

# SESLHD PROCEDURE COVER SHEET



**Health**  
South Eastern Sydney  
Local Health District

<b>NAME OF DOCUMENT</b>	Management of Acute Viral Respiratory Illness (including influenza and COVID-19)
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<b>FUNCTIONAL GROUP(S)</b>	Infection Control
<b>KEY TERMS</b>	Respiratory Viruses, Airborne, Droplet Precautions and Contact Precautions, Surgical Mask Particulate Mask
<b>SUMMARY</b>	Prevention of transmission of respiratory viral infection between healthcare workers, patients and their visitors and enable appropriate accommodation and management.

## **COMPLIANCE WITH THIS DOCUMENT IS MANDATORY**

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**Management of Acute Viral Respiratory Illness  
(including influenza and COVID-19)**

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**SESLHDPR/581****1. POLICY STATEMENT**

This procedure aims to prevent of transmission of respiratory viral infection between healthcare workers, patients and their visitors; and enable appropriate accommodation and management. These viruses can cause more severe illness including pneumonia. This more often occurs in patients who have clinical risk conditions (defined in the Immunisation Handbook). The diagnosis of respiratory viral illness in inpatients is pivotal as they can be highly transmissible. Caution needs to be exercised as respiratory virus infection can occur with more than one agent.

**2. BACKGROUND**

Respiratory viruses cause mild to moderate illness in most people; however, vulnerable patients can be at risk of severe disease. Healthcare workers should ensure that all efforts are made to minimise the risk of transmission of respiratory viruses within health care facilities (HCFs), with a focus on protecting patients, visitors and staff.

**3. RESPONSIBILITIES****Directors of Medical Services and Directors of Nursing and Midwifery:**

- Ensure that compliance is monitored and evaluated.

**Patient Flow Managers:**

- Ensure patients requiring admission with suspected acute respiratory viral infection are isolated correctly to reduce risk of transmission to others.

**Nurse Unit Managers:**

- Maintain a high index of suspicion for acute respiratory viral illness all year and manage according to this guideline.
- The clinical picture overrides diagnostic testing results for isolation and management purposes (i.e. COVID-19, Influenza A/B, RSV may be negative however patients remain symptomatic and may have another transmissible infection which has not been excluded).
- Patients who are tested for Middle East Respiratory Syndrome (MERS) must be cleared by ID Consultant (or local protocol) and according to Communicable Diseases Network Australia (CDNA) guidelines. For MERS, a single negative test may not be sufficient to rule out disease.
- Visitors with respiratory viral symptoms must not be allowed entry unless on compassionate grounds approved by the Director of Clinical Services.
- Manage HCW with respiratory illness according to facility guidelines.
- Promote seasonal influenza vaccination and COVID-19 immunisation for staff and patients.

**Management of Acute Viral Respiratory Illness  
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- Provide support for increased diagnostic testing seasonally and on the advice of the Public Health Unit, with feedback to clinicians via EMR and Infection Prevention and Control reporting.
- Reference testing for respiratory viruses and molecular diagnostics.

**Medical staff or Nurse Practitioner:**

- Ensure appropriate ordering of specimens as per [Flowchart 1](#) and [Table 1](#)
- Ensure COVID-19 is ruled out for any patient with compatible symptoms. “Triplex” testing is available in SESLHD, and includes SARS-CoV-2, influenza A and/or B and or respiratory syncytial virus (RSV). Full respiratory virus panel testing should be requested only if “triplex” testing is negative and the patient is in HDU/ICU or immunocompromised.
- Ensure adequate handover to nursing staff when respiratory viral illness is suspected.
- Ensure follow-up of exposed people occurs as per Influenza Control guidelines and SESLHD COVID-19 Patient, staff and visitor management - contact tracing.

**All Healthcare Workers (HCW):**

- Participate in the seasonal influenza and COVID-19 vaccination program and comply with mandatory vaccination requirements as per the NSW Health Policy Directive [PD2023\\_022 - Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases](#).
- Risk assess and manage all patients as per procedure.
- Adopt airborne, contact and droplet precautions and immediately isolate any patient who has suspected or confirmed COVID-19 or MERS.
- Adopt Contact and Droplet Precautions for patients who are negative for COVID-19 (and cleared by local protocol), without epidemiological risk who still have viral respiratory illness, and attend to increased cleaning of frequently touched surfaces to manage patients with acute viral respiratory illness.
- Provide patient and consumer [NSW Health fact sheets](#).
- Use spacers for respiratory tract medication delivery (do not use nebulisers).
- Staff to remain at home when unwell with a respiratory illness and be tested for SARS-CoV-2 as required by current [NSW Ministry of Health COVID-19](#) guidelines.

**Infection Prevention and Control Staff:**

- Support clinicians in the management of cases and contacts.
- Ensure rapid isolation of cases and monitoring of contacts to prevent and identify outbreaks.

**Patient/Consumer:**

- Be encouraged to be involved in education and consideration for treatment including receiving information in [NSW Health fact sheets](#).

**4. DEFINITIONS****Airborne Precautions:** A type of transmission-based precautions, used to interrupt

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airborne transmission from patients known or suspected to be infected with agents transmitted person-to-person by the airborne route such as COVID-19.

