POLICY IFC-59: COVID-19 Outbreak Management

Infection Control

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Policy:

It is the policy of Norview Lodge to implement a plan as soon as possible in the event of a suspected COVID-19 outbreak.

Clinical Evidence

An Acute Respiratory Infection (ARI) is defined as any new onset ARI that could potentially be spread through the droplet route (either upper or lower respiratory tract), which presents with:

- Symptoms of a new or worsening cough or shortness of breath and;
- Often fever (also known as febrile respiratory illness, or FRI)
- It should be noted that elderly people and people who are immunocompromised may not have a febrile response to a respiratory infection.

COVID-19 compatible symptoms include the following:

- **Fever and/or chills** Temperature of 38 degrees Celsius/100 degrees Fahrenheit or higher.
- **Cough or barking cough (croup)** Not related to asthma, post-infectious reactive airways, COPD, or other known causes or conditions you already have.
- **Shortness of breath** Not related to asthma or other known causes or conditions you already have.
- **Decrease or loss of smell or taste** Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have.
- **Muscle aches/joint pain** Unusual, long-lasting (not related to a sudden injury, fibromyalgia, or other known causes or conditions you already have). If you received a COVID-19 and/or flu vaccination in the last 48 hours and are experiencing mild muscle aches/joint pain that only began after vaccination, select “No.”
- **Fatigue** Unusual tiredness, lack of energy (not related to depression, insomnia, thyroid dysfunction, or other known causes or conditions you already have). If you received a COVID-19 and/or flu vaccination in the last 48 hours and are experiencing mild fatigue that only began after vaccination, select “No.”

- **Sore throat** Painful or difficulty swallowing (not related to post-nasal drip, acid reflux, or other known causes or conditions you already have).
- **Runny or stuffy/congested nose** Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have.
- **Headache** New, unusual, long-lasting (not related to tension-type headaches, chronic migraines, or other known causes or conditions you already have. If you received a COVID-19 and/or flu vaccination in the last 48 hours and are experiencing a headache that only began after vaccination, select "No."
- **Nausea, vomiting and/or diarrhea** Not related to irritable bowel syndrome, anxiety, menstrual cramps, or other known causes or conditions you already have.

Screening Procedures

Residents

New Admission/Re-Admission/Daily surveillance

All new admissions to the home will be assessed for indicators of an Acute Respiratory Infection on the Admission Assessment. If the Resident fails admission screening, they will be placed on droplet/contact precautions and isolated to their room.

Residents returning from hospital or upon their return from a social absence, will be screened for any signs or symptoms of an ARI upon their return at the next screening interval.

Registered staff complete Qshift symptom surveillance via the EMAR system to identify any new sign or symptom of respiratory, enteric or new infectious rash.

Registered staff complete the hard copy daily surveillance sheet and submit to IPAC Q24hs which indicate any new Resident with respiratory/enteric symptoms, new infectious rash or any other health care associated infections which allows IPAC to monitor infectious trends in the home daily.

Enhanced Monitoring of asymptomatic Residents during an outbreak

New admissions/re-admissions and transfers from a hospital to the home, will require the Resident to be placed on enhanced monitoring for 10 days with twice daily temps for ongoing surveillance.

Residents who are on Enhanced Monitoring do not require isolation.

All asymptomatic Residents will have their temperatures taken twice daily for the duration of the outbreak to facilitate early identification and management of ill Residents.

Symptomatic Resident Symptom Monitoring

Symptomatic Residents will be monitored twice daily (including vital signs – temp and O2) to monitor for new or worsening symptoms of COVID-19

Visitors

Outbreak Access

Visitors to the home will enter and exit via the main entrance and self-screen using the signage in the vestibule and perform hand hygiene prior to entry.

Signage is posted at all entrances instructing visitors how to wash hands with ABHR, how to apply a mask and how to conduct proper respiratory etiquette

Visitors who fail passive screening should not enter the home when ill and should leave the home immediately and self isolate at their own home and follow Public Health guidance.

All persons entering the home must sign into the visitor logbook located at the front entrance. The visitor log can be used for contact tracing and is retained for 30 days.

When outbreak signage has been posted at the front reception desk, all visitors are encouraged to speak with reception prior to visiting their loved one.

Additional PPE (mask, eyewear, gown) is required for Caregivers, Support Workers and Essential Visitors when the Resident is on Additional Precautions or resides in the home or an area of the home in an outbreak.

The Caregiver, Support Worker and Essential Visitors will follow proper procedure for Donning and Doffing as instructional signage is located outside of each Resident’s door.

Caregivers should be educated by the staff on the potential risk of exposure when visiting a symptomatic Resident and must wear PPE (mask, gown, gloves, appropriate eye protection) and perform hand hygiene with ABHR before donning and doffing PPE.

General visitors should postpone non-essential visits to Resident’s who are symptomatic and/or self-isolating or when the home is in outbreak.

Visitors must comply with universal masking when entering a home area in outbreak

When a Visitor tests positive for COVID-19

Visitors who test positive for COVID-19 and/or have symptoms compatible with COVID-19 should self-isolate at their own home until symptoms have been improving for 24 hours (48 hours if gastrointestinal symptoms) and no fever is present.

Visitors should notify the home of their recent illness/positive test.

Visitors for a total of 10 days after the date of specimen collection or symptom onset, (whichever is earlier/applicable), should avoid non-essential visits to anyone who is immunocompromised or at a higher risk of illness and avoid non-essential visits to highest -risk settings (such as hospitals and long-term care homes)

Residents who are on isolation and imminently ill (end of life) may receive all visitors – there is no limit to the number of visitors a palliative Resident may receive. If these individuals fail screening, they must be permitted entry, but they must wear a medical mask and maintain physical distance from other Residents and staff.

Volunteers

Volunteers are not allowed in the home when Residents are displaying Acute Respiratory Infection symptoms in an outbreak area to limit community contact. The Supervisor of Programs and Volunteer Services will advise the volunteers of the outbreak.

Staff

All staff must screen for symptoms prior to their shift. Screening questions are posted in the service hallway, in each home area and throughout the home.

Staff and/or Visitor Experiencing Symptoms Compatible with COVID-19

Staff:

Staff who fail the screening process are to stay home and report to the Supervisor of Infection Prevention and Control and/or their department Supervisor to discuss next steps re: testing/work restrictions.

Staff who are asymptomatic and have a high-risk household contact of someone who is COVID-19 positive should notify their department Supervisor or the Supervisor of Infection Prevention and Control and follow additional instructions for 10 days from last exposure:

- Active screening for symptoms ahead of each shift where possible
- Individuals should not remove their mask when in the presence of other staff to reduce exposure to co-workers (i.e., not eating meals/drinking in shared space such as a lunch room)
- Ensure well-fitting source control masking for the staff to reduce the risk of transmission.

Staff who receive a positive COVID-19 test result while they are at the home (or while at home) should leave the facility immediately and are directed to self-isolate at their own home until symptoms have been improving for 24 hours (48 hours if gastrointestinal symptoms) and no fever present.

COVID-19 positive staff may now routinely return to work once they no longer have a fever and their symptoms have been improving for 24 hours (48 hours if gastrointestinal symptoms.)

Upon return to work, staff should follow measures to reduce the risk of transmission for 10 days from their symptom onset/positive test, whichever is earlier/applicable by adhering to the following:

- Ensuring well-fitting source control masking for the staff on early return to work to reduce the risk of transmission (e.g., a well-fitting medical mask or fit or non-fit tested N95 respirator)
- Not removing their mask unless eating or drinking, distancing from others as much as possible
- Avoid caring for Residents at highest risk of severe COVID-19 infection, where possible.

Positive Staff Member Close Contact

A close contact is defined as:

Positive Staff who provided direct care for a Resident and had close physical contact.

- Less than 2 meters from the Resident for more than 15 minutes without PPE
- Or provided care for multiple short periods of time without measures such as masking, distancing.

The RHA (or identified Residents) will be placed on enhanced monitoring for 10 days after last exposure to the staff member

Asymptomatic Residents do not need to be self-isolated/placed on additional precautions.

If a close contact develops symptoms, promptly isolate under additional precautions and test for COVID-19 using molecular testing.

Criteria for a potential COVID-19 Outbreak:

Outbreak Case Definition

Confirmed Respiratory Infection Outbreak Definition (including COVID-19)

- Two or more Resident cases of test-confirmed acute respiratory infections (ARI) with symptom onset within 48hrs and an epidemiological link (e.g. same unit/floor/service area) suggestive of transmission within the setting

OR

- Three or more Resident cases of ARI with symptom onset within 48hrs and an epidemiological link suggestive of transmission within the setting AND testing is not available or all negative

Suspect Respiratory Infection Outbreak Definition (including COVID-19)

- Two Resident cases of ARI with symptom onset within 48hrs with an epidemiological link (e.g. same unit/floor/service area) suggestive of transmission in the setting AND testing is not available or all negative

Cases are not epidemiologically linked if they have different causative organisms identified.

When a Respiratory outbreak is suspected, PCR tests will be done to reveal the causative agent

Case Management

COVID-19

- Confirmed or probable COVID-19 case should self-isolate on Droplet and Contact Precautions for at least 5 days from symptom onset and until symptoms have been improving for 24hrs (or 48 hours if gastrointestinal symptoms) and no fever is present
    - After the 5 days from symptom onset, if symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever is present, Additional Precautions can be discontinued.

- For a total of 10 days from symptom onset, cases should wear a well-fitted mask, if tolerated when receiving care and when outside of the room
    - If unable to mask, the case should remain on Droplet and Contact Precautions for 10 days from symptom onset.

- This includes avoiding attending group dining and group activities that involve unexposed residents where masking cannot be maintained by the case.

- Residents can leave their room for walks in the immediate area or outdoors with staff/visitors wearing appropriate PPE, to support overall physical and mental well-being.

- Residents who test positive for COVID-19 should be assessed as soon as possible to determine if COVID-19 therapeutics are within their goals of care, and if so, to determine eligibility.

Contact Management

Close Contact Definition:

A close contact is defined as an individual who has a high-risk exposure to a confirmed positive COVID-19 case, an individual with COVID-19 symptoms, or an individual with a positive rapid antigen test result.

Close contacts include a roommate as well as other resident contacts who, following a risk assessment, are deemed to have had significant exposures to the case (for example, contacts who have spent significant time together in close proximity without masking during the case's period of communicability. This includes dining table mates.

Roommates who remain in the same room

- Self-isolate on Droplet and Contact Precautions for 5 days (including day zero) from the case's symptom onset
- For a total of 10 days, from the case's symptom onset, wear a well-fitted mask, if tolerated, when receiving care and when outside of their room

Non-roommate close contacts (i.e., Tablemate)

- Self-isolate on Droplet and Contact Precautions for 5 days (including day zero) from the case's symptom onset

- For a total of 10 days, from the case's symptom onset, wear a well-fitted mask, if tolerated, when receiving care and when outside of their room

- All Residents in isolation should be supported to leave their room for walks in the immediate area or outdoors with staff wearing appropriate PPE, to support overall physical and mental well-being.

The local PHU has the discretion to recommend COVID-19 molecular testing of asymptomatic resident close contacts.

This may be considered when:

- There is a rapid increase in cases among residents; and/or
- The outbreak is not responding to usual IPAC measures; and
- The use of asymptomatic testing of close contacts is considered to have higher overall benefit (the identification of asymptomatic positive cases leading to reduced transmission, potentially reducing the duration and extent of the outbreak) than risk (harms associated with the isolation of asymptomatic residents).
- Should this be recommended, testing is advised to occur no sooner than 24 hours following exposure, and, if negative, testing may be repeated 48 hours after the first negative test (i.e., on Day 3 following exposure). Isolation is not required while awaiting test results. Rather, the close contact should be strongly encouraged to follow the risk reduction measures outlined above.
- Due to challenges in interpreting the result, testing is not recommended for asymptomatic residents who have recovered from COVID-19 in the last 90 days.
- If a close contact develops symptoms, promptly isolate under Additional Precautions and test for COVID-19 and other respiratory pathogens (i.e., MRVP or FLUVID).
- An asymptomatic contact who tests positive for COVID-19 should also be promptly isolated under Additional Precautions and managed as per Case Management.

Personal Protective Equipment

1. **Gloves**
- Follow Routine Practices
2. **Gowns**
- Follow Routine Practices
3. **Eyewear:**
   In addition to Routine Practices**,** wear goggles/face shield when working within two (2) meters of the Resident.

Masking:

- All staff will perform a point-of-care risk assessment prior to any ill Resident interaction to determine their use of masking (surgical or N95 mask if COVID-19 is Suspected or Confirmed) and will include assessing the exposure risk specific to the care intervention being performed and the duration of the activity.
- For respiratory illnesses, if the Resident chooses not to wear a mask, or is unable to safely wear a mask, Staff should review their PCRA and adjust PPE accordingly.

When an Outbreak (Suspect or Confirmed) has been declared

Nursing Department

1. All Residents symptomatic with symptoms of an acute respiratory illness and/or have an elevated temperature over 38 degrees with no respiratory symptoms, will be placed on Droplet/Contact Precautions as soon as possible after symptoms are identified.
2. The symptomatic Resident, their applicable roommate and tablemates will be placed on droplet/contact precautions concurrently.
3. All symptomatic Residents will be PCR tested for COVID-19 and other respiratory viruses. Initiate specimen collections of symptomatic Residents immediately. Obtain Naso-pharyngeal swabs on all ill Residents to verify the diagnosis; preferably within 48 hrs of onset of symptoms. Complete swabs as per nasopharyngeal procedure.
4. Symptomatic Residents will be monitored twice daily (including vital signs – temp and O2) to monitor for new or worsening symptoms of COVID-19
5. All asymptomatic close contacts will be placed on enhanced monitoring. Additionally, all asymptomatic Residents in the affected home area will be placed on enhanced monitoring for the duration of the outbreak.
6. Staff will initiate droplet/contact precautions with any Resident being admitted or returning from an LOA with symptoms of an Acute Respiratory Infection (failed ARI screening via the Symptom Surveillance Screening question in the EMAR system completed on all shifts)
7. Additional precautions will be initiated (i.e. PPE container outside of the resident's room with appropriate PPE, linen and garbage bag inside the resident's room, droplet/contact precaution signage)
8. Registered staff will initiate the droplet/contact checklist and document an Isolation Progress Note in Residents software system.
9. Obtain Sanuvox machine and place inside of resident's room to maintain/purify air quality.
10. Staff will notify the Medical Director and/or Nurse Practitioner for an evaluation, assessment, and diagnosis.
11. Notify Infection Prevention and Control of new Resident illness
12. Complete the shift surveillance form to submit to IPAC
13. A single room is preferred, however if this cannot be made possible symptomatic residents living in a basic room: Maintain a 2-metre spatial separation between Residents. Pull privacy curtains closed. Door to room may remain open.
14. All staff providing care or entering the room of a symptomatic resident are to wear Personal Protective Equipment.
15. Symptomatic Residents will be allowed to attend medically necessary appointments or activities, and it is recommended they wear a mask (as tolerated for respiratory illnesses). Receiving facility should be notified of the potential outbreak so appropriate precautions can be taken for the Resident on arrival.
16. If a Resident must be transferred to the hospital for further medical evaluation, the Registered staff will complete the Patient Transfer Authorization Form done via internet–Staff must notify the transportation service and the hospital receiving the Residents status, prior to transfer.
17. Notify Power of Attorney for Care to update them on the Resident's condition and diagnosis.
18. Staff should cohort in affected areas to minimize staff and Resident exposure.

19. The Registered staff will notify all the other departments of isolated Residents via DL-Norview e-mail. E-mail communication will also be completed when the Resident is removed from isolation.
20. Residents who are isolated will have all their nonessential appointments cancelled.
21. Isolated residents are able to have essential caregiver visits but are discouraged from participating in any social or temporary leaves of absence.
22. To prevent social isolation, 1:1 activity and therapy will be offered.
23. Hand hygiene to be completed per the 4 Moments and hand washing when hands are visibly soiled.
24. Dedicated equipment is preferred for the symptomatic Resident when able however all reusable equipment will be cleaned and disinfected after each use. Whenever possible, disposable equipment will be used and discarded immediately upon exiting the room where care is delivered.
25. Surfaces and equipment will be cleaned and disinfected (or discarded) by staff performing procedures in room before leaving the room and before removing personal protective equipment.
26. Documentation in the Resident Chart will include but not limited to: onset time and symptoms, vital signs, lab investigation including specimens collected and sent to The Public Health Unit, isolation if applicable, Doctor or Nurse Practitioner visits and other assessments/observations, as applicable.
27. PPE - Gowns, gloves, mask and eyewear are to be worn by all staff (and visitors) for Residents who are symptomatic.
28. Linen is to be kept separate - place all soiled linen in red isolation bags
29. A mask, hand hygiene and respiratory etiquette instruction to be provided to the Resident. If the Resident is leaving their room and/ or is non-compliant with isolation then wear a mask and perform hand hygiene.
30. No fans in the outbreak home area
31. If symptomatic Residents on room isolation wish to be bathed in the tub and/or shower, they are to be bathed last and the required PPE (gown, goggles, gloves) must be worn by the staff member.
32. If the Residents who are on isolation are non-complaint with room isolation, and if re-direction is not effective, staff are to encourage them to wear a mask when they are out of their room and physically distancing from other Residents and provide hand hygiene.

Housekeeping

Extra housekeeping staff will be implemented for cleaning/disinfecting high touch surfaces twice daily

1. Hand hygiene as per Just Clean Your Hands Policy and Procedure and follow additional precautions.
2. Increase in cleaning procedures to be done throughout the home.
3. Housekeepers will increase cleaning to high touch surfaces in the outbreak home area and in ill Residents room and environment for the duration of the outbreak.
4. Enhanced cleaning of high touch surfaces will include: door handles, bed railings, handrails, light switches, elevator buttons, over bed tables, dining room tables and counters in the outbreak home area and ill Residents immediate environment twice daily.
5. Terminal cleaning the Resident room/environment when Droplet/Contact precautions are removed.

6. Maintain consistent staff in areas when possible.

Activities/Therapy

Outbreak Home Area

- The outbreak home area will remain co-horted to their unit for the duration of the outbreak
- No intermingling of other Residents with the outbreak home area
- All large group activities will be cancelled
- Small group activities may continue as long as physical distancing, masking (when tolerated) and hand hygiene is performed before and after the program.
- 1:1's are preferred
- Therapy- can complete 1:1 in outbreak home areas
- Any shared equipment must be cleaned and disinfected in between use
- Residents who wish to go off the outbreak home area (i.e. to smoke), should be encouraged to mask while travelling within the home, physically distance from others and perform hand hygiene.

All other home areas

- No intermingling with the outbreak home area for the duration of the outbreak
- Residents may walk freely within the home but should not enter the outbreak home area
- Residents can still go outside
- Encourage masking for all large and small group programs
- Assist with hand hygiene before and after all programs
- Any shared equipment must be cleaned and disinfected in between use

Additional Integration measures

- In consultation with the PHU, IPAC will complete a risk assessment for each outbreak to determine the level of integration of Residents from different home areas
    - i.e., Large group programming preceding an increase in Resident illness
        - No integration of all Residents for 5 days

- Every outbreak must be evaluated independently. Control measures will be reviewed and adapted by IPAC, the outbreak management team in collaboration with Public Health authorities. This ensures that strategies are effectively implemented to mitigate risks and manage the outbreak effectively.

Laundry Department

1. Wash isolated linen as per policy and procedure.
2. Hand hygiene to be done before and after each Resident contact and upon entering and leaving the home area.
3. Handle soiled laundry/linen as little as possible.
4. PPE must be worn when handling soiled laundry

Facilities Services Department

1. Air handler filters may require changing to prevent spread of infection.
2. Hand hygiene as per Just Clean Your Hands Policy and Procedure and follow additional precautions.

Contracted Services (Haircare/Podiatry/PT/OT)

1. Hand hygiene as per Just Clean Your Hands Policy and Procedure and follow additional precautions with the Residents who are displaying symptoms.
2. Conduct programs/therapy (1:1) – Personal Protective Equipment required for ill Residents.
3. Cleaning and disinfecting of shared equipment between Residents

Dietary:

- Tray room paper service for all Residents who are on droplet/contact precautions.
- China may be used for Residents in the dining room.
- Cereal and soup may be served first to both home areas with the assistance of nursing staff (see responsibility explanation in servery for details)
- Continue to provide adaptive aids as the Residents require.
- Hand hygiene as per Just Clean Your Hands Policy and Procedure and follow additional precautions.
- Maintain consistent staff in areas when possible.
- Non-outbreak home areas will be served first, following the home area in outbreak to maintain a clean to dirty approach.
- The Dietary carts and all of the tables will be cleaned with disinfectant following each meal

All Staff

1. All staff and Residents must perform proper respiratory etiquette to prevent the spread of respiratory infection.
2. The Manager of Nursing and Personal Care and Supervisors of other departments will determine staffing considerations.
3. Staff should monitor themselves for signs and symptoms of an infectious disease.
2. During a respiratory outbreak, staff working at two facilities should inform their employers that they are working at a facility with an outbreak. Staff are encouraged to change their uniform between facilities.

COVID-19 Outbreak Management

Role of the Infection Prevention and Control Supervisor and/or delegate

Required Steps in an Outbreak: When local Public Health declares a Suspect or Confirmed outbreak in the home, the following measures must be taken:

1. Establish a case definition in consultation with Public Health.

2. Obtain an outbreak number from Public Health
3. Outbreak Management Team (OMT) is activated.
4. Defining the outbreak area of the home and co-horting based on COVID-19 status (ie. Infected or exposed and potentially incubating)
5. Assessing risk of exposure to residents/staff based on cases' interactions
6. Ensuring Additional Precautions are in place for all symptomatic residents and those with suspect or confirmed COVID-19.
7. Facilitate assessment of IPAC and outbreak control measures, as needed
8. Ensures the outbreak home area remains co-horted to their unit for the duration of the outbreak. Group activities and communal dining should be conducted such that the outbreak unit is co-horted separately from unexposed residents and units.
9. At the discretion of the PHU/OMT/IPAC, group activities and communal dining for cohorts (exposed separated from unexposed) may resume.
10. Wherever possible, continuing group activities for exposed cohorts is recommended to support resident mental health and wellbeing.
11. Ensuring staff remain in a single cohort per shift, wherever possible. If staff must work with more than one cohort during a single shift, it is recommended that staff work with unexposed residents first
12. At the discretion of the PHU/OMT/IPAC, communal dining and group activities may be paused completely in the case of a facility-wide outbreak or where transmission is uncontrolled in a single home area, the rate of infection increases in cases or severity or illness is significant or unexpected and the benefits of closure of communal activities are deemed to be greater than the harms caused to resident wellbeing. This decision should be revisited as the outbreak progresses.
13. IPAC will ensure enhanced symptom assessment (twice daily) of all residents in the outbreak area is conducted to facilitate early identification and management of ill residents.
14. IPAC will deliver weekly audits for the duration of the outbreak. The results of these audits are reviewed by the OMT
15. Ensure increased cleaning and disinfection practices (e.g., at least two times a day and when visibly dirty for high touch surfaces)
16. Update signage - General visitors should postpone all non-essential visits to residents within the outbreak area for the duration of the outbreak
17. For admissions or transfers, IPAC will consult with Public Health during an active outbreak.
18. Provides direction on restrictions to admissions/transfers/discharges to the outbreak unit/institution.
19. Implements IPAC measures to all departments in the home including universal masking for the affected home area for all respiratory outbreaks, enhanced monitoring of asymptomatic Residents and enhanced twice daily cleaning of high touch surfaces.
20. Additional measures (e.g., increased use of masking by staff/visitors, increased frequency of infection prevention and control audits with feedback) to prevent respiratory virus transmission during high-risk periods.
21. Identifies high risk activities which are recommended to be stopped during the outbreak.
22. Implements integration strategies as required and changes to activities (if applicable) within the unit
23. Provides direction on isolation of Resident cases.
24. Provides direction on management of staff
25. Facilitate assessment of IPAC and outbreak control measures, as needed.
26. Assessing risk of exposure to residents/staff based on cases' interactions

27. An Outbreak Management Team meeting will be held at the discretion of the Chair at the beginning of the outbreak, as necessary throughout the outbreak and when an outbreak has been declared over.
28. Discuss with Public Health any additional IPAC measures that are required to be implemented.
29. Notify the Ministry of Health and Long-Term Care of the outbreak via CIS – Critical Incident System when outbreaks are confirmed.
30. Notify the other departments of the outbreak via e-mail. An email notification is sent to all persons within the home and applicable staffing agencies.
31. Initiate signage at the front door of the home as well as the affected home area(s) in outbreak
32. Update the outbreak assessment email, communicate PCR results, and will advise when the ill Resident(s) may come off isolation.
33. Check the status of COVID-19 vaccine in Residents and offer the vaccine to eligible Residents if/when the vaccine is available.
34. Maintain accurate records of all Residents affected
35. Maintain accurate records of all Residents affected, inclusive of date time of onset and symptoms and if specimens have been obtained on the Respiratory Outbreak Line Listing Form and communicated with Public Health
36. The Infection Prevention and Control Professional will follow up with notification to appropriate Ministry officials and the Public Health Department if the Employee reports an occupational illness.
37. All Media questions are to be referred to the Administrator.
38. The Medical Director, Pharmacy, JHSC, and applicable unions will be notified.
39. Signs/alerts will be posted on the home area doors/wall, the external doors to the home and at the sign in table indicating that there is an outbreak and the potential for risk of infection.
40. Complete own IPAC audits per policy and procedure
41. Provide education and/or team huddles to staff during the outbreak
42. Monitor ongoing illness in Residents via progress notes
43. Maintain and communicate an accurate line list and send to Public Health as required.
44. Ensures that staff are fit tested for an N95

Role of Public Health in Outbreaks

- Only the local public health unit can declare an outbreak over.
- The IPAC Lead and/or delegate will follow the direction of the public health unit in the event of a suspect or confirmed COVID-19 outbreak.
- The IPAC Lead and/or delegate will follow any guidance provided by the local public health unit with respect to any additional measures that must be implemented to reduce the risk of COVID-19 transmission.
- The local public health unit is responsible for managing the outbreak response.
- Local public health units have the authority and discretion as set out in the Health Protection and Promotion Act to coordinate outbreak investigation, declare an outbreak based on their investigation, and direct outbreak control measures.
- The local PHU will direct testing and public health management of all those impacted (staff, residents, and visitors) using a risk-based approach. It is important to consider both the risk to residents and the potential harm of resident isolation and testing when implementing public health measures.

