

ACUTE RESPIRATORY OUTBREAK PROTOCOL
ATTACHMENT B TO IC- METHODS OF SURVEILLANCE

<p>Acute Respiratory Outbreak LEVEL 1: Two patients/residents develop acute respiratory illness or laboratory confirmed positive Respiratory Viral Panel (RVP) within 72 hours of each other OR There is an increase in employee absences with two or more staff reporting similar respiratory symptoms <i>Acute Respiratory Illness includes any two of the following: fever, sore throat, cough, rhinorrhea, and nasal congestion in the absence of a known cause (e.g., seasonal allergies, COPD)</i></p>	
<p>Infection Prevention (IP) Leadership/IP</p>	<ul style="list-style-type: none"> • Surveillance of patients/residents for similar signs and symptoms of acute respiratory illness • Communicate with Leadership, Medical, Nursing, Therapy, Employee Health and Environmental Services and report to Safety Huddle • Notify public health officials about outbreak in accordance with applicable laws and regulations • Local leadership and IP implement daily infection prevention rounds per shift • Consider daily outbreak review meeting to include holidays and weekends
<p>Medical</p>	<ul style="list-style-type: none"> • Inpatient Providers provide notification for heightened awareness of acute respiratory illness to all on-call physicians and APNs • Notify IP and order Droplet and Contact Precautions if any other patients/residents develop signs and symptoms of acute respiratory illness • Identify pathogen – Order: Mountainside/New Brunswick: Respiratory Viral Panel with COVID; Toms River order: Miscellaneous Lab (PCR Respiratory Pathogen Panel)
<p>Nursing Respiratory Therapy Therapy</p>	<ul style="list-style-type: none"> • Notify Medical and IP if any other patient/resident develop signs and symptoms of acute respiratory illness • Institute Droplet and Contact Precautions when patient/resident has acute respiratory illness • Nursing and Respiratory Therapy carts to be cleaned and disinfected between all patient/resident rooms • Continue to clean and disinfect all shared equipment between patient/residents • All patients/residents on transmission-based precautions to have single patient use stethoscope kept at the bedside • Therapies can treat at the bedside with PPE on if the resident is able to tolerate the session • Close curtains when performing aerosol producing procedures. Close the privacy curtain between beds to minimize opportunities for close contact if safe to do so. • Remove fans from rooms when Droplet and Contact Precautions are in effect. If fan is medically necessary move resident to negative pressure room if available. • Laundry should be transported to washers in plastic bags. Plastic bags should be discarded after transport to laundry room. If plastic bags are not available use container or bags that can be disinfected after each use. • In long-term care and other patient/residential settings, make decisions regarding patient/resident placement on a case-by-case basis, balancing infection risks to roommates with the adverse psychological impact room placement might have. • For patients/residents on Droplet and Contact Precautions, if transport/movement outside of room is necessary have patient/resident wear a mask if tolerated • A face covering must NOT be worn by children under the age of two (2) or anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. Source control of patient may be provided with cloth face coverings or facemasks. If possible, perform procedures/tests in the patient's room. • Restrict use of shared equipment and supplies within designated areas
<p>Environmental Services</p>	<ul style="list-style-type: none"> • Ensure that units and rooms of patient/residents on Droplet and Contact Precautions are prioritized for frequent cleaning and disinfection • Consider ATP testing • Confirm that cleaning process and disinfectant being used is appropriate for outbreak • Spray curtains daily and have adequate curtains for terminal cleans available • If room change occurs for suspected viral illness, change curtain in addition to terminal clean if a pathogen was identified • Disinfect high touch surfaces in the immediate vicinity of the patient/resident on each shift using EPA-approved products for healthcare settings • Prioritize high touch surfaces in common areas (hallways and dining rooms) for frequent cleaning. Assess staffing needs to provide increased support to unit through daily update by Nursing