**Case:** a person presenting with acute onset respiratory or influenza like illness.

**Contacts:** are patients, their carers or staff that were potentially exposed to respiratory droplets or aerosols from a case

e.g. same room or area or providing care for the case. Specific definitions are applied depending on the virus and may include high, moderate and low risk contacts which may be managed differently.

**Contacts of high risk:** high risk immunocompromised, >65 years, ATSI or pregnant patients or children contacts if there is a high suspicion of influenza (as per Ministry of Health).

**Contact Precautions:** type of transmission-based precautions used to interrupt the transmission of infectious agents that are spread by direct or indirect contact with the patient or the patient’s environment.

**Droplet Precautions:** precautions applied to patients known or suspected to be infected with pathogens that can be transmitted by droplets to reduce the risk of transmission.

**Influenza-like Illness:** flu signs and symptoms usually come on suddenly. People who are sick with flu often feel some or all of these symptoms:

- Fever\* or feeling feverish/chills
- Cough
- Sore throat
- Runny or stuffy nose
- Muscle or body aches
- Headaches
- Fatigue (tiredness)
- Some people may have vomiting and diarrhea, though this is more common in children than adults

*\*It’s important to note that not everyone with influenza will have a fever.*

**Post exposure prophylaxis:** provision of an antiviral or other therapy after exposure to prevent or ameliorate disease. Contact tracing should be undertaken when patients or staff working in high-risk settings (hospital wards specifically for people who are immunosuppressed or neonatal wards) have been exposed to a confirmed infectious case of influenza. Vulnerable patients who are close contacts should be advised of their risk and, if indicated, and in consultation with their health care provider, should be offered early treatment should symptoms develop.

**Respiratory viruses:** a group of viruses with predominant effects on the respiratory tract.

**Surgical Mask:** a fluid resistant single use loose fitting mask that covers the nose and mouth.

**Particulate mask (P2, N95 or PFR95):** a mask which provides a tight facial seal with a face-seal leakage of <10% and ability to filter particles one micron in size in the unloaded state with a filter efficiency of greater than/equal to 95% given flow rates of up to 50 litres

per minute.

**Pooled swab:** the collection of a single swab consisting of tonsillar beds, back of throat and both nostrils from patients with suspected viral respiratory illness. A pooled swab is collected by first swabbing the oropharynx, the same swab is then used to swab the inside of the nares.

## 5. PROCEDURE

### 5.1 Respiratory Virus Testing

If symptoms consistent with acute respiratory viral illness isolate with airborne, droplet and contact precautions and manage until COVID-19 is ruled out. Obtain **throat and deep nasal pooled swab** from patients who may have respiratory viral illness.

Obtain one (1) pooled swab from tonsillar beds, and back of throat, the same swab is then inserted into both nares. [See Section 6.2 for swab technique.](#)

For patients with a negative “triplex” swab (and cleared by local protocol) isolate with droplet and contact precautions

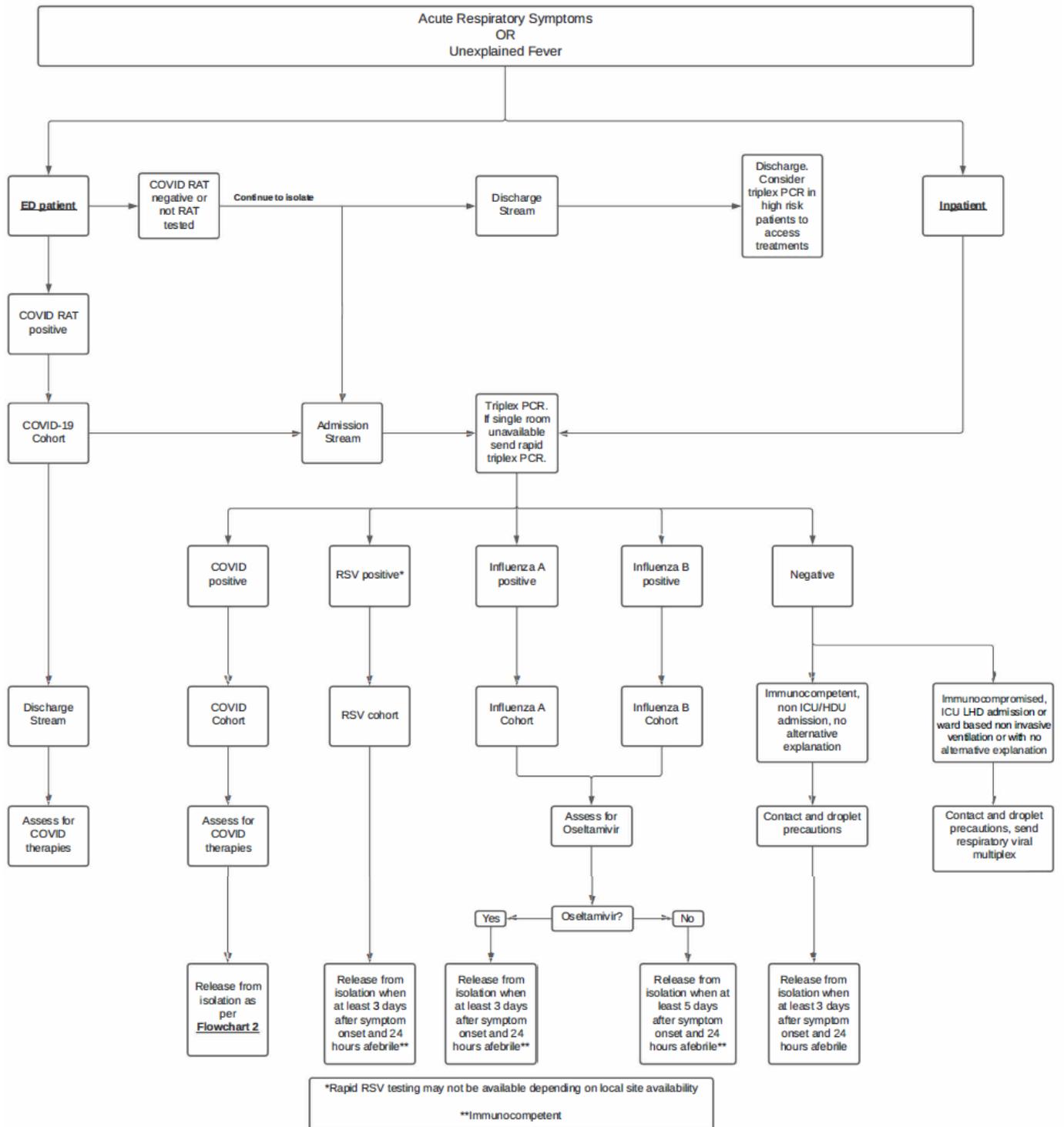
- Patients who are identified as a high falls risk may need to be placed in an area where ability to visually observe patient can be achieved to ensure safety. Please contact site Infection Prevention and Control Consultant or contact Infectious Diseases Consultant on call to help with risk assessment.

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Flowchart 1 - Respiratory virus testing and bed management in SESLHD facilities

Flowchart 1



## SESLHD PROCEDURE

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#### Cohorting when isolation needs exceed available single rooms

Only same viruses can be cohorted together (i.e. influenza A with influenza A, rhinovirus with rhinovirus).

- Suspected COVID-19 cases must not be cohorted
- Patients with more than one respiratory virus must not be cohorted

#### 5.2 Ordering Respiratory Virus Screening Panels on eMR

Clinicians to order “triplex” PCR (COVID-19/influenza/RSV) testing according to clinical assessment as per [Flowchart 1](#) and [Table 1](#). Additional respiratory virus testing is only recommended for patients being admitted to ICU/HDU or if immunocompromised.

Diagnosis of respiratory viruses other than COVID-19/Influenza/RSV are significant for the following groups:

- **Immunocompromised patients**
- **Paediatrics:** Immunocompromised patients (as above); moderate-severe viral exacerbations of chronic airways disease (e.g. asthma, CF).
- **Any:** patients with severe pneumonia requiring admission to ICU/HDU.

\*All viruses can be ordered using one swab

In patients with severe illness PCR testing can also be undertaken on sputum as swabs may be falsely negative. If in doubt consult with Infectious Diseases.

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**Table 1 - Respiratory Virus Testing**

Virus test set	When to Order NB. More than one test/ panel can be ordered on the one swab
<p><b>SARS-CoV-2/Influenza/RSV ‘triplex’ test</b></p> <p>(RSV may not be available on all ‘triplex’ assays, so needs to be specifically requested if needed)</p>	<p>For any patient who presents with the following symptoms: unexplained fever, cough, dyspnoea, malaise, fatigue, loss of taste and/or smell, and sputum/respiratory secretions. Other symptoms include headache, sore throat, fatigue, myalgia, rhinorrhoea, chills, and vomiting. Atypical symptoms may include chest pain, diarrhoea, conjunctivitis, and ILI.</p>
<p><b>RSV</b></p>	<p>As applicable if not included in triplex test and indicated as per local hospital policy.</p>
<p><b>Panel 2:</b> Adenovirus, enterovirus, parainfluenzae 1-4, human metapneumovirus</p>	<p><b>Adults:</b> Immunocompromised patients with acute respiratory illness e.g. haematology patients, solid organ transplants, immunology patients.</p> <p><b>Paediatrics:</b> Immunocompromised patients (as above); suspected enterovirus infections; moderate-severe viral exacerbations of chronic airways disease (e.g. asthma, CF).</p>
<p><b>Panel 3:</b> Rhinovirus, coronaviruses, bocavirus</p>	<p><b>Adults:</b> Immunocompromised patients with acute respiratory illness e.g. haematology patients, solid organ transplants, immunology patients.</p> <p><b>Paediatrics:</b> Immunocompromised patients (as above); moderate-severe viral exacerbations of chronic airways disease (e.g. asthma, CF).</p>
<p><b>Panel 4:</b> Mycoplasma pneumoniae (MP), Chlamydophila pneumoniae (CP), Legionella pneumophila (LP), Haemophilus influenzae (HI), Streptococcus pneumoniae (SP), Bordetella pertussis (BP) and Bordetella parapertussis (BPP)</p>	<p><b>Adults:</b> Severe (ICU/HDU admission) community-acquired pneumonia or immunocompromised patients with acute respiratory illness e.g. haematology patients, solid organ transplants, immunology patients.</p> <p><b>Paediatrics:</b> Immunocompromised patients (as above); moderate-severe viral exacerbations of chronic airways disease (e.g. asthma, CF).</p>

**NB:** Clinical picture overrides diagnostic testing results for isolation and management purposes. COVID-19, influenza A/B, RSV may be negative; however, patients remain symptomatic and may have other transmissible infections which have not been excluded.

