Infection control guidance for influenza-like illness:

Surveillance:
On admission:
As influenza activity becomes widespread, patients with influenza-like illness (fever ≥ 100.0°F and sore throat and/or cough) are very likely to have influenza.

Perform influenza and other viral testing on all patients admitted with the following diagnoses:
- Influenza or rule-out influenza
- Influenza-like illness
- Pneumonia or rule-out pneumonia
- Bronchiolitis
- Exacerbation of underlying pulmonary disease (e.g. asthma, cystic fibrosis, COPD)
- Fever of unknown origin
- Cough
- Dyspnea/shortness of breath/respiratory distress
- CHF or CHF exacerbation, associated with fever
Perform testing on all patients being treated with antivirals for influenza

During hospitalization:
Admitted patients are at risk of nosocomial influenza transmitted by visitors and healthcare workers
For admits and all inpatients with new onset of fever during hospitalization, (T > 37.8°C) order viral respiratory panel via nasopharyngeal swab (order code RESPFA) as part of routine fever workup. Consider nosocomial influenza in all patients with new onset fever in hospital and isolate accordingly.

Infection control:
Note: CDC HICPAC has updated guidance to concur with WHO guidelines that droplet precautions are in effect for all patients with ILI, with expanded precautions only for specified aerosol-producing procedures. Previous CDC guidance no longer applies. The following is also in concordance with NMDOH guidelines.

Inpatient settings:
Patients with influenza-like illness should be placed in droplet precautions pending further evaluation and diagnosis. Note-the term “respiratory precautions” is not a current term.
For all patients with influenza-like illness, the new signage for droplet and expanded precautions should be used.
Droplet precautions for ILI are house patient in private room, surgical/procedure masks worn on room entry, good hand hygiene practice, gloves plus gown as needed for extensive contact with respiratory secretions.
Expanded precautions for all patients with ILI should be instituted during aerosol-generating procedures (open suction, CPR, endotracheal intubation, extubation, sputum induction or bronchoscopy) HCW must wear N-95 mask and eye protection. Note: administration of nebulized medication is not an aerosol-generating procedure.
To perform the nasopharyngeal swab, the clinician should don a surgical mask on room entry, and gloves.

**Outpatient settings:**
*Respiratory hygiene* should be instituted for all patients with cough: place a mask on the patient, encourage hand hygiene and use of tissues.

**Signage:**

**Visitors: Some restrictions apply**
Please see a nurse for instructions before entering the room. Surgical mask required with hand hygiene on entry and exit. Protective equipment is not available for children <12 years.

**Droplet Precautions**

**Before entering the room:**
- Hand Hygiene
- Don Surgical Mask
- Don *Gown, Gloves and Eye Protection* depending on task and risk of exposure to body fluids
- Expanded Precautions indicated for aerosol generating procedures – turn sign over

**On exit from room:**
- Remove and Discard PPE
- Hand Hygiene
- Disinfect all shared equipment.

Alternatives: Cone-style surgical mask or ear-loop procedure mask. (N-95 respirators are NOT required)
Discontinuation of precautions:
Expanded precautions may be discontinued if an alternate diagnosis is made that does not require these precautions (such as RSV). Nasopharyngeal swab results are not sufficiently sensitive to guide decisions about discontinuation of precautions.
If influenza is documented or highly suspected, precautions should continue for 7 days or at least 24 hours of no fever off antipyretics, whichever time is longer.

EXCEPTION: for immunocompromised patients such as those with HIV or immunosuppression due to medication, viral shedding may be prolonged. Precautions should continue until the patient is discharged or three negative viral cultures or PCR results are received.

Patient placement
Cohorting: under conditions where cohorting is necessary, patients documented to have the same respiratory viral pathogen may be cohorting together.

Visitation: all visitors should be screened for illness. Children cannot enter the rooms of patients in precautions of any kind. Visitors for patients with ILI should be provided with a surgical mask and instructed in hand hygiene. Visitors for patients with ILI should be provided with information regarding high risk persons so that they may elect not to visit (eg pregnant women) Pediatric areas should refer to guidelines developed previously for families.

Transport: patients with ILI should put on a clean gown, surgical mask and perform hand hygiene prior to transport in the hospital.

Important facts about testing for influenza:
A recent evaluation of rapid influenza tests by CDC indicated that the overall sensitivity was low (40%–69%) among all specimens tested and declined substantially as virus levels decreased.
(These findings indicate that, although a positive rapid test result can be used in making treatment decisions, a negative result does not rule out infection with novel influenza A (H1N1) virus.)

**If treatment of possible or documented influenza is considered, oseltamivir should be started within 48 hours of onset of symptoms.** Treatment decisions should not wait until test results are available. Oseltamivir is strongly recommended for pregnant women with suspected influenza, where the risk of complications of influenza outweigh any potential risks of drug therapy.

**Specific testing for H1N1:** State Laboratory Division will be testing a specimens from inpatients only for epidemiologic purposes; results are not available in time to guide therapy or other decisions. *Clinicians should assume that all influenza A is H1N1 based on current epidemiology.*