

Management of Influenza in Facilities 2010-2011
Operated and/or Certified by the OPWDD

12/15/10 - These guidelines are accurate as of the date written. Guidance may change as the influenza season progresses and more becomes known about the prevalent circulating strains. Please check back for updates.

Please note: the term "individual(s)" will be used in this document to indicate individuals with developmental disabilities.

Influenza is a contagious respiratory illness caused by viruses. It can cause mild to severe illness. Every year in the United States, on average 5% to 20% of the population gets the flu; more than 200,000 people are hospitalized from flu complications, and about 36,000 people die from flu-related causes.

The management of **influenza** or (Influenza like Illness- **ILI**) in facilities operated and/or certified by OPWDD - is a complex task. Complicating factors include:

- Large and small congregate care settings. Residential facilities range from 2 people to over 200 people in a building. They range from apartments and small residences to large institutional settings.
- Day programs. Individuals from many residences may attend a single day program. Staff from residences may be assigned for part of their day to the day program. Bus drivers and bus aides are exposed to individuals within the confines of a bus for sometimes upwards of 2 hours/day.
- Medical conditions of individuals. While some people have few medical issues, many have a complex medical profile with multiple complicating diagnoses. Pulmonary, cardiac, gastrointestinal and neurological conditions are common, with many individuals having two or more such conditions. Individuals are frequently unable to articulate how they are feeling, so it is often difficult to diagnose the flu.
- Ability of individuals to participate in infection control measures and/or respiratory "etiquette." While some individuals are able to follow simple infection control measures, the vast majority are unable to participate in any infection control measures or to comply with the most basic aspects of respiratory etiquette.
- Staff. Staff frequently provides intimate personal care for the individuals they serve. This close personal contact coupled with the limited ability of individuals to participate in transmission prevention places staff in a "high exposure" category.

PREVENTION

The most effective strategy for preventing influenza is **vaccination**. The Influenza vaccine is recommended for ALL individuals over the age of 6 months. Routine vaccination of certain persons (e.g., children, caregivers of children less than 6 months old, contacts of persons at risk for influenza complications, and staff of health care facilities, nursing homes, and programs that serve the developmentally disabled) who serve as a source of influenza virus transmission provides additional protection to persons at risk for influenza complications and can reduce the overall influenza burden.

Hand hygiene is the first line of defense against a pandemic, the common cold, the flu, SARS, food borne illnesses, and other infectious diseases. Adherence to proper hand hygiene is proven to prevent outbreaks in healthcare facilities, reduce transmission of antimicrobial resistant organisms, and reduce overall infection rates. Reinforce the need for strict hand hygiene in staff, individuals and visitors. Instruct staff to cleanse their hands if they come in contact with blood, body fluids, secretions or excretions and contaminated items; after removing gloves; and between contacts with individuals. Hands must be washed with soap and warm water if they are visibly soiled.

TRANSMISSION

Influenza viruses are spread from person to person primarily through the coughing and sneezing of infected persons. Influenza transmission occurs predominantly by large respiratory droplets (particles $>5 \mu$ in diameter) that are expelled from the respiratory tract during coughing or sneezing. Particles usually do not remain suspended in the air, and close contact (<6 feet) usually is required for transmission. Transmission also occurs through direct contact with respiratory droplets or secretions (such as found on used tissues), followed by touching the eyes, nose or mouth.

INCUBATION PERIOD

The incubation period is typically 1–4 days, with an average of 2 days.

INFECTIOUS (CONTAGIOUS) PERIOD

Adults typically are contagious from the day before symptoms begin through approximately 7 days after illness onset. Children can be contagious for ≥ 10 days, and young children can shed the virus for up to 6 days before their illness onset. Severely immunocompromised persons can shed the virus for weeks or months.

SIGNS AND SYMPTOMS

If a person has a fever over 100 degrees (37.8 c) and a cough or sore throat, they are considered to have "Influenza-like illness" (ILI) and should be treated the same as if they had diagnosed influenza.

Influenza and Influenza-like illness (ILI) can include any or all of these symptoms:

- fever
- chills
- muscle aches
- headache
- significant lack of energy
- dry cough
- sore throat

Initially, influenza and /or ILI may seem like a common cold, with a runny nose, sneezing and sore throat. But colds usually develop slowly, whereas influenza and ILI tend to come on suddenly. The fever and body aches can last 3-5 days and the cough and lack of energy may last for 2 or more weeks.

DIAGNOSIS

Appropriate treatment of persons with respiratory illness depends on accurate and timely diagnosis. The accuracy of clinical diagnosis of influenza on the basis of symptoms alone is limited because the initial symptoms of influenza can be similar to those caused by other infectious agents. Several other respiratory viruses, including

respiratory syncytial virus, adenovirus, and para-influenza virus, frequently co-circulate with influenza viruses during the influenza season. Therefore, clinicians will most likely have to rely on clinical signs and symptoms, and may diagnose an individual with ILI rather than a particular type of influenza. The lack of specificity should not impact on the treatment provided or the management strategies used to prevent transmission.

REPORTING REQUIREMENTS:

In facilities operated or certified by OPWDD **all** cases of ILI are to be reported as soon as possible to OPWDD. This notification is to be made electronically via the [ILI form](#).

Outside of New York City: If an individual is tested and is positive for influenza, the case must be reported to OPWDD electronically via the ILI form as well as to the Local Health Department (LDH) and the NYSDOH Regional Epidemiology Program, both of which can be found through the following link: [NYSDOH Regional Epidemiology Offices](#)

In New York City: If an individual is diagnosed as having influenza, the case is to be reported to the New York City Department of Health, Bureau of Communicable Diseases via telephone (212-788-9830) or fax (212-788-4268).

TREATMENT (2010-2011)

The CDC guidelines for antiviral use for influenza indicate that the neuraminidase inhibitors oseltamivir (Tamiflu) or zanamivir (Relenza) are generally to be used for treatment of cases of influenza. Advisory Committee on Immunization Practices (ACIP) recommends that neither amantadine nor rimantadine be used for the treatment or chemoprophylaxis of influenza A in the United States because of data indicating widespread resistance of influenza virus to these medications. Because zanamivir is administered by oral inhaler, it may not be the best choice for persons with developmental disabilities who may have difficulty using the Diskhaler correctly.

- Persons treated with influenza antiviral medications continue to shed influenza virus while on treatment. Thus, hand hygiene, respiratory hygiene and cough etiquette practices should continue while on treatment.
- **Antiviral treatment** should begin within 48 hours of symptom onset if possible, but treatment should still be considered for persons who present more than 48 hours after illness onset if they have severe influenza illness or are at higher risk for severe complications from influenza.

For the most-up-to-date recommendations on anti-viral treatment of influenza, please go to: <http://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm>

Potential Side Effects

Tamiflu (Oseltamivir) can cause nausea and vomiting. Symptoms may be reduced if taken with food. Individuals taking Tamiflu (Oseltamivir) must be closely monitored for signs of unusual behavior. Report ANY unusual behavior or other possible side effect immediately to the RN.

Relenza: Because persons with asthma and/or chronic obstructive pulmonary disease may experience bronchospasm (wheezing) or serious breathing problems when using Relenza it is typically NOT recommended for people with these

diagnoses. Most people who do not have a pre-existing respiratory disease do not experience significant problems while taking the drug. Some of the most common side effects include fever, sinus infections, and dizziness. Relenza has also been reported to cause unusual behavior, particularly in children. Report ANY potential side effect to the RN immediately.

PROPHYLAXIS

While the use of antiviral drugs for chemoprophylaxis is not a substitution for vaccination, it is a key component of influenza and ILI outbreak control in residences and programs operated and/or certified by OPWDD.

All persons (individuals and staff) in smaller residences where there is unrestricted interaction among the individuals and staff should be given either of the neuraminidase inhibitors.

In large facilities and day programs, the persons identified for prophylaxis depend upon the organization of the facility or program, and the interaction pattern of individuals and staff. A health care professional should determine which individuals and staff can be reasonably assumed to have been exposed to the flu and recommend prophylaxis accordingly.

Post exposure antiviral chemoprophylaxis is not recommended if more than 48 hours have elapsed since the last contact with an infectious person.

Duration of post-exposure chemoprophylaxis is 14 days after the last known exposure to a person with influenza. If there is ongoing transmission within the residence/facility/unit/wing, chemoprophylaxis should be continued for an additional 7 days after the date of onset of the most recent case of ILI. As chemoprophylaxis lowers but does not eliminate the risk of influenza, individuals given post-exposure chemoprophylaxis should be monitored and should seek medical evaluation immediately should they develop a febrile respiratory illness that might indicate influenza.