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### 6. COLLECTION OF VIRAL RESPIRATORY SWABS

#### Upper respiratory tract samples

Deep nasal and oropharyngeal swab: may be dacron or rayon, although flocked is preferred. A pooled swab is undertaken to swab the tonsillar beds, back of throat and both nostrils in the following way:

- Oropharyngeal (throat): swab the tonsillar beds and the back of the throat, avoiding the tongue, then using the same swab deep nasal swab
- Using a pencil grip and while gently rotating the swab, insert the tip 2–3 cm (or until resistance is met), into the nostril, parallel to the palate, to absorb mucoid secretion.
- Rotate the swab several times against the nasal wall.
- Withdraw the swab and repeat the process in the other nostril. To conserve swabs the same swab that has been used to sample the oropharynx should be utilised for nasal sampling.
- Place the swab back into the accompanying transport medium
- Sampling both sites, deep nasal and oropharynx, is recommended to optimise the chances of virus detection. The swab should be placed in appropriate transport medium.

**1 OROPHARYNGEAL (THROAT) SWAB:**

- Swab the tonsillar beds and the back of the throat, while avoiding the tongue.
- To conserve swabs, the same swab can be used for steps 1 and 2.



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**2 BILATERAL DEEP NASAL SWAB:**

- Using a pencil grip and while gently rotating the swab, insert the tip 2-3cm for adults and 1-2cm for children (or until resistance is met), into the nostril, parallel to the palate, to absorb mucoid secretion.
- Rotate the swab several times against the nasal wall.
- Withdraw the swab and repeat the process in the other nostril.

Note: Consideration must be given to the size of the swab being used to collect specimen from children and babies.



Source: Adapted from the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention<sup>1</sup>

**Note:** PHLN recommend using a combined deep nasal and oropharynx swab, to optimise the chances of virus detection while minimising discomfort for the individual being tested. However, this does not preclude the use of nasopharyngeal swab where the medical practitioner deems appropriate.

**3 SEND TO LABORATORY:**

- Place the swab(s) back into the accompanying transport medium (unless dry swabs are being used)
- If SARS-CoV-2 testing is to be undertaken in a different laboratory to testing for other respiratory viruses, then the original swab and remaining eluate should be forwarded for SARS-CoV-2 testing.

Source [Public Health Laboratory Network 2020](#)

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### 6.1 SWAB TYPES

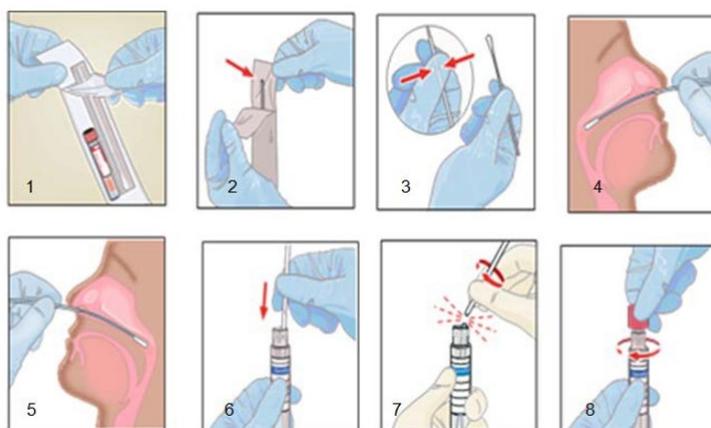
Viral respiratory swabs are often green in colour; however new types of swabs are able to be used as per below Test Information NSW Health Pathology. If in doubt, please contact your laboratory service.

TEST INFORMATION		NSW Health Pathology	
Swab types for collection of upper respiratory samples for SARS-CoV-2 (the virus that causes COVID-19)			
<b>Sample types:</b> Various swab types may be used for PCR testing for SARS-CoV-2, but some require additional handling to ensure good test sensitivity.			
Swab Type	Picture	Information	
Viral Swabs (Use)		<ul style="list-style-type: none"> <li>The best specimens are those containing viral or universal transport media (VTM or UTM).</li> <li>These are typically available as 'green swabs' or 'red swabs' and contain either a liquid soaked sponge, or liquid media in the bottom of the specimen tube.</li> </ul>	
Dry Swabs (Use)		<ul style="list-style-type: none"> <li>Require additional treatment. These are typically available as orange or red capped swabs and do not have transport media or a sponge visible in the bottom of the tube.</li> <li>These swabs should be placed into a screw-top tube (NOT the swab sheath) containing 2mL of sterile saline. Snap the swab into the tube at the perforation in the swab's shaft, so that the transport tube can then be capped and sent safely.</li> </ul>	
Wooden Shafted Swab (Use in a pinch)		<ul style="list-style-type: none"> <li>Can sometimes inhibit PCR tests. For some patients wooden swabs will give a result of 'indeterminate' or 'inhibitory'—recollection will be required for that patient. Wooden swabs are dry swabs and also require the addition of saline or transport media (see above).</li> </ul>	
Bacterial Swabs (Do not use)		<ul style="list-style-type: none"> <li>Typically have blue caps and contain Amies gel media; they are routinely used for culture of bacteria and can NOT be used for PCR testing. These swabs should NOT be collected for detection of SARS-CoV-2.</li> </ul>	

