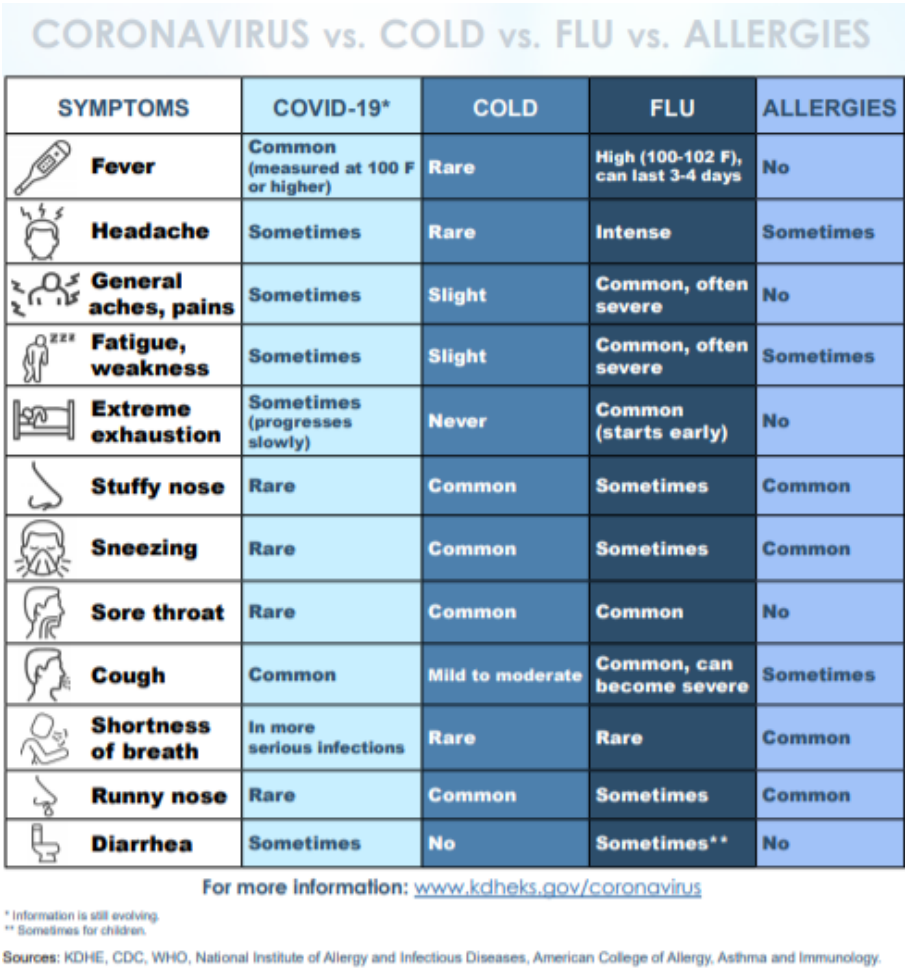
Influenza/COVID-19 Co-Infection Outbreak Plan

Vaccination Program:

- ☐ Order influenza vaccines with particular focus on high dose formulations, if available
- ☐ Signed flu vaccine consents completed for all residents with risk/benefits provided
- ☐ Influenza vaccinations should be administered by the end of October (Vaccination later in the year may be beneficial if refused earlier in the year or in the event of outbreak)
- ☐ Facility staff to have vaccination performed (recommend mandate among staff)

Symptoms:



CORONAVIRUS vs. COLD vs. FLU vs. ALLERGIES

SYMPTOMS	COVID-19*	COLD	FLU	ALLERGIES
Fever	Common (measured at 100 F or higher)	Rare	High (100-102 F), can last 3-4 days	No
Headache	Sometimes	Rare	Intense	Sometimes
General aches, pains	Sometimes	Slight	Common, often severe	No
Fatigue, weakness	Sometimes	Slight	Common, often severe	Sometimes
Extreme exhaustion	Sometimes (progresses slowly)	Never	Common (starts early)	No
Stuffy nose	Rare	Common	Sometimes	Common
Sneezing	Rare	Common	Sometimes	Common
Sore throat	Rare	Common	Common	No
Cough	Common	Mild to moderate	Common, can become severe	Sometimes
Shortness of breath	In more serious infections	Rare	Rare	Common
Runny nose	Rare	Common	Sometimes	Common
Diarrhea	Sometimes	No	Sometimes**	No

For more information: www.kdheks.gov/coronavirus

* Information is still evolving.
** Sometimes for children.

Sources: KDHE, CDC, WHO, National Institute of Allergy and Infectious Diseases, American College of Allergy, Asthma and Immunology.

K-CART
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Isolation:

Influenza-like illness requires immediate isolation of patient and roommate, if applicable, and must commence with testing for Influenza A&B, COVID-19, and RSV

Confirmed Influenza Alone:

- Isolation to current room with proper treatment with available agents -DO NOT cohort influenza alone patients
- Residents with influenza alone should not be isolated on COVID-19 units
- Standard and Droplet isolation should be instituted until 7 days after symptom onset or 24 hours after last fever
- Standard surgical facemask is sufficient for isolation of confirmed influenza cases (use KN95 or N95 if suspicion for or confirmed COVID-19 in facility)
- If two or more laboratory confirmed cases of influenza in a single unit or community, influenza control measures should be implemented which may include: consult public health department, limit large group activities, hold new admissions to facility, administer influenza vaccine to those unvaccinated and isolate staff to work solely in units where active outbreak is present

Confirmed co-infection with COVID-19 and Influenza:

- Isolation to a COVID-19 unit
- Treatment for influenza should be started and treatment for COVID-19, if warranted
- Persons entering the room should be limited to designated staff who will only care for patients that are known to be positive for COVID-19
- PPE usage should be initiated to include gown, gloves, mask, and face shield. If available, N95 or higher respirators should be used
- Local and state health departments should be notified, as should CDC per 12-hour requirement
- Patient should be evaluated on a regular basis to identify clinical changes, including decrease in oxygen saturation, decrease in blood pressure, and increase in pulse. Vitals should be taken at least every 6 hours

Testing:

- Molecular testing (Rapid Molecular Testing or RT-PCR via Nasal, Nasopharyngeal specimen) for Influenza, COVID-19, and RSV should be conducted for involved unit regardless of symptoms (particular focus on those with symptoms)
- Antigen testing may be performed if available but consideration should be made to confirm with molecular testing for both influenza and COVID-19 if symptoms are present.

Treatment:

- Treatment dosing for influenza should be initiated prior to confirmed laboratory diagnosis if influenza is suspected
- Oral oseltamivir (Tamiflu) in pill or suspension, Zanamivir (Relenza) as an inhaled powder, one dose of intravenous peramvir (Rapivab) and single dose baloxavir marboxil (Xofluza) may all be used. Amantadine and rimantadine are not recommended due to resistance. Renal dosing is appropriate for medications listed.

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Prophylaxis:

- Pre-approved orders on file from physicians in the event of an outbreak to initiate prophylactic and treatment dosing as needed is strongly encouraged. Osteltamivir is the recommended chemoprophylaxis medication and should be initiated to all residents on the unit if a confirmed case of influenza is accompanied by another resident with influenza-like illness acquired within 72 hours. Chemoprophylaxis should continue for 14 days minimum and at least until 7 days past the last known influenza case on the unit.
- Chemoprophylaxis for staff should be considered if caring for particularly high-risk populations, if influenza vaccination is contraindicated in staff member, or if staff member is at high risk of complications from influenza.

Surveillance:

- Daily surveillance for respiratory signs/symptoms of residents, staff and visitors should be performed if one case of influenza is found and continued until 7 days after the last confirmed case of influenza.

Reference: https://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm