Respiratory Pathogen Response Checklist in Nursing Homes and other Post-Acute Care Settings

NJHealth New Jersey Department of Health Communicable Disease Service

This checklist will aid in quickly responding to a respiratory illness at your facility in accordance with recommendations set forth by the CDC and NJDOH. For more detailed information on respiratory outbreak management, please refer to the New Jersey Department of Health Guidelines for the Control of Respiratory Virus Outbreaks in Long-Term Care and Other Institutional Settings.

Initial Measures
1. Upon identification of an acute respiratory infection in a patient/resident or healthcare personnel (HCP), take rapid action to prevent the spread to others and implement infection prevention and control strategies immediately. **a.** Investigate suspect case(s) **b.** Establish a case definition **c.** Prepare a line list of patients/residents and HCP cases **d.** Perform active surveillance to rapidly identify new cases **e.** Implement infection control measures. Once the etiology is identified, response efforts should be tailored based on the epidemiology of the specific pathogen.
2. Notify facility administration (Infection Preventionist, Medical Director, Infectious Disease Physician) and other necessary HCP of potential case(s)/outbreak of respiratory illness.
3. Report a suspected or confirmed respiratory outbreak to your local health department (LHD). Identify LHD contacts using the NJDOH Local Public Health Directory. Review the NJDOH How to Report a Disease and Communicable Disease Reporting Requirements.
4. Review and follow the facility outbreak response plan.
5. Notify patients/residents and their families, as appropriate, of the presence of a respiratory outbreak per facility policy and procedure. Refer to N.J. Stat. § 26:2H-12.87.

Check	Patient/Resident Management
☐	Place patients/residents who are symptomatic or have a positive viral test on transmission-based precautions (TBP) with appropriate signage outside the room. • Droplet Precautions for influenza (mask) – at least 7 days after illness onset or at least 24 hours since the last fever without the use of fever-reducing medications and respiratory symptom improvement, whichever is longer. • TBP for COVID-19 (N95 or higher, gown, gloves, eye protection) – at least 10 days since the first symptom, at least 24 hours since the last fever without the use of fever-reducing medications, and symptom improvement; or at least 10 days since first positive viral test for asymptomatic patients/residents. Duration of TBP can range from 10 to 20 days or more, depending on the severity of illness, immunocompromised status, and risk of other patients in the facility. ○ For the duration of empiric TBP for asymptomatic patients/residents following close contact with someone with SARS-CoV-2 infection, please refer to the CDC. • For other pathogen-specific recommendations for TBP, refer to Appendix A in the CDC Guideline for Isolation Precautions.
☐	Place the patient/resident in a single room. • If limited single rooms are available, patients/residents could remain in their rooms. • Explore CDC options to improve ventilation in the room. In-room high-efficiency particulate air (HEPA) cleaners may be considered. Review the NIOSH Improving Air Cleanliness. • Patients/residents confirmed positive with the same pathogen can be placed in the same room; review the facility's cohorting policy and procedure. • Exposed roommates should not be placed with new roommates if possible and should use source control when around others. The duration of source control can be determined by the incubation period for the identified pathogen and consultation with the infectious disease team and state/local health department.
	Assess the number of ill patients/residents and consider designating entire units within the facility with dedicated HCP to contain the etiology of the outbreak.

Check	HCP Management
☐	HCP who presents with acute respiratory symptoms should discontinue patient/resident care, wear source control, and report to their supervisor. Evaluate HCP sick policy to ensure HCP who are sick do not report to work and follow guidance for return to work concerning SARS-CoV-2, influenza, and other respiratory pathogens.
☐	Institute universal source control for HCP as per facility policy.
☐	For SARS-CoV-2, asymptomatic HCP with high-risk exposure should monitor for symptoms and wear source control while working for 10 days following exposure.
Check	**Testing and Surveillance**
☐	Investigate the cause of transmission and perform daily active surveillance during the respiratory season to identify additional patients/residents via symptom screening and contact tracing.

☐	Test patients/residents and HCP with signs or symptoms of respiratory illness as soon as possible.
	• Selection of diagnostic testing should depend on the suspected cause of infection, clinical judgment, and consultation with public health authorities.
	  ○ At a minimum, testing should include SARS-CoV-2 and influenza.
	  ○ Consider a full respiratory panel or other multiplex assay if respiratory syncytial virus (RSV) or other respiratory pathogens are circulating.

☐	For COVID-19, proactively test patients/residents and HCP who are asymptomatic on day 1, 3, and 5 following exposure; however, a broad-based approach (e.g., unit, floor, or other specific area[s] of the facility), testing all patients/residents every 3-7 days for 14 days from the last known positive, is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
Check	**Treatment and Prophylaxis**
☐	In consultation with the medical director, immediately initiate antiviral treatment for patients/residents with confirmed or suspected influenza, starting within two days of symptom onset. • Antiviral chemoprophylaxis can be considered or offered to unvaccinated HCP who care for patients/residents at a higher risk of influenza complications.
☐	Immediately initiate chemoprophylaxis for non-ill patients/residents exposed to a symptomatic individual or for those residing on the unit with an influenza outbreak, regardless of vaccination status; continue chemoprophylaxis for at least 2 weeks and continue for at least 7 days after the last known case.
☐	Provide treatment for patients/residents with mild to moderate COVID-19 or those at risk of severe COVID-19 in consultation with an infectious disease physician.
Check	**Vaccinations**
☐	Educate all eligible patients/residents and HCP on vaccination for the prevention of severe respiratory illness.
☐	Encourage everyone to remain up to date with the recommended influenza, COVID-19, and RSV vaccines.
Check	**Education, Auditing, & Competency**
☐	Educate HCP on the pathogen, mode of transmission, standard and transmission-based precautions, movement restrictions, and environmental measures.
☐	Ensure current competency assessment of infection prevention and control elements and implement routine auditing with feedback to staff to monitor for compliance. • Refer to the NJDOH Infection Prevention & Control: Observational Audit vs. Competency Assessment.
Check	Visitation
☐	Establish a process to identify symptomatic individuals entering the facility. • Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias). Alerts should include instructions about current infection prevention and control recommendations (e.g. when to use source control).
☐	Educate visitors about their potential to be exposed to respiratory illness in the facility; symptomatic visitors should be asked to defer their visit if it is non-urgent until they are no longer infectious and offered a remote visit or another alternative.
Check	**Environmental Measures**
☐	Review environmental cleaning and disinfection protocols and evaluate products for effectiveness against the pathogens of concern.
☐	Conduct audits of routine cleaning and disinfection of high-touch surfaces and shared medical equipment.
☐	Increase the frequency of routine cleaning and disinfection facility-wide, especially in areas/units of increased transmission and communal congregation.

Additional Resources:

NJDOH Guidelines for the Control of Respiratory Virus Outbreaks in Long-Term Care and Other Institutional Settings

CDC Infection Control Guidance: SARS-CoV-2

CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2

CDC Viral Respiratory Pathogens Toolkit for Nursing Homes

CDC Infection Prevention and Control Strategies for Seasonal Influenza in Healthcare Settings

CDC Immunizations for Respiratory Viruses Prevention