



Purpose: To outline the required management of Viral Respiratory Illness (VRI) in the Long-Term Care (LTC) setting to prevent the transmission of organisms, reduce the incidence of infections and promote the health and safety of staff, residents, and visitors.

Cultural Safety and Humility: Island Health offers programs and services on the unceded and traditional territories of the Coast Salish, Nuu-chah-nulth, and Kwakwaka’wakw Peoples.

As a signatory to the 2015 Declaration of Commitment to Cultural Safety and Cultural Humility, Island Health is committed to addressing the ongoing impacts of colonialism and Indigenous-specific racism in order to provide a culturally safe, inclusive, healthy and respectful environment.

The organization is committed to strengthening diversity, equity, and inclusion to enable excellence in health and care for everyone, everywhere, every time. Through these commitments, Island Health strives to deliver the highest possible standard of care and to promote safe workplaces.

Scope:

- **Audience:**
 - Staff and medical staff of Island Health and its subsidiaries; including affiliated and licensed LTC facilities.
 - Contractors.
 - Physicians, dentists and other allied health professionals with an Island Health appointment and privileges or who contract with Island Health who provide care or services on behalf of Island Health.
 - Medical residents.
 - Students, trainees, and educators.
 - Volunteers.
- **Environment:**
 - Island Health-wide.
 - All LTC care settings across the continuum of care.
- **Indications** (when this document is to be used):
 - For management of VRI within all LTC facilities.
- **Exceptions:**
 - All acute care settings
 - All urgent and primary care settings
 - All community or other congregate living settings outside of those identified above.

Outcomes:

- Provide safe and effective care for residents and prevent the transmission of VRI in LTC settings.

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Last Revised:	2025-JAN-14	Last Reviewed:	2025-JAN-14	First Issued:	2025-FEB-27
					Page 1 of 11



1.0 Background

- Viral respiratory illnesses (VRIs), such as that caused by influenza, coronavirus, respiratory syncytial virus (RSV), and ‘common cold’ viruses are widespread around the globe. VRIs are most often transmitted across a spectrum of small (aerosols) and large sized respiratory droplets expelled.
- Multiple factors may influence transmission and infection with VRI (e.g., transmissibility of the virus, enclosed spaces, relative humidity, ventilation etc.). Viruses in respiratory droplets can land on the recipient’s eyes, nose, or mouth, or are inhaled when close to an infected person. Because microorganisms in droplets can often survive on surfaces, infections can also be spread indirectly when people touch contaminated hands, surfaces and objects and then touch their mouth, nose or eyes.^{1,2}
- Infections in healthy individuals are generally mild and self-limiting, but they can lead to severe illness and death, especially in people who are more clinically vulnerable.
- Outbreaks of VRI in long-term care (LTC) and acute care settings cause significant disruption and harm to patients, residents, and health care workers (HCW) every year. LTC facilities are homelike settings for those residing there, and the primary focus should be to consider the appropriateness of any intervention for the residents’ quality of life and well-being.

2.0 Case Definitions

2.1 Probable VRI Case

- A resident is suspected to have VRI when they have rapid onset of signs and symptoms of VRI (as below) based on clinical judgement **AND** testing has not yet occurred, or results are pending.
 - Clinical judgement is required to assess symptoms of VRI. Other etiologies including non-respiratory infections (e.g., UTI) and non-infectious causes must be considered and ruled out (e.g., side effect of medication or chronic health conditions).
- A resident with VRI signs and symptoms includes:
 - New or worsening cough **with fever***
 - AND**
 - One or more of the following (not listed in any order of significance):
 - Shortness of breath
 - Sore throat or hoarseness or difficulty swallowing
 - Tiredness, malaise, prostration
 - Muscle aches (myalgia)
 - Joint pain (arthralgia)
 - Headache

***Note:** Fever may or may not be present, particularly in young children, the elderly, the immuno-compromised, or those taking medications such as steroids, Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), or Acetylsalicylic Acid (ASA). **A temperature <35.6°C or > 37.4°C in the elderly may be an indication of infection.**

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Issuing Authority:	Population and Public Health – Communicable Disease Program				
Last Revised:	2025-JAN-14	Last Reviewed:	2025-JAN-14	First Issued:	2025-FEB-27
					Page 2 of 11



2.2 Confirmed VRI Case Definition

- A resident with:
 - Signs and symptoms of acute respiratory infection (as listed above)
 - AND**
 - Confirmation of infection with the pathogen causing VRI, (i.e., influenza, SARS-CoV-2, parainfluenza, RSV, adenovirus, rhinovirus, metapneumovirus) by validated laboratory testing.

2.3 Healthcare-Associated VRI Case Definition

- A resident who:
 - Has developed VRI signs and symptoms (as listed above) more than 5 days after admission (consider typical incubation period for that illness)
 - AND**
 - Had no known exposure to the VRI outside the facility within the incubation period
 - AND**
 - An epidemiological investigation suggests an infection was more likely to have been acquired in the facility/unit than from outside it. (e.g., placed in the same room as another resident while the other resident was infectious, direct physical contact with a case or exposure to infectious body fluids).
- Contact local Communicable Disease (CD) or Infection Prevention and Control (IPAC) team to assist with identification and confirmation of health care associated VRI cases.

3.0 Management of VRI

3.1 Notification to CD or IPAC

- Cases of influenza and COVID-19 are reportable to the Medical Health Officer (MHO).
- LTC facilities are required to notify the MHO or IPAC of probable or confirmed VRI cases among residents in the facility. Notification is required when there are/is:
 - Two or more residents meeting the probable VRI case definition AND awaiting test results.
 - Any positive influenza or COVID-19 test results.
 - Any healthcare associated VRI cases.
 - Influenza or COVID-19 positive cases who are hospitalized.
 - Any death in an influenza or COVID-19 positive case.
 - As directed by the MHO or Medical Microbiologist (MM) during a cluster or outbreak.
- Once informed, CD or IPAC will initiate an investigation and recommendations will be provided.

3.2 Testing of Residents for VRI

- A resident should only be tested for VRI when they meet the probable case definition and their diagnosis will change the course of treatment. If done, perform the test within 72 hours of symptom onset or as soon as possible.
- Perform a nasopharyngeal respiratory virus test. COVID-19 Rapid Antigen Tests should NOT be used as they do not identify any other respiratory virus.

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Issuing Authority:	Population and Public Health – Communicable Disease Program				
Last Revised:	2025-JAN-14	Last Reviewed:	2025-JAN-14	First Issued:	2025-FEB-27
					Page 3 of 11



- Inappropriate testing can result in unnecessary and prolonged additional precautions and have serious impacts on resident well-being and health.

3.3 Additional Precautions for Residents

- Consult the Suspected Viral Respiratory Illness (VRI) [algorithm](#) for symptomatic people and when other etiologies have been ruled out.
- LTC facility staff should implement additional precautions as appropriate and do not need direction from MHO or IPAC to initiate additional precautions on individual residents.
- Prolonged additional precautions for residents can have serious impacts on their health and well-being.
 - Exclude residents from congregate activities only when there is a high risk of exposure to others.
 - Residents may continue rehabilitation activities with the appropriate additional precautions if they are well enough to attend.
- Apply droplet and contact precautions for residents in the following scenarios:
 - Residents with acute respiratory symptoms who are awaiting a test result,
 - Lab positive and healthcare associated influenza cases for 5 days from onset of symptoms or resolution of fever (whichever is longer),
 - For all other VRI, including COVID-19 and RSV, duration of additional precautions according to direction from Island Health IPAC or CD/MHO.
- During a declared VRI outbreak, recommendations for resident additional precautions may be modified by the MHO or MM to better control the outbreak.
- **Note:** *Not all symptoms need to resolve before additional precautions are lifted, a cough often persists for some time after the infection has resolved.*

4.0 Outbreaks

4.1 Declaration of an Outbreak

- Outbreaks are declared at the discretion of the MHO or Medical Microbiologist.
- LTC facilities are required to follow the direction of CD or IPAC in the event of an outbreak. This could include, but is not limited to, pausing admissions, limiting congregation of residents, masking measures, and visitor restrictions.
- The duration of an outbreak typically lasts for two incubation periods from symptom onset of the last case (e.g., 8 days for influenza, 10 days for COVID-19, etc.), and is at the discretion of the MHO or Medical Microbiologist. See [Appendix A](#).