CLEANING AND ENVIRONMENTAL MEASURES

Though less important than *hand hygiene* and *respiratory etiquette*; cleaning and disinfection may help to prevent the transmission of influenza and other infections. [The following cleaning practices and environmental measures are recommended:](#)

1. Have waste baskets available and visible. Make sure wastebaskets are emptied on a regular basis.
2. Clean and disinfect frequently touched surfaces such as doorknobs, door handles, handrails, telephones, remote controls, etc. as well as surfaces in sleeping areas, kitchen and dining areas and common areas. Refer to the EPA list of antimicrobial disinfectants at <http://www.epa.gov/oppad001/influenza-a-product-list.pdf> for more information on appropriate disinfectants.
3. If hard surfaces are visibly dirty, clean first using a general cleaner or soap and water. After the surface is clean, apply disinfectant following the manufacturer's directions or a chlorine bleach solution made by mixing 1 tablespoon of chlorine bleach to 1 quart (4 cups) of water or 1 teaspoon to one pint (2 cups) of water.
4. "Sit time" for disinfection must be observed. The length of the sit time is dependent on the product that is being used; therefore it is important to follow the manufacturer's recommendations.
5. Leftover cleaning fluids are to be discarded after use.

6. Bathrooms are in to be kept in good condition and cleaned on a regular schedule with cleaners and/or disinfectants.
7. Soap and paper towels are to always be available in bathrooms.
8. Shower/bathe "well" individuals first (i.e. those who are not presenting with symptoms of ILI), and then shower/bathe individuals with ILI.
9. Clean showers and bath tubs well between individuals.
10. Ventilation may help reduce transmission. Open windows and use fans when practical, and keep ventilation systems and filters clean.
11. Linens (such as bed sheets and towels) should be washed by using household laundry soap and tumbled dry on a hot setting. Individuals should avoid "hugging" laundry prior to washing it to prevent contaminating themselves. Individuals should wash their hands with soap and water or alcohol-based hand rub immediately after handling dirty laundry.
12. Eating utensils, and dishes belonging to those who are sick do not need to be cleaned separately, but it is important to note that these items should not be shared without washing thoroughly first. Eating utensils should be washed either in a dishwasher or by hand with water and soap.

RESTRICTION OF ACTIVITY

(**Note:** Team leaders and/or residence managers should develop a plan to address the possibility that individuals will not be able to attend day program and other group activities secondary to influenza.)

As there is no evidence that treatment with antiviral medication reduces a person's contagious state, it must be assumed that persons remain contagious for 7 days from the onset of symptoms regardless of whether or not they are treated with antiviral medication. The following restrictions on activity shall be implemented when there is a suspected or confirmed case of influenza.

1. To the extent possible, maintain individuals with suspected or confirmed influenza on droplet precautions in their bedroom for 7 days from the onset of symptoms.
2. At a minimum, restrict individuals(s) with suspected or confirmed influenza to the affected unit/residence.
3. To the extent possible, individuals with suspected or confirmed influenza are to dine in their rooms.
4. If dining in the common area, individuals(s) with suspected or confirmed influenza should dine separately from those who are well/not exposed, with the well individuals dining first followed by the individuals(s) with suspected or confirmed influenza.
5. When in common areas, promote spatial separation of at least 3 feet to preferably 6 feet between individuals(s) with suspected or confirmed influenza and other well individuals.
6. To the extent possible in large facilities, cohort individuals with suspected influenza with other individuals with suspected influenza; cohort individuals confirmed to have influenza with other individuals with confirmed influenza.
7. All individuals in a residence (or in a large facility, in the area, wing or unit) who have suspected or confirmed influenza or who have been exposed to influenza are not to be allowed to attend day program, to interact with individuals or staff from other residences or units, or go to group activities outside of the residence.
8. Individuals with ILI or confirmed influenza are to remain out of day program for a minimum of **7** days from the onset of symptoms. Individuals may return to day program **after 7** days provided the following criteria are met:

- a. The individual has completed at least **5 days** of anti-viral medication; AND
- b. The individual is asymptomatic and has been without a fever (100°F [37.8°C] or greater without taking fever-reducing medication) for at least 24 hours; AND
- c. There is no evidence of on-going transmission in the residence, area, wing or unit.

(NOTE: If the primary care provider determines that a person can not/should not have antiviral medication therapy, conditions b and c above must be met prior to the person returning to program.)

