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** ***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)***	
Infection Prevention (IP) Leadership/IP	• 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
Medical	• 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)
Nursing Respiratory Therapy Therapy	• 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
Environmental Services	• 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

Daily Safety Huddle Reminders: Direct Patient Care Departments (Department heads communicate daily to staff throughout entire Outbreak period)	• 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. ➢ 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
Staffing Review	Review staffing for the duration of the outbreak for the following teams: Nursing, Therapy, Respiratory Therapy, Materials Management and Environmental Services

Acute Respiratory Outbreak LEVEL 2: (In addition to LEVEL 1 above) Three laboratory confirmed positive cases (e.g., COVID-19, 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 ≥ 100°F OR 2° above the established baseline for that resident).	
Infection Prevention (IP) Leadership/IP	• 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: ➢ 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.
Medical	• 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
Nursing Respiratory Therapy Therapy	• 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
Pharmacy	Clean out bins with Oxivir 1 or bleach wipes.
Materials Management	Ensure adequate product for increased glove, gown, mask, and disinfectant wipes.
All Departments	Daily IP reminder same as Level 1 for Direct Patient Care Departments

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	
Infection Prevention (IP) Leadership/IP	• 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.
Medical	Increase frequency of PEWS scoring and vital signs to Q8 hour for exposed and known positive individuals
Nursing Respiratory Therapy Therapy	• 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
Environmental Services	• 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
Marketing and Public Relations	Notify all employees about outbreak.
Safety/ Security	Post signage at entrances to unit informing visitors about outbreak.
Leadership Patient/ Resident Care Coordination Family Faculty	• 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 DCPP about outbreak • Leadership of all disciplines: Monitor compliance with all Infection Prevention activities (hand hygiene, PPE donning/doffing, equipment cleaning)

Management of COVID positive and exposed Patients/Residents

A. **<u>Patient/Resident exposed to COVID-19:</u>** Prolonged close contact during the 48 hours prior to symptom onset or if asymptomatic date of positive test.

- A close contact is considered any patient/resident/visitor having 15 cumulative minutes of exposure at a distance of less than 6 feet to an infected person during a 24-hr period or had direct contact with infectious secretions with inadequate PPE. They should be considered potentially exposed regardless of whether either/both of them were wearing masks.
- Date of exposure is day 0

1. Asymptomatic close contact COVID exposures:

a) All identified close contact COVID exposures require testing:

- Testing (antigen or PCR) is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, 48 hours after the second negative test. **Testing will typically be on day 1 (where the day of exposure is day 0), day 3, and day 5.**
- A patient/resident who has clinically recovered from confirmed SARS-CoV-2 infection in the last 30 days typically does not require COVID testing unless they develop symptoms of COVID-19.
- A patient/resident who has clinically recovered from confirmed SARS-CoV-2 infection in the last 31-90 days should be considered for testing. however, an antigen test instead of a PCR is recommended. This is because some people may remain PCR positive but not be infectious during this period.

b) In general, room restrictions are not required and exposed patients/residents should be encouraged to wear a mask for 10 days following the exposure when in the presence of others. *

c) Special Droplet/Contact Precautions may be considered when the patient/resident is:

- Moderately to severely immunocompromised
- Residing on a unit with others who are moderately to severely immunocompromised, and/or
- Residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions
  - ➢ Asymptomatic patients/residents placed in Special Droplet/Contact Precautions can be removed from precautions after day 7 following the exposure

** Because mask use is not recommended for children ages younger than 2 years and may be difficult for very young children or for individuals with disabilities who cannot safely wear a mask, consider other prevention strategies when the COVID-19 hospital admission level is medium or high or in response to an outbreak. Consider implementing universal indoor mask use for staff and visitors.*

B. **<u>Patient/Resident COVID-19 test positive:</u>**

1. Patient/Resident may be moved to a private negative pressure room, the door should be kept closed (if safe to do so) and cared for by staff using personal protective equipment which includes an N95 mask, eye protection, gowns and gloves until criteria to discontinue is met:

a) Patients/Residents with mild to moderate illness who are not severely immunocompromised:

- At least 10 days (up to 20 days for severe or critical illness or those who are severely immunocompromised) have passed since symptoms first appeared and
- At least 24 hours have passed since last fever without the use of fever-reducing medications and

- Symptoms (e.g., cough, shortness of breath) have improved

b) Therapies can occur at the bedside wearing full personal protective equipment (N95, eye protection, gown and gloves).

C. <u>All admissions:</u>

a) Limit testing for COVID-19 to symptomatic patients/residents or patients/residents deemed as a close COVID contact. This will apply to all patients/residents admitted to the units as well as patient/resident transfers. Exceptions to this approach are at the discretion of the medical provider for unique situations.