ACUTE RESPIRATORY OUTBREAK PROTOCOL
ATTACHMENT B TO IC- METHODS OF SURVEILLANCE

<p>Daily Safety Huddle Reminders: Direct Patient Care Departments (Department heads communicate daily to staff throughout entire Outbreak period)</p>	<ul style="list-style-type: none"> • Reminder to clean Vocera and mobile devices and consider additional daily use of UV disinfection (ReadyDock) for those devices before each shift, after each shift and as needed • Monitor sick staff callouts. Communicate to IP if acute respiratory illness symptoms are present by indicating on supervisor report if illness is Outbreak Related yes or no. <ul style="list-style-type: none"> ➤ Specifically ask: Do you have cold symptoms? If yes ask about fever, sore throat, cough, runny nose and nasal congestion. ➤ Send home sick staff with fever ≥ 100.4 and or respiratory symptoms ➤ Staff to remain out from work until at least 24 hours after they no longer have a fever ➤ If afebrile >24 hours, but still symptomatic, a mask can be worn within 3 feet of residents • Oxivir 1 wipes or bleach wipes can be used for disinfection of patient/resident care equipment and other surfaces (place on all PPE carts). • PPE remove in order: (Remove first) Gloves → gown → exit room and perform hand hygiene → eye protection → (last) mask → HAND HYGIENE. Front of mask is contaminated DO NOT TOUCH! Grasp ONLY ties/elastic to remove. Source control masks are to be changed between each resident room
<p>Staffing Review</p>	<p>Review staffing for the duration of the outbreak for the following teams: Nursing, Therapy, Respiratory Therapy, Materials Management and Environmental Services</p>

<p align="center">Acute Respiratory Outbreak LEVEL 2: (In addition to LEVEL 1 above) Three laboratory confirmed positive cases (e.g., rhinovirus, influenza, RSV, adenovirus) in a patient/resident within a 72 hour period OR Three or more patients/residents with sudden increase over the normal background rate of acute respiratory illness (ARI), with or without documented fever (temperature $\geq 100^{\circ}\text{F}$ OR 2° above the established baseline for that resident).</p>	
<p>Infection Prevention (IP)</p> <p>Leadership/IP</p>	<ul style="list-style-type: none"> • Develop case definition and compose line list • Identify pathogen, provide outbreak organism FAQ sheet to all staff at site. Determine appropriate duration of Transmission-Based Precautions, symptoms of illness, incubation period and disinfection products. • Notify Inpatient Section Chief, CMO, and CNO. Report to Safety Huddle. • Report to Safety Huddle and set up conference call and notify all disciplines upon initiation of Level 2 Outbreak Protocol: <ul style="list-style-type: none"> ➤ Leadership, Medical, Nursing, Pharmacy, Employee Health, Respiratory Therapy, Environmental Services, Safety /Security, Therapy, Materials Management, Patient/Resident Care Coordination, Risk Management services, Media communication, Family Faculty and Volunteers.
<p>Medical</p>	<ul style="list-style-type: none"> • Assess patients/residents who develop signs and symptoms of acute respiratory illness • Close the facility to new admissions if the physical set-up does not allow for complete segregation between “not ill/not exposed” and “ill/exposed” cohorts. • Consider cohorting patient/residents into sick, exposed (if common source and pathogen is known), and well groups in consultation with Nursing and Infection Prevention • Inform receiving facilities of the outbreak when transferring any patients/residents
<p>Nursing</p> <p>Respiratory Therapy</p> <p>Therapy</p>	<ul style="list-style-type: none"> • Consider cohorting patients/residents into sick, exposed (if common source and pathogen is known), and well groups in consultation with Medical and Infection Prevention • Suspend outside school for sick and notify school. • Limit groups and keep groups with the same cohort of well children. Suspend volunteers and outside groups from visitation. • Students from schools of nursing, respiratory, and/or therapy are permitted to come onsite but will not be assigned to residents currently involved in the outbreak. CSH will reserve the right to restrict students for a reasonable clinical or resident safety cause. • Assess inventory of testing supplies (viral transport swabs) • Assess staffing needs if increased clinical care is required • Inform receiving facilities of the outbreak when transferring any patients/residents • Provide EVS leadership with all anticipated room changes due to cohorting or suspected viral illness
<p>Pharmacy</p>	<p>Clean out bins with Oxivir 1 or bleach wipes.</p>
<p>Materials Management</p>	<p>Ensure adequate product for increased glove, gown, mask, and disinfectant wipes.</p>
<p>All Departments</p>	<p>Daily IP reminder same as Level 1 for Direct Patient Care Departments</p>