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Reference: Droz, J. et al. (2022) Evaluation of Swabs, Transport Media, and Specimen Transport Conditions for Optimal Detection of Viruses by PCR. *Journal of Clinical Microbiology*, 60(12), 3064-3080.

NSW Health Pathology  
Contact us: 1800 073 257

### 6.2 COLLECTION OF RAPID VIRAL SWABS



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1. Open the individual collection package that contains the swab and Xpert Viral Transport
2. Medium tube. Set the tube aside before beginning to collect the specimen.
3. Open the collection swab wrapper by peeling open the top of the wrapper. Remove the swab, taking care not to touch the tip of the swab or lay it down.
4. Hold the swab in your hand, placing your thumb and forefinger in the middle of the swab shaft across the score line.
5. Gently insert the swab into the nostril. Keep the swab near the septum floor of the nose while gently pushing the swab into the posterior nasopharynx.
6. As a visual reference, the swab should be inserted about half the distance from the opening of the patient's nostril and the ear. Rotate the swab several times.
7. While holding the swab in the same hand, aseptically remove the cap from the tube. Insert the swab into the tube with the transport medium.
8. Identifying the score line, break the swab shaft against the side of the tube. If needed, gently rotate the swab shaft to complete the breakage. Discard the top portion of the swab shaft. Avoid splashing contents on the skin. Wash with soap and water if exposed.
9. Replace the cap onto the tube and close tightly. Send immediately to pathology lab.

**6.3 ORDERING OF RAPID VIRAL SWABS**

- Clinician to Order Rapid SARS-CoV-2/Influenza/RSV PCR on eMR
- Rapid SARS-CoV-2/Influenza/RSV testing of nasopharyngeal swabs should only be requested if a single isolation room is not available or in an outbreak when approved by infectious diseases or infection control (see Flowchart 1) (result within one to four hours).

**7. SURVEILLANCE TESTING FOR COVID-19 IN SESLHD FACILITIES**

Surveillance testing for COVID-19 in asymptomatic patients in SESLHD facilities should be undertaken in accordance with [Appendix A](#).

This guidance provides locally tailored recommendations based on the latest Clinical Excellence Commission (CEC) guidance found here: [CEC Infection and Prevention Manual](#) and the [CDNA COVID-19 National Guidelines](#).

Surveillance testing must occur in the context of all other infection prevention and control measures as per Amber alert, to reduce the risk of COVID-19 transmission in health facilities. Staff should wear a mask and eye protection whenever they are less than 1.5m from a patient.

People who have recovered from COVID-19 are EXEMPT from surveillance testing for **4 weeks** after release from isolation.

Asymptomatic patients with a positive test result should be managed according to [Flowchart 2](#).