D. <u>Visitor(s) of COVID positive patients/residents:</u>

1. The visitor shall wear the following personal protective equipment while in the patient's/resident's room:
   - Facemask (not N95), Eye protection, Gown and Gloves
   - Parents who stay overnight are not required to wear PPE to sleep but they must fully understand the risk level

- The surgical facemask covering must be worn properly covering both the nose and mouth at all times
- Instruct visitor to perform hand hygiene before donning PPE and after doffing PPE
- Visitors should be instructed on appropriate PPE use and told to remove gown and gloves prior to exiting the room and to remove the eye protection and facemask immediately outside the room and perform hand hygiene. A new surgical mask must be used when outside the patient/resident room.
- Preferably, visitor should use the bathroom inside the patient's/resident's room
- Remain in room as much as possible
- Visitor must leave room during Aerosol Generating Procedures
- A parent/visitor who tested positive for COVID-19 may resume visitation if:
  - At least 10 days (up to 20 days for severe or critical illness or those who are severely immunocompromised) have passed since symptoms first appeared and
  - At least 24 hours have passed since last fever without the use of fever-reducing medications and
  - Symptoms (e.g., cough, shortness of breath) have improved

  OR if asymptomatic visitation can occur Day #11 after initial positive test

Visitors must contact the facility if they develop any signs or symptoms or test positive for COVID-19 within 14 days of their visit. If symptoms occur, self-isolate at home and contact their healthcare provider.

COVID Outbreak Reporting requirements to Local Health Departments

New Brunswick Inpatient Rehabilitation:

- ≥2 cases of laboratory-confirmed (RT-PCR or antigen) COVID-19 cases in patients occurring 4 or more days after admission for a non-COVID condition, who are epidemiologically linked (e.g., overlap on the same unit or ward, or cared for by same HCP) within a 7-day time period.
- ≥3 cases of laboratory-confirmed (RT-PCR or antigen) or suspect (detection of SARS-CoV-2 specific antigen by immunocytochemistry OR detection of SARS-CoV-2 RNA or specific antigen using a test performed without CLIA oversight) COVID-19 cases in HCP who are epidemiologically linked (e.g., having the potential to have been within 6 ft for 15 minutes or longer while working in the facility during the 7 days prior to the onset of symptoms and/or specimen collection date) AND no other likely source of exposure is identified for at least 2 of the cases.

Mountainside and Toms River Long Term Care:

- ≥1 facility-onset COVID-19 case in a patient/resident
  Facility-onset COVID-19 infection in a patient/resident is defined as a laboratory-confirmed diagnosis that originated in the facility. Does not apply to patients/residents who were positive for COVID-19 on admission to the facility and were placed into appropriate Transmission-Based Precautions (TBP) OR patients/residents who were placed into TBP on admission and developed SARS-CoV-2 infection (unless there is confirmation of possible transmission or exposure through a breach in PPE).
- ≥3 cases in HCP of laboratory-confirmed (RT-PCR or antigen) or suspect (detection of SARS-CoV-2 specific antigen by immunocytochemistry OR detection of SARS-CoV-2 RNA or specific antigen using a test performed without CLIA oversight) COVID-19 cases who are epidemiologically linked (e.g., having the potential to have been within 6 ft for 15 minutes or longer while working in the facility during the 7 days prior to the onset of symptoms) AND no other likely source of exposure is identified for at least 1 of the cases.

Outbreak Protocol Complete	
Infection Prevention Medical Leadership	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. Examples of one/two incubation periods: ➢ Rhinovirus/Enterovirus 6 days/12 days ➢ Parainfluenza 6 days/12 days ➢ Influenza 1-4 days/8 days ➢ Adenovirus – respiratory 14 days/28 days ➢ Sars-CoV2 – 14 days/28 days • 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. **Individual Discontinuation of Droplet/Contact or Special Droplet/Contact Precautions**: After 7 days (minimal)/COVID 10 days (minimum) • If ongoing transmission NOT evident on unit and one incubation period has passed: ➢ 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: ➢ Consider extending 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	• Meet with Environmental Services to facilitate moving patients out of room to allow for terminal cleaning and use of UV room disinfection
Environmental Services	• 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	• Check levels of supplies which may have been depleted during outbreak protocol
Safety/Security	• Remove Outbreak signage posted at points of entry
All	• All volunteers, schools of nursing and outside visiting group may return to LTC unit.
Therapy	If ongoing transmission NOT evident on unit and one incubation period has passed consider to: ➢ Reinstate outside school for previously positive patients/residents Outbreak over: ➢ 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	Email notification to families and DCPP when the outbreak is considered over as directed by Infection Prevention

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 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 *Emergency after hours: 732-745-3271*

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