Acute Respiratory Outbreak LEVEL 3: (In addition to LEVELS 1 & 2 above) More than THREE patient/residents with acute respiratory illness identified within a 72 hour period	
<p>Infection Prevention (IP)</p> <p>Leadership/IP</p>	<ul style="list-style-type: none"> • IP with increased presence on location to provide support and re-education on PPE/hand hygiene and disinfection of equipment • If possible commonality showing only one school has been associated with multiple residents with acute respiratory illness, contact school and ask about others (staff or other students) with acute respiratory illness. Consider stopping specific school attendance for one incubation period. • Report to Safety Huddle • Set up conference call and notify all disciplines upon initiation of Level 3 outbreak protocol: Leadership, Medical, Nursing, Pharmacy, Employee Health, Respiratory Therapy, Environmental Services, Safety /Security, Therapy, Materials Management, Patient/Resident Care Coordination, Risk Management services, Media communication, Family Faculty and Volunteers.
<p>Medical</p>	<p>Increase frequency of PEWS scoring and vital signs to Q8 hour for exposed and known positive individuals</p>
<p>Nursing</p> <p>Respiratory Therapy</p> <p>Therapy</p>	<ul style="list-style-type: none"> • Staff assigned to affected patients/residents should not rotate to unaffected patients/residents. This restriction includes prohibiting HCP from working on unaffected teams after completing their usual shift on the affected team. • If sharing staff, resident care should flow from unaffected to affected residents. • Provide daily medical updates for patient/residents transferred to higher level of care • Monitor compliance with PPE donning and doffing and hand hygiene
<p>Environmental Services</p>	<ul style="list-style-type: none"> • Monitor compliance with PPE donning and doffing & Terminal Cleaning • Anticipate increased product (soap, paper towels), increased PPE disposal, increased staffing needs, and increased need for curtain changes
<p>Marketing and Public Relations</p>	<p>Notify all employees about outbreak.</p>
<p>Safety/ Security</p>	<p>Post signage at entrances to unit informing visitors about outbreak.</p>
<p>Leadership</p> <p>Patient/ Resident Care Coordination</p> <p>Family Faculty</p>	<ul style="list-style-type: none"> • Advise visitors of the need to adhere to Droplet and Contact Precautions if required and strict hand hygiene. • CSH will reserve the right to restrict visitation for a reasonable clinical or resident safety cause. Exceptions may be made when there is an urgent resident condition (such as end of life). If a visitation is made under these circumstances, the visitor may be required to wear personal protective equipment (mask, gown, gloves and eye protection) and will perform hand hygiene and limit their movement within the facility to the resident's room. The room will be disinfected following each visit. • Email and phone notification to families and DCPD about outbreak • Leadership of all disciplines: Monitor compliance with all Infection Prevention activities (hand hygiene, PPE donning/doffing, equipment cleaning)