Declaring the outbreak over

- In consultation with the outbreak management team and the local public health unit, the outbreak may be declared over when no new cases, which were reasonably acquired in the setting, have occurred for 8 days, and there is no evidence of ongoing transmission.

Use of Rapid/PCR tests

Test-to-treat

Publicly funded COVID-19 testing should only be available to:

1. Ontarians eligible for COVID-19 treatment (i.e., symptomatic individuals who are immunocompromised, or 65 years of age or older, or those with high-risk medical conditions).

2. People in high-risk and some congregate living settings (including long-term care homes) and other specific populations to support outbreak prevention and management.

As long as rapid tests are available, Norview Lodge will keep a supply to support outbreak management.

Further information about COVID-19 testing eligibility and testing

All positive molecular tests or RAT results in residents, staff, or visitors associated with a suspect or confirmed outbreak in the home will be reported to the PHU and Outbreak Management Team.

Negative RAT results should not be used independently to rule out COVID-19 in an outbreak situation due to its limited sensitivity and the increased pre-test probability of COVID-19.

If a RAT is used for a resident with symptoms or high-risk exposure (e.g., in extraordinary circumstances when access to timely PCR testing is not available), staff will also complete a PCR in parallel.

Specimen Collection and Testing for Outbreak Management

Testing/Retesting:

- All symptomatic residents will be tested for COVID-19 and other respiratory pathogens
- In general, it is recommended that outbreak testing be guided by clinical and epidemiological risk factors for the purposes of active case finding.
- Point prevalence testing may be done at the discretion of the PHU to guide assessment and management in the context of a new (sub)variant or an especially challenging/prolonged outbreak, however, if done, it is recommended that asymptomatic individuals not be required to remain in isolation pending test results.
- PH assigns the home an outbreak number.

Notify Public Health regarding visitors who were potentially exposed, check daily log book.

*To ensure homes in outbreak are prioritized, all requisitions will be submitted on green paper with outbreak number included.

Considerations for Management of Mixed Outbreaks in LTCHs

In the context of one or more residents testing positive for COVID-19 and one or more residents testing positive for influenza, a cautious approach is warranted. The following recommendations may be considered, at the discretion of the PHU:

- All additional symptomatic residents and staff may be considered for FLUVID testing (beyond the first 4 MRVP+). PHUs are to contact PHOL.
- Influenza antiviral prophylaxis should be initiated for all asymptomatic residents and residents who are COVID+/influenza negative until the influenza outbreak is declared over.
- For COVID-19 positive residents, both Tamiflu and Paxlovid can be given at the same time; however, given potential drug-drug interactions, the decision to initiate treatment is at the discretion of the treating physician

Diagnostic Testing for ARI/Mixed Outbreaks in LTCHs

- All symptomatic residents and staff should be tested for COVID-19 and other respiratory pathogens as soon as symptoms present.
- PHO's laboratory has expanded the eligibility for outbreak-related respiratory virus FLUVID (influenza A, influenza B, RSV, and SARS-CoV-2) PCR testing to all specimens from symptomatic residents and staff.
- In general, it is recommended that outbreak testing be guided by clinical and epidemiological risk factors for the purposes of active case finding. Point prevalence testing may be done at the discretion of the PHU to guide assessment and management in the context of a new (sub)variant or an especially challenging/prolonged outbreak, however, if done, it is recommended that asymptomatic individuals not be required to remain in isolation pending test results.
- PHUs are responsible for following usual outbreak notification steps to PHO's laboratory to coordinate/facilitate outbreak testing and ensuring an outbreak number is assigned. See PHO's Respiratory Outbreak Testing Prioritization protocol for details.

Antivirals/Therapeutics

The Physician and/or NP will assess each Resident eligibility to begin antivirals quickly because treatment is most effective when started within 48 hours of symptom onset

The Physician/NP will determine if a Resident meets eligibility, including reviewing medications for potential drug-drug interactions.

Norview Lodge has rapid access to antiviral (Paxlovid) medications from the local pharmacy.