4.2 Outbreak Definitions

- **Influenza:**
 - Two or more epidemiologically linked healthcare associated cases among residents occurring within seven days in a geographic area (e.g., unit or floor) over two or more rooms. This excludes cases transmitted within the same multi-bed room.
- **Other VRI Etiologies** (e.g., COVID-19, RSV), or where the organism is unknown:

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Issuing Authority:	Population and Public Health – Communicable Disease Program					
Last Revised:	2025-JAN-14	Last Reviewed:	2025-JAN-14	First Issued:	2025-FEB-27	Page 4 of 11



- An unexpected or unusual increase in confirmed VRI cases or increase in case severity among residents in a seven day period.
- AND**
- Evidence of continued transmission in the unit/facility despite additional measures taken.
- AND**
- The MHO or Medical Microbiologist determines that there is a need for extraordinary measures (i.e., limiting visitations and/or restricting admissions/transfers).
- AND**
- Application of additional measures are considered to have a higher overall benefit than harm to the facility residents.
- Factors to consider in case investigation include:
 - An epidemiological link to the facility.
 - An exposure source outside the facility.
 - The interval between exposure(s) and symptom onset.
- Once initial testing has identified the causative agent within a select group of symptomatic residents, further testing of symptomatic residents may be suspended at the discretion of the MHO/MM. Healthcare-associated cases may be considered based on symptomology in the context of an outbreak.

5.0 Influenza Chemoprophylaxis

- The MHO or MM will recommend chemoprophylaxis for residents and/or staff to prevent or respond to an outbreak when appropriate. The use of antiviral medications as prophylaxis in the context of an outbreak is to reduce spread, shorten the outbreak, and reduce harms related to influenza or outbreak measures.^{3,4,5}
- The most responsible provider (MRP) assesses appropriateness for and orders influenza antiviral prophylaxis for individual residents. Staff access prophylaxis through their primary care provider.
- LTC facilities develop a plan to ensure timely access and administration of prophylaxis during the time of year with peak influenza activity. The facility should be prepared to give influenza antiviral prophylaxis when required for outbreak control.

5.1 Administrative and Environmental Outbreak Measures

- Facilities should be prepared to implement additional outbreak measures to control and prevent further transmission of VRI. These measures may include restricting admissions and transfers to the facility; modifying meal service and social activities; enhancing housekeeping services; enhancing communication and education to residents, staff and visitors about the outbreak measures and increasing monitoring of resident health status.
- Facilities should develop and regularly review VRI outbreak response plans to ensure efficient and effective implementation of these measures.

6.0 Vaccinations

6.1 Vaccination of Residents and Staff

- LTC facilities are required to develop a plan to ensure all residents and staff are offered vaccination for influenza, COVID-19, and other publicly funded vaccines protecting against respiratory infections.

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Issuing Authority:	Population and Public Health – Communicable Disease Program				
Last Revised:	2025-JAN-14	Last Reviewed:	2025-JAN-14	First Issued:	2025-FEB-27
					Page 5 of 11



- Early influenza vaccination prior to peak influenza activity is recommended as it takes two weeks to generate maximum protection after being vaccinated.
- LTC facilities must maintain annual records of resident and staff vaccination status.
 - Records include name, date of birth, and date of vaccination. Staff records also include position (job) and where in the facility they work.