9. Individuals exposed to a person with ILI or confirmed influenza are to remain out of day program for a minimum of **7 days** after the last known **exposure**. Individuals may return to day program after **7 days** provided the following criteria are met:
 - a. The individual has completed at least **7 days** of prophylactic medication; AND/OR
 - b. The individual is afebrile and without any signs or symptoms consistent with ILI.
10. Restrict visitors to the residence to the extent possible until the contagious period is over.
11. Restrict the use of respite in any residence when there is an individual presently residing there with ILI or confirmed influenza. Any individual admitted to respite should be free of ILI or confirmed influenza and should have no known recent exposure (within the previous 7 days) to ILI or confirmed influenza.
12. Restrict admissions, discharges or transfers of individuals during the period of infectivity. In the event that an individual must be re-located, the following measures should be followed:
 - Determine the vaccination status of individuals to be relocated
 - Carefully screen individuals to be relocated for symptoms of, and exposure to, influenza.
 - If discharging/transferring an individual with respiratory symptoms, a known exposure, or confirmed influenza, notifies the receiving facility.
 - Individuals admitted with respiratory symptoms, a known exposure, or confirmed influenza are to be placed on droplet precautions.
 - Individuals admitted without respiratory symptoms or known exposure may be admitted to the residence and treated as any other individual in the residence without influenza.

USE OF MASKS/RESPIRATORS

All agencies should provide instruction for individuals and staff on the proper use and disposal of masks. The CDC and New York State Department of Health recommend the use of surgical or procedural masks for the care of individuals with suspected or confirmed influenza **except** during procedures that **generate aerosols** (i.e. deep suctioning or ventilation—see below).

- Health care personnel (HCP) should don a facemask when entering the room of a patient with ILI or confirmed influenza
- HCP should continue to wear respiratory protection equivalent to an N95 or higher filtering face-piece respirator during **aerosol-generating procedures**.

- For information regarding the use of masks and definition of procedures that qualify as **aerosol-generating**, agencies should consult the [CDC website](http://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm) <http://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm>

OTHER MANAGEMENT STRATEGIES

1. **Hand washing**- Reinforce the need for strict hand hygiene in staff, individuals and visitors. Instruct staff to cleanse their hands if they come in contact with blood, body fluids, secretions or excretions and contaminated items; after removing gloves; and between contacts with individuals. Hands must be washed with soap and warm water if they are visibly soiled.
2. Provide hand hygiene materials in common room areas (as appropriate) and encourage individuals and staff to clean their hands often.
3. Staff are to wear **gloves** if hand contact with respiratory secretions, blood, body fluids, secretions or excretions or potentially contaminated surfaces is anticipated.
4. Staff are to wear a **gown** if soiling of clothes with a resident's respiratory secretions is anticipated.
5. Provide **tissues** and instruction on when to use them (i.e. when coughing, sneezing or controlling nasal secretions), how and where to dispose of them and the importance of hand hygiene after handling dirty tissues. If hands are visibly contaminated with respiratory secretions, they are to be washed with soap and water.
6. Individuals with respiratory symptoms, ILI or confirmed influenza are to be **physically segregated** from other individuals, to the extent possible. Spatial separation of at least 3 feet, preferably 6 feet, is recommended (see CDC Guidelines).
7. Promote respiratory hygiene and cough etiquette to the extent possible.

DAY PROGRAM CONSIDERATIONS

1. Day programs where an individual with developmental disabilities or staff person has been diagnosed with ILI or confirmed influenza need to **assess** the pattern of interaction among participants and staff.
2. Notification is to be sent to **all** residences that have individuals attending the day program, including families of individuals who live at home. Residences/caregivers must ensure that any exposed individuals get appropriate prophylaxis and that other individuals in the residence/home be closely monitored for signs and symptoms of ILI. If any individuals or staff become ill, the residence/home is to immediately seek medical attention for the person, and inform the health care provider that the individual has been exposed to ILI or influenza.
3. Day program and residential nurses must maintain close contact and communication. The day program nurse must notify the residential nurse of any respiratory illness, ILI or confirmed case of influenza. The residential nurse must notify the day program nurse of the same. The day program nurse and the residential nurse are to coordinate their efforts in the management of influenza.
4. Individuals and staff, including bus drivers, bus aides, cafeteria workers and others who have been exposed to ILI or confirmed influenza are to be notified of their exposure. Individuals are to be offered prophylaxis treatment. **Staff may be offered prophylaxis, **or** they may be instructed to notify their primary care physician, inform the provider that they have been exposed to ILI or*

confirmed influenza and indicate that the agency has recommended that they receive influenza prophylaxis.

STAFF CONSIDERATIONS

*(State Operated Facilities should also consult information provided by the OPWDD Office of Employee Relations for implementation of these considerations in state facilities.)

1. Educate staff about the benefits of vaccination, the signs and symptoms of respiratory illness, and the potential health consequences of influenza illness for themselves, their family members and the individuals they care for.
2. Encourage all staff, volunteers, including temporary and part time staff, to get vaccinated against influenza. Particular emphasis should be made on the importance of vaccination of staff that provides direct care.
3. Because ill staff present a risk to the individuals they serve and to other staff, all staff are to be advised to stay home from work if they have respiratory symptoms consistent with ILI (fever over 100°F , muscle aches, headache, significant lack of energy, dry cough and/or sore throat.)
4. If a staff person who appears to have ILI upon arrival at work or becomes ill during the shift, that person should be promptly separated from other staff and individuals and be requested to go home immediately. If they cannot be placed in an area away from others, staff with ILI should be given a surgical mask to wear (if they can tolerate it) until they go home.
5. If a staff person calls off work, the manager or supervisor is to ask if the cause is ILI. If the cause is ILI, the staff person should be advised to call their primary care provider for advice/guidance.
6. If a staff person has ILI or a confirmed case of influenza, the staff person should not return to work until they have been without a fever (*100°F [37.8°C]* or greater *without taking fever-reducing medication*) for at least **24 hours**.
7. According to the CDC, more stringent guidelines and longer periods of exclusion than indicated in subparagraph 6 above – for example, until complete resolution of all symptoms – may need to be considered for people returning to a setting where high numbers of high-risk people may be exposed,
8. In a setting with an individual with ILI or confirmed influenza: during the period of possible contagion, staff who *have not received* the seasonal influenza vaccines are to be restricted from floating into or out of the residence, area, wing or unit. In addition, staff who have not received the seasonal vaccine that have been exposed are to be restricted from doing overtime or extra service in other programs, residences, areas, wings or units for at **least 7** days after the last known exposure. Staff restrictions may be lifted after **7** days provided the following criteria are met:
 - a. the staff person has completed at least **7** days of prophylactic medication; *AND*
 - b. the staff person is asymptomatic and has been afebrile for at least 24 hours; *AND*
 - c. There is no evidence of on-going transmission in the residence, area, wing or unit; *OR*
 - d. *if staff do not receive prophylactic medication they must be asymptomatic and without a fever (100°F [37.8°C] or greater without taking fever-reducing medication) for at least 24 hours; AND there*

must be no evidence of on-going transmission in the residence, area, wing or unit where they are returning to work.

9. Staff who are well but who have an ill family member at home with ILI or confirmed influenza can go to work as usual. However, these staff should monitor their health every day, and be advised to stay home if they become ill.

GUIDELINES for TRIAGING OF STAFF IN A STAFFING CRISIS:

If there is a staffing crisis (that being that a large percentage (e.g. 30-40%) of staff are out ill, or there is a natural event like a major snow storm, ice storm, flooding **and** there is no staff to mandate (meaning that they have already worked 16 hours) no staff on pass day willing to come in, no staff available from temporary agencies, etc AND the facility/unit/house will fall below safe staffing levels without additional help) it may be necessary to triage which staff can float where, in priority order:

- Any staff that are immunized against seasonal flu can be floated anywhere as theoretically they are immune.
- Unimmunized or immunized staff who have completed at least 5 days of chemoprophylaxis as that is supposed to prevent infection.
- Staff from the house closest to the end of the 7 day restriction. Theory: viral load, thus infectivity decrease from the onset of symptoms through about day 7 after onset of symptoms. So the farther one gets from the LAST known new onset, the less likely that the staff will get sick and thus be able to be a vector (cause illness) to others.
- **EXAMPLE:**
 1. House A last onset of illness Oct 19
 2. House B last onset of illness Oct 15
 3. House C last onset of illness Oct 16

**If you have to float staff, triage staff from House B to be floated first, as they are 4 days out; then if necessary House C as they are 3 days out. Do not float unimmunized staff from house A as it has only been one day, and the incubation period is 2-4 days.*
- Require staff who are not immunized but must be floated to another residence and who are within the incubation period to wear a mask at any time they are within 6 feet of another person.

If you have any questions or concerns, or require assistance in implementing these management strategies, please feel free to contact the **Infection Control Nurse** at the appropriate DDSO.

OPWDD | 44 Holland Avenue | Albany, NY 12229-0001 | (866) 946-9733 | TTY:
(866) 933-4889