Infection Prevention & Control guidelines for assessment & management of Acute Respiratory Infection (ARI)

Any patient presenting with or undergoing investigation for an **ARI**, should be **managed** using the framework below.
APPLY droplet precautions for all ARIs; add airborne precautions for AGPs[1] and COVID-19. **NOTIFY** Infection Prevention and Control (IPAC) or relevant team (as per local process)

HAND HYGIENE COMPLIANCE REMAINS ESSENTIAL TO PREVENT HEALTHCARE TRANSMISSION

Category A Health workers (HW) MUST be vaccinated[1]. Unvaccinated workers (due to medical conditions) in Category A roles must always wear a surgical mask while providing care.

Management guide ED/clinic

- screen all patients for symptoms of ARI and other communicable diseases
- all patients with an ARI to wear a mask on presentation and transit if able or tolerated, patients to be placed in a separate area
- rapid clinical assessment and testing with decision to admit or discharge after clinical assessment
- use testing strategies for early diagnosis and treatment
- implement transmission-based precautions
- patients with ARI should be isolated in a single room if available OR cohorted based same pathogen or on presenting symptoms
- spacers are the preferred method for the safe delivery of inhaled medications
- communicate acute respiratory virus* risk with relevant department for admitted patients prior to any transfer
- HWs to wear surgical mask or P2/N95 respirator and eye protection based on risk assessment.

Testing strategy:

1. COVID-19 RAT, if RAT negative PCR
2. respiratory triplex PCR (COVID-19, flu A/B, RSV) or multiplex test
3. extended respiratory panel only if recommended by treating team.

Management guide Ward areas

- isolate patients with suspected or confirmed ARI including COVID-19
- cohorting should only occur based on known results (same respiratory pathogen), risk assessment and as directed by IPAC or Infectious Diseases (ID) team
- implement transmission-based precautions for all patients with an ARI
- if patients with ARI - requiring aerosol generating procedures (AGPs) implement airborne precautions
- patient with an ARI to wear surgical mask when outside their designated patient zone if able or tolerated
- adhere to hand hygiene, respiratory hygiene, and cough etiquette
- spacers are the preferred method for the safe delivery of inhaled medications
- implement enhanced cleaning of the environment and patient equipment with a TGA approved disinfectant
- communicate acute respiratory virus* risk with the relevant department during intra and inter hospital transfer
- identify and manage vulnerable patients as per the risk assessment
- additional controls required during an outbreak or increased community transmission.

Precautions and isolation period

Ending droplet precautions

Influenza

3 days after commencement of anti-influenza medication[2] AND resolution of ARI symptoms for ≥24 hours (afebrile without the use of antipyretics)

OR

5 days after onset of respiratory symptoms if patient not treated with anti-influenza medication AND afebrile /asymptomatic for ≥24 hours see CDNA National Guidelines.

If pregnant woman delivers within the above time frames:

- baby to be isolated with mum and mum to be instructed on droplet precautions.

COVID-19**

De-isolate according to current CEC IPAC COVID-19 manual.

Respiratory syncytial viruses (RSV)

At the minimum:

- adults – must be asymptomatic for 24hours and clearance documented in eMR
- children – must be asymptomatic AND reviewed by medical team. Results of review to be documented in patients eMR.

IPAC service monitoring and consultation

- notification to IPAC of patient admission by ED/Patient Flow/AHM# as per local process
- ID referral and advice as necessary should occur as per the current process
- notify IPAC if new cases of ARI or COVID-19 occur during admission that were not present at time of admission and/or if 2 or more patients or HWs are identified with an ARI (in relation to cross infection/ outbreak risk).

Ensure:

❒ Process in place for IPAC to monitor ARI cases in ED and clinical areas to optimise support bed allocation and patient flow

❒ IPAC attendance at patient flow huddles/ meetings

❒ IPAC to review patient reports and lab results

❒ ARI activity report to patient flow and executive teams

❒ Escalate risks/outbreaks as per CEC Triggers for escalation

Site IPAC Contact: _____

District IPAC contact (if available):

_____

Notes:

[1]Vaccination Compliance: Category A HWs MUST be vaccinated against influenza (annual), all unvaccinated workers (due to medical condition) in Category A roles must wear a surgical mask at all times while providing care (June 1 – Sept 30) (Vaccination takes approximately 2 weeks for antibodies to develop and provide protection, therefore if the 2-week period is not reached by the 1 June, staff are required to wear a mask until this period is reached)

[2]anti-influenza medication should be commenced within 48hrs of symptom onset

*Acute respiratory viruses include respiratory syncytial virus, parainfluenza, rhinovirus, metapneumovirus, adenoviruses, and so forth

** Local Risk assessment of cases and transmission will be guided by the Response and escalation framework; state alert level will be directed by the NSW Health Secretary

#AHM = After Hours Manager

Read in conjunction with 'Winter Strategy – Testing and IPAC for acute respiratory infection (ARI)', 'Supporting bed allocation and patient flow' documents, Infection Prevention and Control Manual Acute Respiratory Infections including COVID-19 For acute and non-acute healthcare settings, Management of patient or visitor exposed to acute respiratory infections including COVID-19, and COVID-19: Managing Health Worker Exposures and Return to Work in a Healthcare Setting.