptoms compatible with influenza OR visits to clients without symptoms if it is a family member(s) who has ILI, request the ill person(s) not enter the room/area where the care is being provided to the client. Minimally, the ill family member(s) should maintain a distance of 2 metres from the HCW

### 3.4.2. Aerosol-Generating Medical Procedures (AGMPs)

Perform a PCRA to evaluate the risk factors related to the interaction between the HCW, the client and the client's environment to assess and analyze their potential for exposure to infectious agents and identifies risks for transmission. Appropriate administrative controls, environment controls, and PPE are based on the evaluation of the risk factors identified. See [Point of Care Risk Assessment \(PCRA\)](#).

An AGMP is any procedure conducted on a client that can induce production of aerosols of various sizes, including droplet nuclei. AGMPs should be performed on clients only when medically necessary.

Examples include:

- Non-invasive positive pressure ventilation (CPAP, BiPAP).
- Nebulized therapy
- Open deep tracheal suctioning
- Lung Volume Therapy
- Intubation and related procedures (e.g., manual ventilation, extubating, open endotracheal suctioning)
- Cardiopulmonary resuscitation

An N95 respirator, eye protection, gloves, and a long-sleeved gown are worn by all persons in the room where an AGMP is being performed:

- Put on all PPE before entering the room/bed space
- N95 Respirator shall be:
  - Fit tested for HCWs
  - Seal-checked before each use, as follows:
    - cover respirator with both hands
    - perform either an inhalation test (if respirator collapses slightly there is an adequate seal) or an exhalation test (if no air escapes respirator, there is an adequate seal)
  - Changed if contaminated/wet





- Respirators shall never dangle around the neck. Disposable respirators shall never be reused.

#### 3.4.3. Environmental Control (Housekeeping, Laundry and Waste) <sup>[6.3]</sup>

Staff to maintain usual housekeeping practices, unless advised otherwise by Public Health/IP&C.

Contaminated linen does NOT require special handling.

Waste does NOT require special handling.

Dishes do NOT require special handling.

#### 3.4.4. Equipment Cleaning and Disinfection

Clean and disinfect non-critical medical devices and medical equipment (e.g., oximeters, intravenous infusion pumps, armrests, stethoscopes, blood pressure devices, infant scales) before use by a client AND in between clients.

See WRHA [IP&C Cleaning and Disinfection of Non-Critical Reusable Equipment/Items for Clients in Community Health Services Operational Directive](#).

#### 3.4.5. Information Sheets

Provide client with information regarding Respiratory Etiquette and instructions to immediately report symptoms of a respiratory infection. Provide Pandemic Influenza information sheets.

#### 3.4.6. Staff

During the pandemic period, HCWs perform and interpret a daily influenza self-assessment according to [Appendix 5: Influenza Self-Assessment Tool](#) to determine their influenza status and thus their ability to work.

HCW who develops ILI symptoms while on duty should report the occurrence and should be relieved of his/her duties.

HCW considered fit-for-work: is asymptomatic as per self-assessment for ILI  
HCW who is considered unfit-for-work: should, at a minimum, not report to work for at least one period of communicability after the onset of symptoms.

HCWs considered fit-for-work with restrictions: in a severe or prolonged pandemic where personnel shortages compromise patient client safety; HCWs with mild influenza symptoms who feel well enough to work may be allowed to return to work. Consider assigning these personnel to influenza cohort areas.

OESH should provide education to HCWs on all shifts, in all departments. This includes providing an explanation of why and how to perform the daily Influenza Self-Assessment.

HCWs that self-identify they are at high risk of complications related to influenza, including pregnant HCWs should be offered an





assessment by OESH. OESH shall provide these HCWs with education including information pertaining to the severe outcomes of influenza and reinforcement of protective measures such as PCRA, appropriate use of PPE, access to treatment and use of antiviral medication. <sup>[6.3]</sup>

HCWs should be aware of appropriate use of PPE. See [Point of Care Risk Assessment \(PCRA\)](#).

Intensify pandemic influenza education and skills training when an influenza pandemic is imminent.

#### 4. POST PANDEMIC – ALL SETTINGS

Activate after care/recovery plans. Review and update policies/guidelines as appropriate with objectives of returning to routine operations.

#### 5. GLOSSARY

**Administrative Controls:** One element in the Hierarchy of Controls. Administrative Controls include but are not limited to: policies and procedures for hand hygiene; training; immunization of PRCs, HCWs and outbreak management and for care of PRCs with infection.

