

Official websites use .gov A .gov website belongs to an official government organization in the United States. Secure .gov websites use HTTPS A lock () or https:// means you've safely connected to the .gov website. Share sensitive information only on official, secure websites. The following practices should be considered when SARS-CoV-2 and Influenza viruses are found to be co-circulating based upon local public health surveillance data and testing at local healthcare facilities. While these considerations are specific to care of residents residing in nursing homes, some practices could be adapted for use in other long-term care settings (e.g. assisted living communities). Place symptomatic residents in Transmission-Based Precautions using all recommended PPE for care of a resident with suspected SARS-CoV-2 infection.¹ Because some of the signs and symptoms of influenza and COVID-19 are similar, it may be difficult to tell the difference between these two respiratory diseases based on symptoms alone. Residents in the facility who develop symptoms of acute illness consistent with influenza or COVID-19 should be moved to a single room, if available, or remain in their current room, pending results of viral testing. They should not be placed in a room with new roommates, nor should they be moved to a COVID-19 care unit (if one exists), unless they are confirmed to have COVID-19 by SARS-CoV-2 testing. Nursing home residents, including older adults, those who are medically fragile and those with neurological or neurocognitive conditions, may manifest atypical signs and symptoms of SARS-CoV-2 or influenza virus infection and may not have fever. Older adults with COVID-19 may not always manifest fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, and loss of taste or smell. Test any resident with symptoms of COVID-19 or influenza for both viruses. Because SARS-CoV-2 and influenza virus co-infection can occur, a positive influenza test result without SARS-CoV-2 testing does not exclude SARS-CoV-2 infection, and a positive SARS-CoV-2 test result without influenza testing does not exclude influenza virus infection. Stay connected with

the healthcare-associated infection program in your state health department, as well as your local health department, and their notification requirements. The local public health and state health departments should be notified of every suspected or confirmed influenza or SARS-CoV-2 outbreak in a long-term care facility, especially if a resident develops influenza while on or after receiving antiviral chemoprophylaxis.

A) Obtain respiratory specimens for influenza and SARS-CoV-2 testing.^{2,3} Check the manufacturer's package insert for approved respiratory specimens. There are no FDA-cleared influenza diagnostic assays that utilize saliva specimens. If available, multiplex nucleic acid detection assay for SARS-CoV-2, influenza A and B viruses can be performed onsite, or at an offsite clinical laboratory.^{4,5} Two different specimens may need to be collected if a multiplex nucleic acid detection assay including both influenza viruses and SARS-CoV-2 is unavailable.^{2,3}

B) Test for SARS-CoV-2 by nucleic acid detection⁵ OR by SARS-CoV-2 antigen detection assay.⁶ Because antigen detection assays have lower sensitivity than nucleic acid detection assays for detecting SARS-CoV-2 in upper respiratory tract specimens, a negative SARS-CoV-2 antigen detection assay result in a symptomatic person does not exclude SARS-CoV-2 infection and should be confirmed by either a negative result from a SARS-CoV-2 nucleic acid detection assay or a second negative antigen test result on an upper respiratory tract specimen collected 48 hours after the first negative test result. ⁷ If the second antigen test is negative, per FDA guidance, a third antigen test could be considered if there is a high clinical suspicion of COVID-19. New SARS-CoV-2 infection identified in HCP or nursing home-onset infection in a resident should prompt additional testing of other residents and staff in the facility.¹

C) Test for influenza by rapid influenza nucleic acid detection assay;⁸ if a rapid influenza nucleic acid detection assay is not available, perform rapid influenza antigen detection assay.⁹ Because of lower sensitivities to detect influenza viruses, confirm negative rapid influenza antigen detection test results in a symptomatic person by influenza nucleic acid detection assay.

D) Test for other

respiratory pathogens; if residents with acute respiratory illness test negative for both influenza and SARS-CoV-2 per the above testing recommendations, consider additional viral (e.g., RSV) or bacterial testing based on respiratory pathogens known or suspected of circulating in the community.

Placement Decisions

A) Residents confirmed to have SARS-CoV-2 infection should be placed in a single room, if available, or housed with other residents with only SARS-CoV-2 infection. If unable to move a resident, he or she could remain in the current room with measures in place to reduce transmission to roommates (e.g., optimizing ventilation). Residents found to have SARS-CoV-2 and influenza virus co-infection should be placed in a single room or housed with other co-infected residents. These residents should continue to be cared for using all recommended PPE for the care of a resident with SARS-CoV-2 infection.¹ If single room isolation or cohorting of residents with SARS-CoV-2 and influenza virus co-infection is not possible, consult with public health authorities for guidance on other management options (e.g., transferring the resident; placing physical barriers between beds in shared rooms and initiating antiviral chemoprophylaxis for roommates to reduce their risk of acquiring influenza, improving ventilation by adding HEPA filters).

