Management of Influenza in Facilities 2016 - 2017
Operated and/or Certified by the OPWDD

November 7, 2016 - 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. A range of 3,000 to 49,000 people die from the flu each year.

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 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 in preventing the spread of influenza, the common cold, and other common infectious diseases. Adherence to proper hand hygiene has been proven to prevent outbreaks of influenza in healthcare facilities, resulting in reduced overall infection rates.

All agencies should provide regular instruction in appropriate hand decontamination methods, and reinforce its necessity with staff, individuals, and visitors. Staff should be advised to wear non-permeable gloves any time they anticipate coming in contact with blood and/or other bodily fluids. Staff should be instructed to wash their hands with soap and water any time their hands become visibly soiled. The use of alcohol based hand sanitizers are an acceptable alternative to hand washing only when hands remain clean and dry during routine contact with individuals.

**Respiratory Hygiene and Cough Etiquette** are additional infection control strategies aimed at reducing the spread of influenza and other serious respiratory illnesses. All should be encouraged to cover one’s mouth and nose with a tissue when coughing or sneezing. Used tissues should be disposed of in a garbage can. If tissues are not immediately available one should cough or sneeze into fabric. Coughing or sneezing into one’s elbow or sleeve is a preferred alternative. One should never cough or sneeze directly into one’s hands. If coughing or sneezing into one’s hands does occur, all should be instructed to wash hands immediately with soap and water.

**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 µ 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 (less than 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 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 the treatment provided or the management strategies used to prevent transmission.

REPORTING REQUIREMENTS:
Outside of New York City: Under public health law, outbreaks of influenza or ILI occurring in community or facility settings such as schools, colleges, group homes, adult homes, and assisted living facilities must be reported by the community or facility setting to the Local Health Department (LHD) of the county where the outbreak is occurring.
For the purposes of reporting, OPWDD is utilizing the following from the New York State Department of Health (NYSDOH) – Healthcare Epidemiology and Infection Control Program:

- A cluster or outbreak of ILI (defined as a measured temperature* ≥37.8 °C [100 °F] with cough or sore throat) in a health care facility is defined as:
  - One or more health care facility–associated case(s) of confirmed influenza in patient(s)/resident(s), or
  - Two or more cases of ILI among health care workers and patients/residents of a facility on the same unit within 7 days.
- *Infants, elderly adults, and persons with compromised immune systems may have atypical presentations, such as presenting without a fever, sepsis-like syndrome, or an unexplained exacerbation of a chronic lung or heart condition.

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 (347-396-2600) or fax (347-396-2632). Their reporting form #PD16 is available on their website: http://www.nyc.gov/html/doh/downloads/pdf/hcp/urf-0803.pdf

Additionally, confirmed influenza cases or incidents of ILI should be reported to your local DDSOO Infection Control Nurse or Nursing Program Coordinator. http://www.opwdd.ny.gov/opwdd_contacts/ddsoo

TREATMENT 2015-2016

The Centers for Disease Control (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. The Advisory Committee on Immunization Practices 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 individuals 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 antiviral 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 on duty/RN on-call.

**Relenza:** Because persons with asthma and/or chronic obstructive pulmonary disease (COPD) 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 on duty/RN on-call 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.

According to the CDC, chemoprophylaxis should be reserved for exposed persons who are considered to be at high risk for complications of influenza. Facilities are encouraged to identify at risk persons, in advance, so that receipt of chemoprophylaxis, if indicated, is not delayed.

**People at High Risk for Developing Flu-Related Complications (Especially when unvaccinated):**
- Children younger than 5, but especially children younger than 2 years old
- Adults 65 years of age and older
- Pregnant women

**Also at Risk- People Having Medical Conditions, Including but not limited to:**
- **Asthma**
- Neurological and neurodevelopmental conditions (including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy [seizure disorders], stroke, intellectual/developmental disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury). Note: These disorders may also compromise a person’s ability to manage respiratory secretions
- Chronic lung disease (such as COPD and cystic fibrosis)
- **Heart disease** (such as congenital heart disease, congestive heart failure and coronary artery disease)
- Blood disorders (such as sickle cell disease)
- Endocrine disorders (such as **diabetes** mellitus)
- Kidney disorders
- Liver disorders
- Metabolic disorders (such as inherited metabolic disorders and mitochondrial disorders)
- Weakened immune system due to disease or medication (such as people with HIV or AIDS, cancer, or those on chronic steroids)
- People younger than 19 years of age who are receiving long-term aspirin therapy
- People who are morbidly obese (Body Mass Index, or BMI, of 40 or greater)

For more information: [http://www.cdc.gov/flu/about/disease/high_risk.htm](http://www.cdc.gov/flu/about/disease/high_risk.htm)

All individuals in smaller residences (16 residents or less) who are considered to be at high risk for complications of influenza and have unrestricted interaction with other individuals and staff, should be given either of the neuraminidase inhibitors, within 48 hours post exposure.