**Aerosol-Generating Medical Procedures (AGMPs):** AGMPs are medical procedures that can generate aerosols as a result of artificial manipulation of a person's airway. There are several types of AGMPs which have been associated with a documented increased risk of tuberculosis (TB) or SARS transmission:

- Intubation and related procedures (e.g., manual ventilation, open endotracheal suctioning)
- Insertion of a Laryngeal mask airway (LMA)
- Open deep suction via endotracheal tube/tracheostomy tube
- Cardiopulmonary resuscitation
- Bronchoscopy
- Tracheostomy procedure (open or percutaneous)
- Laryngoscopy (with instrumentation below the vocal cords)
- Sputum induction
- High flow nasal cannula oxygenation (e.g., Optiflow)
- Nebulized therapy does not include Metered dose inhaler (MDI)
- Some dental procedures (e.g., high speed drilling, ultrasonic scalers etc)
- Autopsy
- Non-invasive positive pressure ventilation (CPAP, BiPAP)

There is debate whether other medical procedures may result in the generation of aerosols through cough induction and lead to transmission of infection. However, to date there is no evidence of the transmission of respiratory infections, including TB, SARS or influenza, by these methods. Examples of these procedures include:

- High-frequency oscillatory ventilation
- Tracheostomy care



- Chest physiotherapy
- Obtaining nasopharyngeal swabs or aspirates

Note: Irrigation of a wound / cavity or joint of a PRC with suspected or confirmed non-respiratory TB has also been associated with an increased risk of TB transmission <sup>[6.7]</sup>.

**Community Health Centres:** Community-governed health organizations that provide primary healthcare, health promotion and community development services, using an inter-disciplinary team of healthcare providers.

**Engineering Controls:** Physical or mechanical measures put in place to reduce the risk of infection to staff or PRCs (e.g., heating, ventilation and air conditioning systems, room design, and placement of hand washing sinks). Also see Hierarchy of Controls.

**Influenza Case Definition:** 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 PRCs less than 5 years or greater than 65 years of age, fever may not be prominent <sup>[6.8]</sup>



## 6. REFERENCES

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- 6.2. [Pandemic influenza preparedness and response: WHO guidance document](#). (2009). World Health Organization. Accessed March 23, 2023
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- 6.5. [Prevention and Control of Influenza during a Pandemic for All Healthcare Settings](#). Public Health Agency of Canada. (2011, May). Accessed March 23, 2023
- 6.6. [Routine Practices and Additional Precautions in All Health Care Settings, 3<sup>rd</sup> edition](#). (2012, November). Provincial Infectious Diseases Advisory Committee (PIDAC). Accessed March 23, 2023.
- 6.7. [Routine Practices and Additional Precautions: Preventing the Transmission of Infection in Health Care](#). (2019, June). Manitoba Health. Accessed March 23, 2023.
- 6.8. [Seasonal Influenza: Communicable Disease Management Protocol. \(2016, August\)](#). Manitoba Health. Accessed March 23, 2023.
- 6.9. [Canadian Pandemic Influenza Preparedness: Planning Guidance for the Health Sector](#). (2016, February 12). Public Health Agency of Canada. Accessed March 23, 2023.
- 6.10. [Provincial guidance for Aerosol Generating Medical Procedures \(AGMPs\)](#)F (August 22, 2022) Shared Health, Government of Manitoba. Accessed March 21, 2023.



## 7. Appendices

### 7.1. Appendix 1: Triage and Assessment

Immediately separate PRCs with symptoms of an influenza like illness (ILI) symptoms from others, until the pandemic wave has been declared over.

#### **Consider the following when developing a triage and assessment strategy:**

- Implement a multi-step process for PRC screening, triage, and assessment that minimizes influenza transmission and allows efficient PRC flow
- Use generic assessment forms for screening, triage, primary assessment, and secondary assessment
- Use pre-printed influenza admission orders
- Minimize infection transmission when transporting PRCs from assessment areas to the appropriate care areas. Create Admission Teams or designate a person to be responsible for PRC flow from assessment areas
- Develop a system for prioritizing admissions when beds are limited, using both clinical and ethical support.

As the pandemic progresses separation may be unnecessary and impractical. Consult IP&C before making this decision.

Provide influenza information to all PRCs upon discharge, regardless of diagnosis.

#### **Consider admission to the following areas to limit transmission early in the pandemic:**

- **Influenza and ILI areas:** suspected and confirmed influenza, in-patient or resident units
- **Non-Influenza areas:** assume PRCs admitted to these areas have been exposed to influenza, and assess for influenza symptoms every 4-6 hours for 1 incubation period <sup>[6.3]</sup>
  - **Note:** More intensive monitoring for ILI symptoms is required to protect PRCs at high risk for complications, including but not limited to intensive care units, obstetrical units, newborn nurseries, Long Term care (LTC) facilities, and units/areas with immunocompromised PRCs
- Accommodate immune PRCs in the most appropriate area to address their care needs (either influenza or non-influenza areas). Immune PRCs are those who have recovered from the pandemic influenza strain or those immunized against the pandemic strain at least 2 weeks previously. Continue to assess immune PRCs for signs/symptoms of ILI as the vaccine may not be completely effective in providing immunity.



### Consider the following elements for PRC TRIAGE:

Direct PRCs with symptoms of an influenza like illness (ILI) to attend a dedicated Influenza Assessment Clinic, depending on the current pandemic phase. Ask these PRCs not to present to the Emergency Department (ER). ERs will remain open to persons brought in by EMS.

- Should ERs be closed to direct visits, media communication should advise persons to first contact Health Links-Info Santé, unless immediate medical attention is warranted
- Provide security personnel for persons awaiting triage
- Screen for ILI symptoms rapidly: Acute onset of respiratory illness with fever AND cough, AND one or more of the following
  - Sore throat
  - Arthralgia (joint pain)
  - Myalgia (muscle pain)
  - Prostration (extreme exhaustion)
    - In children less than 5 years of age, gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea) may be present
    - In PRCs less than 5 years or greater than 65 years of age, fever may not be prominent
- Separate PRCs on entry to the hospital/clinic as soon as possible into those requiring assessment for ILI, and those requiring assessment for other conditions
- Implement IP&C measures for healthcare workers and PRCs waiting in line (e.g.: spatial separation of 2 meters/6 feet)
- Ensure supplies needed at this stage are available, including but not limited to:
  - Masks
  - Eye/face protection
  - Alcohol based hand rub
  - Tissues
  - Markers indicating 6 foot/2-meter separation)
  - Line dividers, and
  - Garbage receptacles
  - Triage and separate persons presenting:
    - i. *For ILI assessment only* into a designated assessment area. Consider family members accompanying these PRCs exposed, therefore assess them for influenza as well
    - ii. *WITH ILI symptoms and assessment/treatment of another condition* into a different designated area. Consider family members accompanying these PRCs exposed, therefore assess them for influenza as well
    - iii. *Without ILI symptoms* into a physically separated, non-influenza designated area.



- Redirect PRCs, if required, to appropriate area (i.e., influenza or non-influenza), upon screening assessment results. Screening may change based upon Manitoba Health recommendations at the time of the pandemic.

## References:

1. [Canadian Pandemic Influenza Preparedness: Planning Guidance for the Health Sector](http://www.phac-aspc.gc.ca/cpip-pclcpi/ann-f-eng.php). (2016, February 12). Public Health Agency of Canada. Available at: <http://www.phac-aspc.gc.ca/cpip-pclcpi/ann-f-eng.php>.
2. Routine Practices and Additional Precautions: Preventing the Transmission of Infection in Health Care. (2012 April). Manitoba Health. Available at: <http://www.gov.mb.ca/health/publichealth/cdc/docs/ipc/rpap.pdf>.
3. Seasonal Influenza: Communicable Disease Management Protocol. (2015, September). Manitoba Health. Available at: <http://www.gov.mb.ca/health/publichealth/cdc/protocol/influenza1.pdf>.



## 7.2 Appendix 2: Influenza Assessment Tool

Influenza Assessment Tool		
<b>Allergies</b>		
1. SUDDEN ONSET of any following symptoms <i>(check all that apply)</i>		
Fever greater than or equal to 38°C • In patients/residents/clients less than 5 or greater than 65 years of age, fever may not be prominent	<input type="checkbox"/>	Onset Date (dd/mm/yyyy)
Cough: new onset or worsening of existing cough	<input type="checkbox"/>	Onset Date (dd/mm/yyyy)
2. Must also have abrupt onset of any following symptoms:		
Sore Throat	<input type="checkbox"/>	Onset Date (dd/mm/yyyy)
Joint Pain (Arthralgia)	<input type="checkbox"/>	Onset Date (dd/mm/yyyy)
Muscle Pain (Myalgia)	<input type="checkbox"/>	Onset Date (dd/mm/yyyy)
Extreme tiredness, physical exhaustion (Prostration)	<input type="checkbox"/>	Onset Date (dd/mm/yyyy)
If chronic exhaustion - is this new or worse?	<input type="checkbox"/>	Onset Date (dd/mm/yyyy)
Other: Gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea) may be present in children less than 5 years of age	<input type="checkbox"/>	Onset Date (dd/mm/yyyy)
<p>The presence of a fever and cough (#1), or any of the additional symptoms (#2) warrants further assessment. Other findings based upon clinical judgment may also warrant further assessment.</p> <ul style="list-style-type: none"> <li>• Manage patients/residents/clients per the Pandemic Influenza Plan</li> <li>• HCWs should be assessed for influenza by OESH</li> <li>• Visitors should not enter facility until assessed by their family physician or at an Influenza Assessment area</li> </ul>		
<b>Outcome:</b>		
<input type="checkbox"/> Suspected influenza (meets case definition): Implement Enhanced Droplet/Contact Precautions <input type="checkbox"/> Suspected influenza (does not meet case definition): _____ Implement Enhanced Droplet/Contact Precautions _____ Further assessment required <input type="checkbox"/> Non-influenza: follow Routine Practices; implement appropriate Additional Precautions as required for other conditions. Precautions as required for other conditions Has the suspected Influenza Case been Lab Confirmed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Completed by: _____ Date: _____ Time: ____ Signature: _____		