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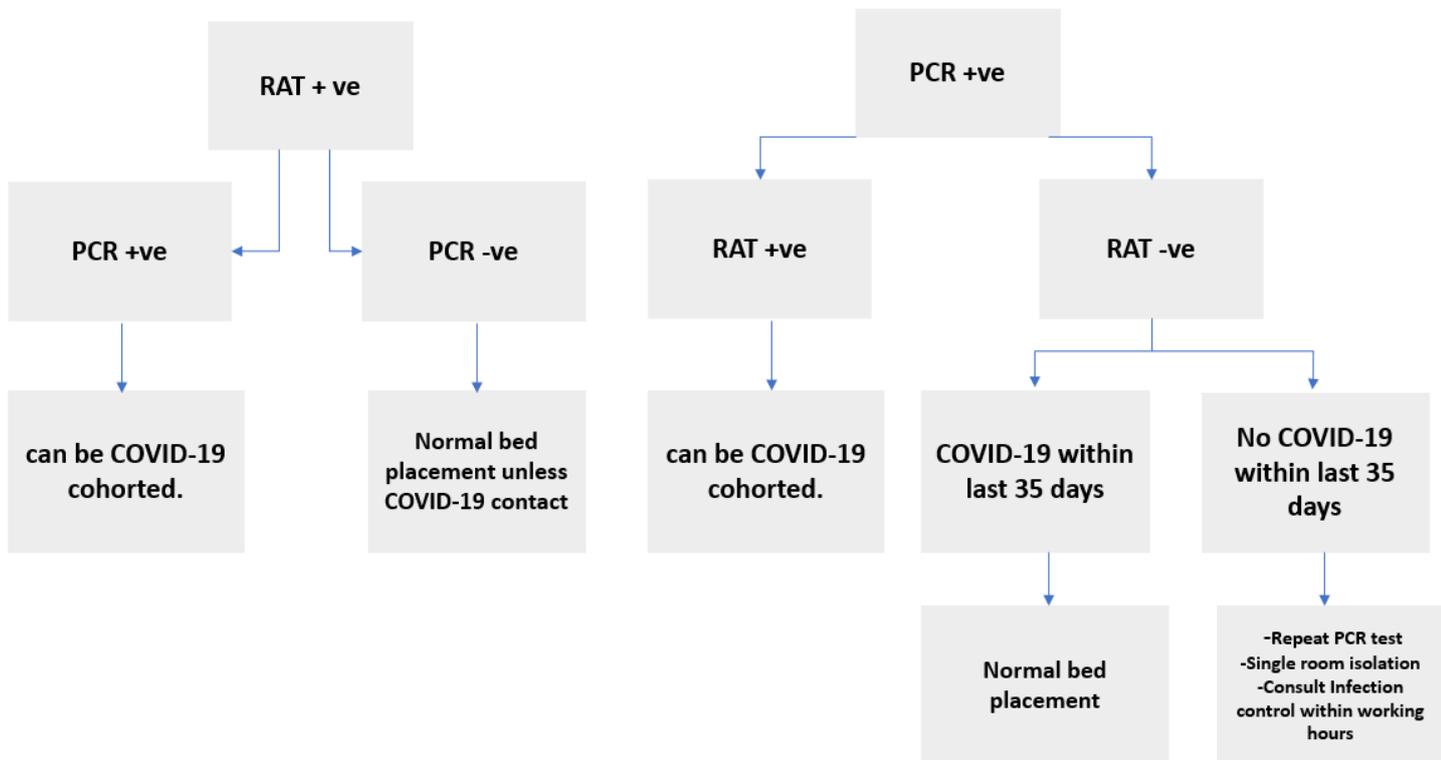
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### Flowchart 2 - COVID Positive results in patients without COVID symptoms in SESLHD facilities

#### Flowchart

COVID-19 Positive Results in Patients Without COVID-19 Symptoms within SESLHD Facilities



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### 8. COLLECTION OF SEROLOGY

- In general, serology is of limited value in the diagnosis of acute respiratory illness. Consult with Infectious Diseases.

### 9. CONTACTS OF A CASE

Manage as per [Table 3](#).

**Table 3 – Summary of contact screening requirements**

Virus	Incubation (days)	Infectious period (days)	Contact tracing yes/no	Management
<b>SARS-CoV-2</b>	Usually 5-6 Range 1-14	Variable  For clearance see flowchart 3	Yes Consult with infection control/ID team	High risk and moderate risk contacts must be isolated with airborne, droplet and contact precautions for a period and tested as advised according to current SESLHD or <a href="#">CEC advice</a> .
<b>Influenza A &amp; B</b>	Usually 2-3 Range 1- 7	Normal host 3-5 Immunocompromised >10	Yes Consult with infection control/ID team	Monitor temperature 4/24 for 72 hours.  Isolate if becomes symptomatic with droplet and contact precautions. Consider antivirals for influenza A and B contacts if necessary in particular for the at risk groups as per <a href="#">Influenza Control Guidelines</a> or advice from Infectious Diseases team.  RSV- Contact Infectious Diseases for advice  Use airborne precautions if aerosol generating procedures are performed
<b>Parainfluenza</b>	2	Normal host 3-5 Immunocompromised >10		
<b>Respiratory syncytial virus</b>	2	Normal host 3-5 Immunocompromised >10		

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Virus	Incubation (days)	Infectious period (days)	Contact tracing yes/no	Management
Rhinovirus	1/2-3	Normal host- variable	Yes, if likely outbreak of 2 or more cases Consult with infection control/ID team	In the event of an outbreak, monitor patient's temperature 4/24 for 72 hours.  Isolate if become symptomatic with droplet precautions.  Use airborne precautions if aerosol generating procedures are performed
		Immunocompromised-variable		
Common coronaviruses (229E, NL63, OC43)	Variable	Normal host- variable		
		Immunocompromised-variable		
Bocavirus	7-13	Normal host- variable		
		Immunocompromised-variable		
Adenovirus	Variable	Normal host- variable		
		Immunocompromised-variable		
Enterovirus	Variable	Normal host- variable		
		Immunocompromised-variable		
Polyomaviruses Wu Ki	3-10	Normal host- variable		
		Immunocompromised-variable		
Human metapneumovirus	3-5	Normal host- variable		
		Immunocompromised-variable		

### 10. CLEARANCE OR DE-ISOLATION OF A CASE

For de- isolation purposes, the key factors to consider are:

- Day of symptom onset or positive test result
- Infectious Period
- Infecting pathogen
- Any treatment given
- Current symptoms

For **immunocompetent** patients:

- De-isolate influenza and RSV according to [Flowchart 1 or Table 4.](#)
- De-isolate COVID-19 according to [Flowchart 3.](#)
- For patients who are not diagnosed with COVID-19, influenza or RSV manage as per flowchart 1

In general immunocompetent hosts will NOT be tested for other respiratory viruses, but if they have been tested they can be de-isolated with reference to table 4 (generally >3d from symptom onset AND 24h afebrile).