Outbreak Protocol Complete	
Infection Prevention Medical Leadership	<p>Generally, the outbreak is considered to be over when two incubation periods have passed without a new case being identified AND/OR when the Department of Health declares Outbreak is complete.</p> <p>Examples of one/two incubation periods:</p> <ul style="list-style-type: none"> ➤ Rhinovirus/Enterovirus 6 days/12 days ➤ Parainfluenza 6 days/12 days ➤ Influenza 1-4 days/8 days ➤ Adenovirus – respiratory 14 days/28 days <ul style="list-style-type: none"> • Report to Safety Huddle and notify: Leadership, Medical, Nursing, Pharmacy, Employee Health, Respiratory Therapy, Environmental Services, Safety /Security, Therapy, Materials Management, Patient/Resident Care Coordination, Risk Management services, Media communication, Family Faculty and Volunteers. <p><u>Individual Discontinuation of Droplet/Contact Precautions:</u></p> <p>After 7 days (minimal)</p> <ul style="list-style-type: none"> • If ongoing transmission NOT evident on unit and one incubation period has passed: <ul style="list-style-type: none"> ➤ Medical reevaluation of signs and symptoms, if duration of illness has been confirmed without signs or symptoms discontinue TBP • If ongoing transmission evident on unit and one incubation period has passed: <ul style="list-style-type: none"> ➤ Consider extending Droplet/Contact Precautions until outbreak is declared complete • Provide anticipated date of discontinuation of Transmission Based Precautions for all affected residents/patients to Nursing and Environmental Services
Nursing	<ul style="list-style-type: none"> • Meet with Environmental Services to facilitate moving patients out of room to allow for terminal cleaning and use of UV room disinfection
Environmental Services	<ul style="list-style-type: none"> • Terminal cleaning for patient/residents involved in Outbreak may occur around the same time. Anticipate increased need for staff and curtains. • UV disinfection of all Terminal Cleaning when possible • Consider multiple UV disinfection units.
Materials Management	<ul style="list-style-type: none"> • Check levels of supplies which may have been depleted during outbreak protocol
Safety/Security	<ul style="list-style-type: none"> • Remove Outbreak signage posted at points of entry
All	<ul style="list-style-type: none"> • All volunteers, schools of nursing and outside visiting group may return to LTC unit.
Therapy	<p>If ongoing transmission NOT evident on unit and one incubation period has passed consider to:</p> <ul style="list-style-type: none"> ➤ Reinstate outside school for previously positive patients/residents <p>Outbreak over:</p> <ul style="list-style-type: none"> ➤ Reinstate in-house school for sick ➤ Reinstate outside school for previously positive patients/residents ➤ Group activities that were limited may be restarted.
Leadership/Patient Care Coordination/Resident Care Coordination/Family Faculty	<p>Email notification to families and DCPD when the outbreak is considered over as directed by Infection Prevention</p>



ACUTE RESPIRATORY OUTBREAK PROTOCOL
ATTACHMENT B TO IC- METHODS OF SURVEILLANCE

New Jersey Administrative Code 8:57

New Jersey Department of Health (NJDOH) and Local Health Department (LHD) Contact Information

Immediately contact the LHD to report every suspected or confirmed respiratory outbreak by phone. Contact information for LHD can be found at: www.localhealth.nj.gov and after hours at: [www.nj.gov/health/lh/documents/lhd_after_hours_emerg_contact_numbers.pdf](http://www.nj.gov/health/lh/documents/lhd_after_hours_emerg_contact_contact_numbers.pdf) <https://nj.gov/health/lh/documents/LocalHealthDirectory.pdf>

When LHD staff cannot be reached, the facility shall make the report by phone directly to NJDOH who will then contact the LHD. Call numbers are 609-826-5964 during business hours or 609-392-2020 on nights/weekends and holidays

CSH facility	Jurisdiction	County information
Mountainside Long Term Care	Westfield Regional Health Department	www.westfieldnj.gov/health 908-789-4070
Toms River Long Term Care	Ocean County Health Department	www.ochd.org 732-341-9700
New Brunswick Inpatient Rehab	Middlesex County Office of Health Services	www.co.middlesex.nj.us/Pages/Main.aspx 732-745-3100 <i>Emergency after hours: 732-745-3271</i>

References:

“Adenovirus | Clinical Information For Health Care Professionals | CDC.” Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 28 August 2019.

www.cdc.gov/adenovirus/hcp/index.html Accessed 28 March 2022.