## 7.3 Appendix 3: Perinatal/Obstetrical Considerations

### Accommodations/Cohorting

- Cohort mothers with confirmed pandemic influenza if necessary
  - If laboratory testing to confirm the virus is limited, cohort patients based on symptoms consistent with pandemic influenza. See [Appendix 2: Influenza Assessment Tool](#).
- Make sensible efforts to reduce the likelihood the baby will be infected, while minimizing the effect on the mother-baby relationship. These include:
  - Treating the mother to reduce the risk of transmission
  - Mother and baby sleeping in separate beds two metres apart (in the same room)
  - When breastfeeding, the mother:
    - Performs hand hygiene before interacting with the baby
    - Wears a procedure/surgical mask
    - Uses a clean barrier (e.g., gown, blanket) between mother and baby.

### Mother admitted with suspected/confirmed pandemic influenza and delivers while still on Enhanced Droplet/Contact Precautions

- Follow Routine Practices in care of baby if baby is asymptomatic
- May cohort mother and baby provided parents understand the risk of transmission and if mother:
  - Performs hand hygiene
    - Wears a medical mask, and
    - Uses a clean barrier (e.g., gown, blanket) to hold baby.

If the mother cannot demonstrate understanding and compliance with IP&C procedures, the mother must be supervised and wear gown, glove, and a medical mask.

- Symptomatic mothers may be cohorted with their own baby only; do not cohort multiple symptomatic mothers with asymptomatic babies
- Follow Enhanced Droplet/Contact Precautions if baby is symptomatic

### Asymptomatic mother admitted with influenza like illness (ILI) onset within 7 days of admission

- Follow Enhanced Droplet/Contact Precautions until 7 days after onset of symptoms
- Follow Enhanced Droplet/Contact Precautions with a symptomatic baby
- Follow Routine Practice with an asymptomatic baby
- May cohort mother and baby provided parents understand the risk of transmission and if mother:
  - Performs hand hygiene
  - Wears a medical mask, and
  - Uses a clean barrier (e.g., gown, blanket) to hold baby



If the mother cannot demonstrate understanding and compliance with IP&C procedures, the mother must be supervised and wear gown, glove, and medical mask.

- Symptomatic mothers may be cohorted with their own baby only; do not cohort multiple symptomatic mothers with asymptomatic babies

### **Asymptomatic mother admitted and onset of ILI greater than 7 days before admission**

- Follow Routine Practices for mother and baby.

### **Admission/Discharge**

If the mother has clinically improved but is not asymptomatic, OR it has not been 7 days since onset of symptoms, she may be discharged if she:

- Understands there is still a risk of transmission to the baby
- Is taught how to reduce transmission using cough etiquette and hand hygiene.

### **Aerosol-Generating Medical Procedures (AGMPs)**

Doors to the room must be closed and all staff in the room must wear N95 respirators along with gloves/gowns/eye protection.

Do not delay urgent AGMPs (e.g., intubation associated with cardiac arrest) to transfer a patient to an AIIR or single room

- Ensure doors to the room are closed
- All non-essential people should leave the room
- In multi-bed rooms, draw curtains
- Patients in multi-bed room are not required to wear N95 respirators
- Maintain a 2-meter spatial separation.
- Following an AGMP in a standard single (private) room or in semi-private or open rooms, that has less air exchanges per hour, staff must wear an N95 respirator when in the room AND the door must be kept closed following completion of the AGMP. Keep door closed for three hours following the AGMP to have 99% dilution of any aerosols (based on 2 air exchanges an hour [ACH]). In newer ventilated spaces:
  - Inpatient room (6 ACH): 46 minutes for 99% air clearance.
  - Airborne infection isolation room (negative pressure) (12 ACH): 23 minutes for 99% air clearance.
  - Resuscitation Room (15 ACH): 18 minutes for 99% air clearance.
  - Operating Theatre (20 ACH): 14 minutes for 99% air clearance
- Where a supplemental HEPA scrubber is used, air clearance times must be determined with site Facility Management.