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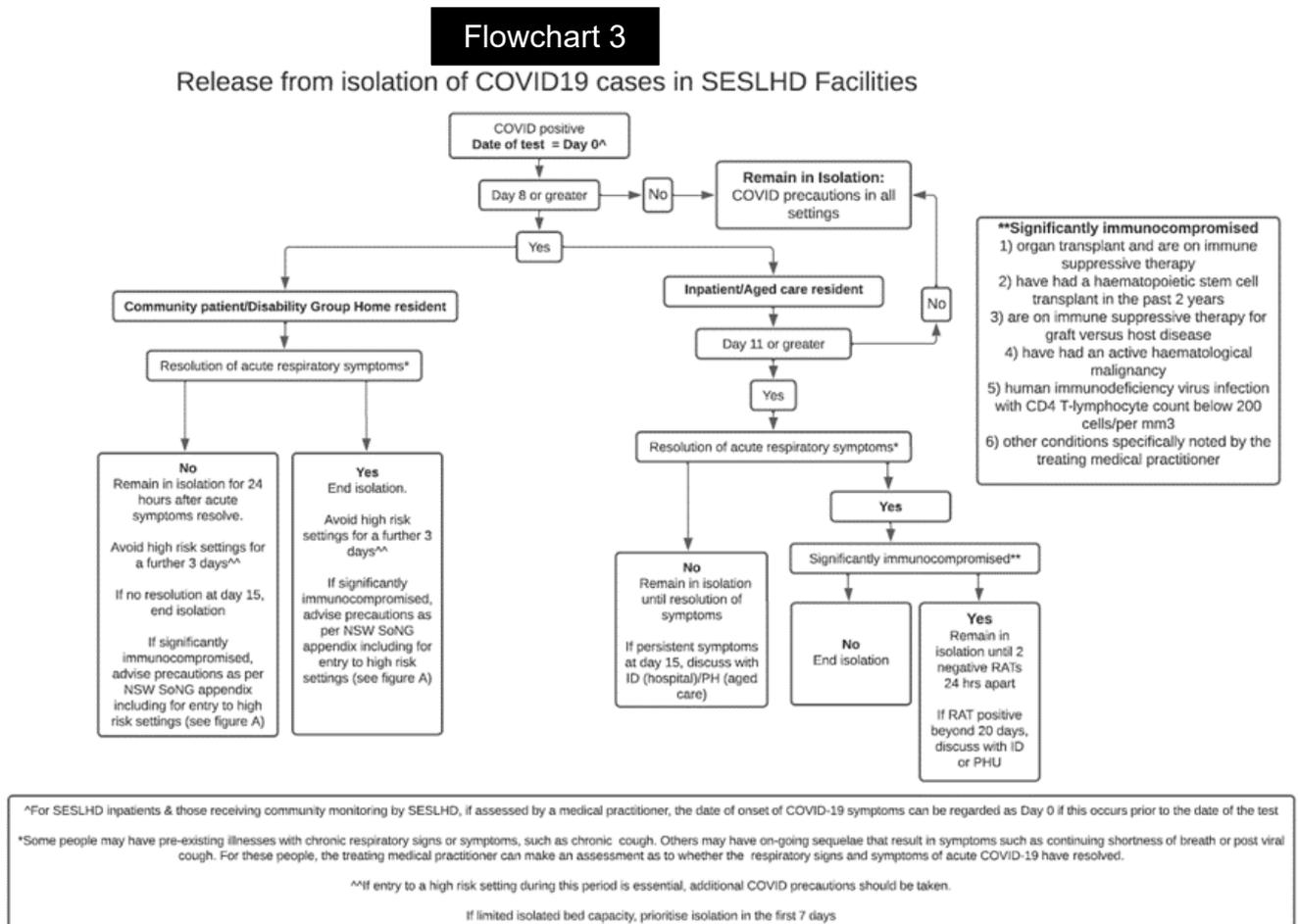
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For immunocompromised patients:

- De-isolate influenza and RSV according to [Flowchart 1 or Table 4](#).
- De-isolate COVID-19 according to [Flowchart 3](#).
- De-isolate other respiratory viruses according to [Table 4](#).

### Flowchart 3 - Release from isolation of COVID-19 cases in SESLHD facilities



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**Table 4 – Infectious periods/de-isolation times for specific viruses**

Virus	Incubation (days)	Infectious period (days)	De-isolation in days (if afebrile for 24 hours prior)	
			Antiviral	No antiviral
<b>SARS-CoV-2 (COVID-19)</b>	Usually 5-6 Range 1-14	Variable	n/a	See flowchart 3
<b>Influenza A &amp; B</b>	1-4	Normal host 3-5	3	5
		Immunocompromised >10	7	10
<b>Parainfluenza</b>	1-7	Normal host 3	n/a	3
		Immunocompromised >10	n/a	7
<b>Respiratory syncytial virus</b>	2-8	Normal host 3	n/a	3
		Immunocompromised >10	7	7
<b>Human metapneumovirus</b>	3-5	Normal host- variable	n/a	3
		Immunocompromised - variable	n/a	7
<b>Rhinovirus</b>	½-3	Normal host - variable	n/a	3
		Immunocompromised - variable	n/a	5
<b>Coronavirus</b>	2-4	Normal host- variable	n/a	3
		Immunocompromised - variable	n/a	5
<b>Bocavirus</b>	Variable	Normal host – variable	n/a	3
		Immunocompromised - variable		Consult with ID/ Infection control
<b>Adenovirus</b>	2-14	Normal host- variable	n/a	3
		Immunocompromised - variable		Consult with ID/ Infection control
<b>Enterovirus</b>	3-10	Normal host – variable	n/a	3
		Immunocompromised - variable		Consult with ID/ Infection control
<b>Polyomaviruses Wu Ki</b>	Variable	Normal host –variable	n/a	3
		Immunocompromised - variable		Consult with ID/ Infection control

**NB: If patient has been febrile, then must be afebrile 24 hours prior to de-isolation.**

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#### 11. TREATMENT

Treatment options for COVID-19 and influenza Influenza A or B are available.

- Use of antiviral drugs for influenza contacts should occur as per [Influenza Control Guidelines](#), or as per assessment by treating teams and infectious diseases clinicians.
- Influenza virus antivirals (neuraminidase inhibitors zanamavir – Relenza® or oseltamivir – Tamiflu®) are not effective against other viruses.
- Ribavirin may be used to treat RSV on a case-by-case basis.
- Antiviral therapy for COVID-19 is available.

#### 12. OUTBREAK

- If two or more cases of respiratory viral disease occur within 72 hours in a ward, or bed unit this must be managed using outbreak management principles. The executive must be notified immediately of a possible outbreak.
- Refer to [SESLHDPR/685 - Outbreak Management and Contact Tracing](#), for outbreak management principles.

#### 13. DOCUMENTATION

- Health Care Records

#### 14. AUDIT

- Annual influenza and COVID-19 vaccination rates of healthcare workers.
- Outbreak investigation reports, facility Infection Prevention and Control Committee.
- Personal protective equipment compliance audits from the facility audit program.

#### 15. REFERENCES

- [NSW Ministry of Health Policy Directive PD2023\\_025 - Infection Prevention and Control in Healthcare Settings](#)
- [NSW Ministry of Health Policy Directive PD2023\\_022 - Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases](#)
- [NSW Ministry of Health Influenza Control Guidelines](#)
- [NSW Ministry of Health COVID-19 Resources](#)
- [Clinical Excellence Commission Infection Prevention and Control Practice Handbook](#)
- [Clinical Excellence Commission COVID-19 Infection Prevention and Control Manual](#)
- [Australian Government, Department of Health, Communicable Diseases Network Australia National guidelines for public health units](#)
- [Australian Government, Department of Health. 2020 Coronavirus \(COVID-19\) resources](#)
- [SESLHDPR/277 - Influenza Clinics for Seasonal Influenza](#)

**Management of Acute Viral Respiratory Illness  
(including influenza and COVID-19)**

**SESLHDPR/581**

- [SESLHDPR/270 - Influenza - Critical Care Escalation and Management](#)
- [Centre for Disease Control and Prevention Influenza Case Definition](#)

**16. VERSION AND APPROVAL HISTORY**

<b>Date</b>	<b>Version</b>	<b>Version and approval notes</b>
26 May 2017	Draft	Kim Brookes, Executive Sponsor, approved final draft for progression
02 June 2017	Draft	Processed by Executive Services prior to submission to CQC
June 2017	0	Approved by Clinical and Quality Council
June 2019	1	Minor review approved by Executive Sponsor. Updated and included cohort flowchart. Updated references to procedures and hyperlinks and definitions. Removed Appendix 2, Respiratory Viral Illness Risk Matrix. Updated treatment to include use of Ribavirin to treat RSV.
July 2019	1	Tabled at July 2019 Quality Use of Medicines Committees (QUMC) for approval to publish.
July 2019	1	Approved by Quality Use of Medicines Committee. Procedure published.
June 2020	2	Inclusion of COVID-19 information.
July 2020	2	Approved by the Quality Use of Medicines Committee
July 2021	3	Minor review: Updated as per CEC COVID-19 and Department of Health Communicable Diseases Network
August 2021	3	Approved by the Quality Use of Medicines Committee
May 2022	4	Major review: Updated with introduction of SARS-CoV-2/influenza/RSV “triplex” testing and syndromal de-isolation in immunocompetent hosts. Approved by Executive Sponsor for interim publication. Draft for Comment period.
August 2022	5	Feedback incorporated. Approved by SESLHD Infection Prevention and Control Committee. Approved by Executive Sponsor.
October 2022	5	Approved at Quality Use of Medicines Committee meeting.
December 2022	5.1	Approved at November 2022 Clinical and Quality Council. Processed and published.
29 November 2023	5.2	Amendment to procedure: update to Flowchart 2; hyperlinks updated. Approved by Executive Sponsor.