B) Residents confirmed to have influenza virus infection only should be placed in a single room, if available, or housed with other residents with only influenza virus infection. If unable to move a resident, he or she could remain in the current room with measures in place to reduce transmission to roommates (e.g., optimizing ventilation, antiviral chemoprophylaxis for exposed roommates). Residents with influenza should be placed in Droplet Precautions, in addition to Standard Precautions. As part of Standard Precautions, eye protection should be worn if splashes or sprays are anticipated (e.g., the resident is coughing or sneezing). Because it can be difficult to anticipate potential for coughs and sneezes, facilities might consider having healthcare personnel routinely wear eye protection for the care of residents with influenza.

C) Residents with symptoms of acute respiratory illness who are determined to have neither SARS-CoV-2

nor influenza virus infection should be cared for using Standard Precautions and any additional Transmission-Based Precautions based on their suspected or confirmed diagnosis.¹⁰ Clinical Management¹¹ A) Prescribe antiviral treatment as soon as possible if influenza testing is positive OR prescribe empiric antiviral treatment based upon a clinical suspicion of influenza while test results are pending for symptomatic residents.¹¹⁻¹³ Antiviral treatment for influenza should be administered as soon as possible following clinical diagnosis. B) Properly manage residents with SARS-CoV-2 infection. Recommendations for treatment of persons with COVID-19 are available from the National Institutes of Health COVID-19 Treatment Guidelines Panel. Treatment should be administered as soon as possible for nursing home residents with mild-to-moderate COVID-19 who are at high risk of progression to severe COVID-19. See the latest recommendations on Therapeutic Management of Nonhospitalized Adults With COVID-19. C) For adult patients with suspected community-acquired pneumonia who do not require hospitalization, see antibiotic treatment recommendations from the American Thoracic Society-Infectious Diseases Society of America Adult Community-acquired Pneumonia Guidelines.¹⁴

D) Influenza antiviral chemoprophylaxis considerations.^{11,12,15} The facility should promptly initiate antiviral chemoprophylaxis with oral oseltamivir to all exposed individuals (e.g., roommates) of residents with confirmed influenza. When at least 2 residents are ill within 72 hours of each other with laboratory-confirmed influenza, the facility should expand antiviral chemoprophylaxis to non-ill residents living on the same unit as the residents with influenza (outbreak affected units), regardless of influenza vaccination status. Persons receiving antiviral chemoprophylaxis who develop signs or symptoms should be tested (see above) and switched to antiviral treatment doses pending results. E) Encourage influenza vaccination for unvaccinated residents and HCP. The facility should encourage influenza vaccination of all residents and staff. F)

Encourage residents and HCP to remain up to date with recommended COVID-19 vaccine doses. The facility should encourage all individuals to be up to date with all recommended COVID-19 vaccine doses, based upon the latest recommendations. G) Encourage RSV vaccination for unvaccinated residents aged 60 years and older, based upon shared decision-making. The facility should encourage RSV vaccination based upon discussions between the patient, the patient's family or guardian, and healthcare provider. H) Encourage pneumococcal vaccination for unvaccinated residents aged 65 years and older, and for younger high-risk individuals. The facility should encourage eligible high-risk residents to receive pneumococcal vaccination. I) Simultaneously administer the vaccines for which residents and HCP are eligible. In general, simultaneous administration of vaccines remains a best practice. Providers should continue to simultaneously administer the vaccines for which a patient is eligible, including COVID-19, influenza, and pneumococcal vaccines. Simultaneous administration of RSV vaccine with other vaccines for older adults is also acceptable. When deciding whether to simultaneously administer other vaccines with RSV vaccine on the same day, providers should consider whether the patient is up to date with recommendations for currently recommended vaccines, the feasibility of administering additional vaccine doses later, risk for acquiring vaccine-preventable disease, vaccine reactogenicity profiles, and patient preferences. To receive weekly email updates about Seasonal Flu, enter your email address:

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<https://www.cdc.gov/flu/professionals/diagnosis/testing-management-considerations-nursinghomes.htm>