## Visitors

Inform asymptomatic parents/guardians who visit their symptomatic child/children of the

- Need for hand hygiene, minimally on entry to and exit from the patient's room
- Choice to use PPE while in the patient's room and the correct method to put on and take off PPE
- Potential inability to enter the hospital, should the parent/guardian develop symptoms
- Restrictions to visit other patients if the parent/guardian chooses not to wear PPE.



## 7.4 Appendix 4: Interim Measures to Optimize Bed Availability during Pandemic Influenza

Implement the following measures only during Pandemic Influenza to optimize availability of in-patient/resident beds. Decisions regarding cohorting are done and in consultation with the attending physician, bed utilization, and the site/program Infection Control Professional (ICP) or designate, as appropriate.

### PRCs with Influenza-like Illness (ILI)

Single rooms are preferred for PRCs with ILI. Implement the following for cohorting people with ILI

- Cohort if necessary
- Assign PRCs with confirmed pandemic influenza to the same room
- If laboratory testing to confirm the pandemic strain is limited, cohort cases based on symptoms.

PRCs who have recovered from influenza are considered immune and may be moved into the “non-influenza” cohort area after the period of communicability of the pandemic strain has passed.

As the pandemic progresses, the ‘suspect/exposed cohort’ and the ‘confirmed influenza cohort’ may require a merge if space does not allow for segregation

- Consult with site/program ICP or designate before making this decision.

Maintain cohorting principles until the pandemic has **been declared over and direction has been received from WRHA IP&C.**

Note: People with ILI do not require AIIRs unless an AGMP is performed.

Wherever possible use physical barriers to minimize exposure of people with ILI to those without ILI.

### Laboratory Process for Confirmation of Influenza

The Molecular Test is a sophisticated test using a successive Real Time-Polymerase Chain Reaction (RT-PCR) technique.

Type of Influenza Test	Influenza Test Result	Cohorting Process	Comment
Molecular Test	Positive for Influenza	Yes, with other flu-positive patients	The diagnosis of influenza should be considered positive.
Molecular Test	Negative for Influenza	No	PRC can be considered to not likely have influenza, but may have another infection

Note: If a second testing process is used after molecular testing, discordant results may occasionally occur in a few cases per season.



### **PRCs Requiring Airborne Precautions**

PRCs requiring Airborne Precautions remain the priority for AIIRs. Priority for AIIRs should be in the following order:

- Novel Pathogens – e.g., Severe Acute Respiratory Illness (SARI)
- Laboratory Confirmed Multi-Drug Resistant or Extensive Drug resistant (MDR/XDR) Respiratory TB
- Laboratory Confirmed Active Respiratory TB (sputum smear positive for AFB or culture positive for MTB) or Clinically-Confirmed (committed to TB treatment) with priority to most infectious
- TB under investigation
- Measles
- Varicella
- When an AGMP is anticipated and Respiratory TB or other pathogens spread by the airborne route are suspected or confirmed. For additional information see Respiratory Protection for AGMPs.

### **Patients Colonized/Infected with Antibiotic Resistant Microorganisms:**

- Patients undergoing MRSA decolonization should be in a single room
- Cohort MRSA positive patients regardless of strain



## 7.5 Appendix 5: Influenza Self-Assessment Tool

This tool is to be used for assessment of symptoms of influenza as follows: [6.9]

- For HCWs: For self-assessment before arriving in the workplace
- For patients/residents/clients: Early identification of persons with emerging ILI symptoms.
- For visitors and families: To assess ILI symptoms.

*This tool is not intended to be used as a clinical management tool.* [6.9]

Do you have the following symptoms? [6.10]

- Sudden onset or worsening of existing cough

AND/OR

- Fever. Note: Fever may be absent in the elderly or newborns

PLUS

- Abrupt onset of any of the following:

- Sore throat \_\_\_\_\_
- Joint pain (Arthralgia) \_\_\_\_\_
- Muscle pain (Myalgia) \_\_\_\_\_
- Extreme tiredness or physical exhaustion (Prostration)  
If chronic exhaustion – is this new or worse? \_\_\_\_\_

Sudden onset of a new or worsening of existing cough AND/OR fever PLUS one of the other above symptoms requires further assessment.