7.0 Definitions

- **Additional precautions:** Interventions implemented for certain pathogens or clinical presentations in addition to routine infection control practices, to reduce the risk of transmission of microorganisms from patient to patient, patient to HCP, and HCP to patient.
- **Aerosol:** Small respiratory particles that can stay airborne for extended periods, especially in enclosed, poorly ventilated spaces.
- **Chemoprophylaxis:** The use of medications or other substances to prevent or slow the development of disease or infection. The use of antiviral medications as prophylaxis in the context of an outbreak is to reduce spread, shorten the outbreak, and reduce harms related to influenza or outbreak measures.^{3,4,5}
- **Clinical judgement:** Using clinical reasoning to make an informed decision based on a patient’s condition, critical thinking, experience, and evidence-based knowledge.
- **Congregate activities:** Activities where people assemble or gather as a group in a shared space.
- **Epidemiologically linked:** The study of the occurrence and distribution of health-related states or events in specified populations, including the study of the determinants influencing such states, and the application of this knowledge to control the health problems.
- **Etiologies:** The causes or origins of a disease or condition. It explains what leads to or triggers a particular health issue or problem.
- **Incubation period:** The time interval between invasion by an infectious agent and appearance of the first sign or symptom of the disease.
- **Infection:** An invasion of the body by microorganism(s) that multiply and cause an interaction between the host and the organism. The interaction may only be a detectable immune response such as a TB skin test conversion (subclinical infection) or produce signs and symptoms resulting from the altered physiology and/or associated cell damage (clinical disease).
- **Microorganism:** microscopic living organisms, such as bacteria, viruses, fungi, and parasites, which can cause infections.
- **Outbreak:** An excess over the expected incidence of disease within a geographic area during a specified time period, synonymous with epidemic.
- **Rehabilitation Activities:** Activities that help people recover, improve, or regain their abilities after an injury, illness, or surgery. These services may include physical therapy, occupational therapy, speech therapy, and other types of support to help individuals regain independence and improve their quality of life.
- **Resident:** Refers to any individual residing in a long-term care facility.
- **Self-Limiting:** A condition or process that resolves or improves on its own, without the need for medical treatment or intervention.
- **Transmission:** The spread or act of transferring an organism from one spot to another.

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Issuing Authority:	Population and Public Health – Communicable Disease Program					
Last Revised:	2025-JAN-14	Last Reviewed:	2025-JAN-14	First Issued:	2025-FEB-27	Page 6 of 11



8.0 Related Island Health Policy Documents

- [Hand Hygiene Policy](#)
- [Hand Hygiene Review Guideline](#)
- [Hand Hygiene Procedure](#)
- [Routine Practices: Infection Prevention and Control](#)

9.0 References

- AMMI statement on antiviral use in LTC- <https://utppublishing.com/doi/pdf/10.3138/jammi.2019.02.08>
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Maintained by:	Population and Public Health - Communicable Disease Program				
Issuing Authority:	Population and Public Health – Communicable Disease Program				
Last Revised:	2025-JAN-14	Last Reviewed:	2025-JAN-14	First Issued:	2025-FEB-27
					Page 7 of 11



- Public Health Agency of Canada (PHAC). Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings. Accessed March 20, 2023. <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/routine-practices-precautions-healthcare-associated-infections.html>
- US Centers for Disease Control and Prevention (CDC). Human Parainfluenza Viruses (HPIVs). Accessed August 24, 2022. <https://www.cdc.gov/parainfluenza/about/index.html>

10.0 Resources

- [Toolkits for Infectious Diseases \(for affiliate and private LTC facilities\)](#)
- [Toolkit for VRI \(for Island Health LTC facilities\)](#)

Maintained by:	Population and Public Health - Communicable Disease Program				
Issuing Authority:	Population and Public Health – Communicable Disease Program				
Last Revised:	2025-JAN-14	Last Reviewed:	2025-JAN-14	First Issued:	2025-FEB-27
					Page 8 of 11