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 (typically the RN on duty or other medical staff employed by the facility or program) should determine which individuals and staff can be reasonably assumed to have been exposed to the flu and recommend prophylaxis accordingly.

For individuals who do not meet indication for prophylaxis, close monitoring and early initiation of antiviral treatment at the first sign of febrile (with fever) respiratory illness is advised.

**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.

Chemoprophylaxis recommendations might be expanded to include all exposed individuals if there is evidence of ongoing transmission or outbreak of influenza or ILI at a particular location, as advised by the NYSDOH/Local Department of Health, or the New York City Department of Health - Bureau of Communicable Diseases.

**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 [www.epa.gov](http://www.epa.gov) 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, if approved for use at your agency, 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 (the amount of time solution must remain in place without drying up) 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 to be kept in good condition and cleaned on a regular schedule with cleaners and/or disinfectants.

7. Soap and paper towels are always to 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 and/or staff should avoid “hugging” laundry prior to washing it to prevent contaminating themselves. Individuals and/or staff 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 hot 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 due to having 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 in their bedroom for 7 days from the onset of symptoms to minimize spread of influenza from coughing or sneezing (i.e., droplet precautions).

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 the 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 antiviral 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 an individual cannot or 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, if indicated; AND/OR
   b. The individual is afebrile (without fever) 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 notify 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**
The CDC and NYSDOH 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.

**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 non-permeable 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 an individual’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.

7. Promote respiratory hygiene and cough etiquette to the extent possible.

**DAY PROGRAM CONSIDERATIONS**

1. Day programs where an individual 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, if indicated, and that other individuals in the residence/home be closely monitored for signs and symptoms of ILI. If any individuals become ill, the residence/home is to immediately seek medical attention for the individual, 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, if indicated.

**STAFF CONSIDERATIONS**

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

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 for whom they care.

2. Encourage all staff, including temporary and part-time staff, and volunteers to get vaccinated against influenza. Particular emphasis should be made on the importance of vaccination of staff that provides direct care.

3. Staff should be encouraged, but not required, to report the receipt of their influenza vaccine to their infection control officer or their nursing management.

4. A staff person who is present at work and is exhibiting symptoms of influenza or ILI should be encouraged to leave work and charge his or her accruals so as not to risk the spread of influenza or ILI.
For State Operated Facilities only: If such staff person refuses to leave, the person’s supervisor may place him or her on involuntary leave only if there is probable cause to believe that his/her continued presence on the job represents a potential danger to persons or property or would severely interfere with operations as required by Civil Service Law § 72 (5). If the supervisor believes that such cause exists, before placing such staff person on involuntary leave, the supervisor must first obtain approval from the Office of Employee Relations if this situation arises during regular business hours (8:30 a.m. – 5:00 p.m., Monday – Friday); or from the Administrator on Duty (“AOD”) if this situation arises at any other time. To determine probable cause, AOD’s must inquire of the supervisor as to whether the staff person is exhibiting any of the “SIGNS AND SYMPTOMS” described in such section above. Any employee who exhibits four or more of such signs and symptoms shall be placed on involuntary leave. The AOD shall direct the staff person to leave work and advise that the local Human Resources Office will inform such person of his/her rights with respect to such involuntary leave and the process that will be followed. Whenever a staff person is placed on involuntary leave pursuant to Civil Service Law § 72 (5), the supervisor or AOD must inform the local Human Resources Office as soon as possible so that notice and other provisions of Civil Service Law § 72 (5) are timely complied with.

For Non-State Operated Facilities: If such staff person refuses to leave work, the agency should take lawful and appropriate action pursuant to any applicable collective bargaining agreement and/or personnel policies.

5. A staff person who appears to have ILI upon arrival at work or becomes ill during the shift, should be placed in an area away from others and given a surgical mask to wear (if they can tolerate it) until they go home.

6. In a setting with an individual with ILI or confirmed influenza: during the period of possible contagion, staff who have \textit{voluntarily} reported that they 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 \textit{voluntarily} reported that they 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, if indicated; \textbf{AND}
   b. the staff person is asymptomatic and has been afebrile for at least 24 hours; \textbf{AND}
   c. There is no evidence of on-going transmission in the residence, area, wing or unit; \textbf{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.

7. Staff who are well but who have an ill family member at home with ILI or confirmed influenza can go to work as usual.

PROHIBITED STAFF INQUIRIES

Notwithstanding the importance of protecting individuals and staff from influenza and ILI, the Americans with Disabilities Act prohibits certain inquiries related to illness, suspected illness, and vaccinations. The following rules MUST be followed at all times:

1. An employer cannot ask a staff person if he or she has received the influenza vaccination.
2. An employer cannot require staff to receive the influenza vaccination.
3. An employer cannot measure a staff person’s body temperature unless pandemic influenza becomes widespread in the community as assessed by state or local health authorities or the CDC.
4. An employer cannot ask staff persons if they have a medical condition that renders them more vulnerable to influenza complications. An employer may, however, ask staff persons if they have influenza symptoms.

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:

- 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.
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 DDSOO.