

## **Guidance on the transfer of hospitalised patients diagnosed with influenza or other respiratory viruses from an acute hospital to a residential care facility**

### **1. Guidance on the transfer of patients diagnosed with influenza or other respiratory viruses from an acute hospital back to a residential care facility (RCF)**

Residents admitted to hospital with a diagnosis of influenza or other respiratory viral infections (e.g. respiratory syncytial virus (RSV), human metapneumovirus) including those who acquire infection while hospitalised may remain infectious to others while they continue to shed viable virus. This should be taken into consideration when discharging patients to a RCF as infection control measures will be needed to prevent onward transmission to others during the period of infectivity.

**Residents, including the frail elderly, may be discharged from hospitals at any point when the following criteria are met<sup>1</sup>:**

- In the opinion of the treating physician, the resident's clinical condition has improved sufficiently so that they can be discharged back to the RCF. Complete resolution of symptoms or a minimum period of treatment is not required prior to transfer.
- Appropriate [infection control measures](#)<sup>2</sup> to prevent transmission of infection including single room or cohorting with other residents with laboratory confirmation of the same respiratory viral infection will be continued in the RCF if the period of infectivity has not yet been completed by the time of discharge. Isolation is continued while the resident is symptomatic - usually a minimum of five days although in some circumstances, this may be longer (see Section 4 below).
- Any on-going treatment course (e.g., influenza antivirals) will be completed after discharge
- **Monitor closely for signs of clinical deterioration**
- The discharge is planned, in accordance with local hospital policy

**Note:** If a RCF has concerns about accepting a particular resident, they should discuss this with the transferring hospital's infection Prevention and Control Team (IPCT) and/or their local Department of Public Health.

**The above principles apply, regardless of the number of influenza cases being reported by individual hospitals, including those experiencing influenza outbreaks.**

## **2. Guidance on the transfer of residents hospitalised for reasons unrelated to influenza or respiratory viral infections to a residential care facility that is currently experiencing an outbreak of influenza or other respiratory virus infection**

Residents who are considered fit for discharge and are hospitalised for reasons not related to influenza or other respiratory viral infections should only be discharged back to a RCF that is experiencing a respiratory viral outbreak after careful assessment of the potential risk of exposure to cases of infection has been undertaken.

The assessment of the likelihood of exposure to infection should take into account:<sup>1</sup>

- The affected sections of the RCF
- The planned location of the resident within the RCF
- The overall geography of the RCF
- The likelihood of contacts between residents
- Cross-over of staff or visitors between affected and unaffected sections of the RCF
- Compliance with infection control precautions by RCF staff (including influenza vaccine uptake)
- The fact that the pathogens causing outbreaks in RCFs may also be circulating in the hospital placing the resident at potential risk if they remain in the hospital when fit for discharge

## **3. Guidance on the transfer of patients who had close contact with a case(s) of flu while hospitalised and require transfer to a RCF**

Residents hospitalised for reasons unrelated to influenza or respiratory viral infections and who have had close contact with a confirmed case(s) of influenza while hospitalised may be transferred to a RCF at any point, so long as the following criteria are met:

- Appropriate infection control measures to prevent transmission of infection including single room isolation or cohorting with other residents who are confirmed contacts of a laboratory confirmed case of the same respiratory virus will be continued in the residential facility
- The date of last exposure to a confirmed influenza case while in hospital needs to be ascertained. After exposure to an infectious case, a person may incubate the virus for up to two days and be potentially infectious to others for a further two days prior to symptom onset. Therefore, upon transfer to the RCF, the resident who has been exposed to influenza should be accommodated in a single room for four days after the date of last exposure to a confirmed influenza case. Duration of confinement may be less than four days if the patient was identified as a flu contact before being discharged from hospital. Staff in the RCF should monitor the returning resident for onset of influenza like illness (ILI) symptoms during this period.

- Anti-viral chemoprophylaxis if commenced is continued in the RCF. For further information on chemoprophylaxis ([see P. 33-37 of Public Health Guidelines on the Prevention and Management of Influenza Outbreaks in Residential Care Facilities in Ireland 2019/2020](#)).<sup>3</sup> Chemoprophylaxis is recommended for individuals in at risk groups ([see at-risk groups for influenza antivirals](#)).<sup>4,5</sup> who have had recent close contact with a person with influenza or influenza-like illness in the same household or residential setting. A close contact is defined as having cared for or lived with a person who has confirmed, probable or suspect influenza or having been in a setting where there is a high likelihood of contact with respiratory droplets and/or body fluids of such a person, including having talked face-to-face with them.<sup>6</sup>

**The above principles apply regardless of the number influenza cases being reported by individual hospitals including those experiencing influenza outbreaks.**

#### **4. Guidance on the duration of infection control precautions for RCF residents with respiratory viral infections**

Influenza cases sometimes shed virus for a lengthy period following infection.<sup>7</sup> Children are known to excrete influenza virus in higher titres and for longer than adults, however there are circumstances under which viral shedding in the frail elderly may also be prolonged.<sup>8,9</sup>

The following risk factors have been associated with prolonged shedding of influenza virus:

- Cases with other major medical conditions<sup>9</sup> such as malignancy, chronic lung disease, renal disease, heart disease, liver disease, stroke
- Cases with an impaired immune system following systemic corticosteroid use,<sup>8</sup> chemotherapy, organ or bone marrow transplantation or those with advanced HIV/AIDS infection<sup>10</sup>
- Cases diagnosed with pneumonia<sup>11</sup>
- Cases where antiviral therapy was started >48 hours after symptom onset<sup>9</sup>
- Case did not receive antiviral therapy<sup>8</sup>
- Case has persistent respiratory symptoms after five days of antiviral treatment<sup>9</sup>

It is currently not possible to give a definitive minimum period of isolation for residents with risk factors for prolonged shedding of influenza virus due to a lack of evidence. However, extending the isolation period from five to seven days would seem sensible.

Residents who do not have any of the above mentioned risk factors for prolonged shedding should remain on appropriate infection control precautions to prevent transmission of influenza, including a single room or cohorting until a minimum of five days after the onset of symptoms.

## References

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