Maintained by:	Population and Public Health - Communicable Disease Program				
Issuing Authority:	Population and Public Health – Communicable Disease Program				
Last Revised:	2025-JAN-14	Last Reviewed:	2025-JAN-14	First Issued:	2025-FEB-27
					Page 9 of 11

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Appendix A: Viral Respiratory Illnesses

<u>Viral Organism</u>	<u>Epidemiology</u>	<u>Incubation period</u>	<u>Symptoms and symptom duration</u>	<u>Period of communicability*</u>
COVID-19⁶⁻⁸	Epidemiology is evolving at the time of writing.	The incubation period for SARS-CoV-2 may differ depending on the variant. Pre-Omicron, the incubation period ranged from 2 to 14 days, with a median of 5 to 7 days. The incubation period for Omicron has a shorter median of 3 days (range 0 to 8 days). Refer to BCCDC COVID-19 guidelines for more information.	New or worsening cough and fever, refer to BCCDC for a list of additional symptoms.	Generally, 48 hours before symptom onset to 5 to 10 days after. Communicable period may be longer than 10 days in immune compromised individuals.
Influenza A	Typically, November to April Causes mild to severe symptoms. Causes infection in all age groups with highest incidence in children; highest mortality in elderly and those with comorbidity. Can infect animals and humans. Causes most outbreaks.	1 to 4 days	Fever*, cough (often severe and may last longer than other symptoms), headache, muscle/joint pain, sore throat, prostration, and exhaustion. Gastro-intestinal symptoms may occur in children. Duration: 2 to 7 days	1 day before symptoms onset and up to 5 to 7 days after clinical onset in adults. Young children and people with immune-compromise may be greater than 7 days. People with asymptomatic infections may also be infectious.
Influenza B	Historically November-April Causes milder infection. Mostly affects children. Can cause outbreaks.	1 to 4 days	Similar to influenza A.	1 day before symptoms onset and up to 5 to 7 days after clinical onset in adults. People with asymptomatic infections may also be contagious.

Maintained by:	Population and Public Health - Communicable Disease Program			
Issuing Authority:	Population and Public Health – Communicable Disease Program			
Last Revised:	2025-JAN-14	Last Reviewed:	2025-JAN-14	First Issued: 2025-FEB-27
				Page 10 of 11



Parainfluenza virus	Entire year (little seasonal pattern) Predominantly causes infection & outbreaks in young children and the elderly.	2 to 6 days	Fever, cough, bronchiolitis, bronchitis, pneumonia Croup, 1-3 weeks	Duration of active symptoms.
Respiratory Syncytial virus (RSV)	Usually seasonal: winter and early spring. Predominantly causes infection and outbreaks in young children and the elderly.	2 to 8 days	Fever, cough, wheezing. Bronchiolitis in children. Pneumonia in adults.	Shortly before clinical onset and duration of active disease. Viral shedding may persist for several weeks or longer after symptoms have subsided, especially in children.
Adenovirus	Usually fall and winter Causes infection in all ages	Range 1 to 10 days	Conjunctivitis, sore throat, croup, fever, and other respiratory symptoms.	Shortly before symptom onset and until symptoms cease. Symptoms may be prolonged in immune-compromised people.
Common respiratory viruses such as -Rhinovirus -Coronavirus (other than COVID-19) -Metapneumo-virus -Echovirus -Coxsackie-virus -other entero-viruses.	Throughout the year with peaks in the spring and fall.	Usually 2 to 3 days, but may be longer	‘Common cold’ type illness: Sneezing, runny nose, cough, sore throat, sinus congestion malaise, headache, myalgia and/or low-grade fever.	Viral shedding usually most abundant during the first 2 to 3 days of clinical illness. Shedding usually ceases by 7 to 10 days but may continue for up to 3 weeks in young children.

Maintained by:	Population and Public Health - Communicable Disease Program				
Issuing Authority:	Population and Public Health – Communicable Disease Program				
Last Revised:	2025-JAN-14	Last Reviewed:	2025-JAN-14	First Issued:	2025-FEB-27
					Page 11 of 11