“Adenovirus | Home | CDC.” Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 28 August. 2019, www.cdc.gov/adenovirus/index.html Accessed 29 March 2022.

“Appendix A | Isolation Precautions | Guidelines Library | Infection Control | CDC.” Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 22 July 2019,

www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/index.html Accessed 29 March 2022.

Boyce, John M., and Didier Pittet. “Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force.” *Infection Control & Hospital Epidemiology*, vol. 23, no. S12, 2002, doi:10.1086/503164. Accessed 30 April 2021.

Centers for Medicare and Medicaid Services QSO-20-39-NH Nursing Home Visitation. 17 September 2020, updated 10 March 2022. Accessed 29 March 2022.

Diversey Products Adenovirus update. Received communication of efficacy statement, 10/24/2018. Reviewed 30 April 2021.

Elnahal, Shereef. Policy Recommendations for Infection Control at Long-Term Care Facilities. NJ Department of Health, 6 June 2019, nj.gov/health/healthfacilities/documents/Wanaque%20Policy%20Report_DOH_06062019.pdf Reviewed 30 April 2021.

Hoyle, Elizabeth, et al. “An Adenovirus 4 Outbreak amongst Staff in a Pediatric Ward Manifesting as Keratoconjunctivitis—a Possible Failure of Contact and Aerosol Infection Control.” *American Journal of Infection Control*, vol. 44, no. 5, 2016, pp. 602–604., doi:10.1016/j.ajic.2015.11.032.

“Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities | CDC.” Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 17 November 2020. <https://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm> Updated 17 November 2020. Accessed 28 March 2022.

James, L., et al. “Outbreak of Human Adenovirus Type 3 Infection in a Pediatric Long-Term Care Facility--Illinois, 2005.” *Clinical Infectious Diseases*, vol. 45, no. 4, 2007, pp. 416–420., doi:10.1086/519938.

Kampf, Gunter. “Letters to the Editor .” *American Journal of Infection Control | Vol 44, Issue 10, Pages A1-A26, e167-e182, 1083-1196 (1 October 2016) | ScienceDirect.com, American Journal of Infection Control*, 2016, www.sciencedirect.com/journal/american-journal-of-infection-control/vol/44/issue/10.

NJDOH Guidelines for the Control of Respiratory Virus Outbreaks in Long-Term Care and other Institutional Settings. NJDOH-CDC January 2015. Accessed 29 March 2022.

Pankhurst, Louise. "Routine Monitoring of Adenovirus and Norovirus within the Health Care Environment." American Journal of Infection Control, 2014. American Journal of Infection Control 42 (2014) 1229-32

"Section 3 Summaries of Infectious Diseases." Red Book: 2021 - 2024 Report of the Committee on Infectious Diseases, by Michael T. Brady et al., American Academy of Pediatrics, 32nd Edition. Accessed 29 March 2022.

"Selected EPA-Registered Disinfectants." EPA, United States Environmental Protection Agency, 23 February 2021. , www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants Accessed 29 March 2022.

Senate No. 3900 State of New Jersey 218th Legislature "Requires certain long-term care facilities to submit outbreak response plan to DOH." August 16,2019

Using Personal Protective Equipment (PPE) Centers for Disease Control and Prevention (CDC) 19 August 2020. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html> Accessed 29 March 2022.

Uzuner, H., et al. "Investigation of the Efficacy of Alcohol-Based Solutions on Adenovirus Serotypes 8, 19 and 37, Common Causes of Epidemic Keratoconjunctivitis, after an Adenovirus Outbreak in Hospital." Journal of Hospital Infection, vol. 100, no. 3, 2018, doi:10.1016/j.jhin. 2018.05.011.