Consent for antiviral medication use is obtained from Residents (or SDM) in advance.

Admissions and Transfers

- Public Health approval is not required for admissions/transfers, but Public Health Unit consultation is recommended when IPAC advice or risk mitigation is needed.

- In general, admissions and transfers in an outbreak should be avoided. However, if the risks of not admitting a resident are determined to outweigh the risks of admitting the resident into an outbreak, informed consent from the resident should be obtained.

- Enhanced monitoring for 10 days is implemented to all Resident admissions, re-admissions and transfers from hospital to quickly identify any new or worsening symptom.

Admissions/Transfers during an outbreak

Residents admitted to hospital prior to the outbreak, or admitted to hospital for reasons other than enteric illness may be admitted/re-admitted to the Long Term Care Home if the following conditions are met:

(a) The Resident or legally authorized substitute has been informed of the outbreak status and provided consent;

(b) The Residents physician has been informed of the outbreak status and provided consent (taking into consideration the severity of the particular outbreak relative to the Resident's condition).

Reporting to the Public Health/Ministry of Health and Long-Term Care

- A confirmed COVID-19 outbreak immediately using the CIS during regular working hours or;
- Ministry of Health and Long-Term Care will be notified via on-call inspection after hours 1-888-999-6973 after hours and on weekends.

Additional Reporting

- Occupational Health and Safety.
- Ministry of Labour within 4 days.
- WSIB in 72 hours.
- Unions.
- Pharmacy

Instructions for Cases and Close Contacts Associated with LTCH's Chart

	Self-Isolation Period	**Additional Instructions**
Resident Case- tests positive for COVID-19 **Is able to independently and consistently wear a mask**	At least 10 days after the date of specimen collection or symptom onset (whichever is applicable/earlier), and until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever present	After day 5, if the resident is asymptomatic or their symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever is present, the resident: • May routinely participate in communal areas/activities but must wear a well-fitted mask at all times when outside of their room; and • May not

	Self-Isolation Period	**Additional Instructions**
		participate in communal activities where they would need to remove their mask within the setting (e.g., group dining)
Resident Case-tests positive for COVID-19 **Is unable to mask**	At least 10 days after the date of specimen collection or symptom onset (whichever is applicable/earlier), and until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever present.	Residents are able to leave their room for walks in the immediate area with a staff person wearing appropriate PPE, to support overall physical and mental well-being.
Resident asymptomatic close contact (Roommate/Tablemate)	Roommate/Tablemate close contacts: isolate and place on Additional Precautions. Individuals who remain asymptomatic may discontinue isolation after a minimum of 5 days of isolation (based on 5 days from when the case became symptomatic or tested positive if asymptomatic).	For a total of 10 days after last exposure to the COVID-19 case (or individual with symptoms): • Daily monitoring for symptoms; • Wear a well-fitted mask, if tolerated, and physically distance from others as much as possible when outside of their rooms; and • Not visit other (unaffected) areas of the home or interact with residents who have not been exposed.
Resident-Co-Residents on RHA	Does not need to self-isolate if asymptomatic.	Monitoring twice daily for symptoms Strongly encouraging the resident to wear a well-fitting mask, if tolerated, and physically distance from others when outside of their room for 7 days following their last exposure to the individual with COVID-19. - This may include avoiding attending group dining and group activities that involve unexposed residents where masking and physical distancing cannot be maintained by the close contact. Encouraging the resident to wear a well-fitted mask, if tolerated, when receiving care.

	Self-Isolation Period	**Additional Instructions**
Staff positive case	Follow community guidance when community settings outside of the LTCH	Staff may return to work if they are afebrile, and their symptoms have been improving for 24 hours (48 hours if vomiting/diarrhea). For a total of 10 days after date of specimen collection or symptom onset (whichever is earlier/applicable), staff should: • Strictly adhere to workplace measures for reducing risk of transmission (e.g., masking for source control, not removing their mask unless eating or drinking, distancing from others as much as possible); and • Avoid caring for patients/residents at highest risk of severe COVID-19 infection, where possible.
Visitor positive case	Does not need to self-isolate if asymptomatic.	For a total of 10 days after the date of specimen collection or symptom onset, whichever is earlier/applicable, visitors should avoid non-essential visits to anyone who is immunocompromised or at higher risk of illness (e.g., seniors) and avoid non-essential visits to highest-risk settings such as hospitals and long-term care homes. • Where visits cannot be avoided, visitors should wear a medical mask, maintain physical distancing, and notify the setting of their recent illness/positive test. If the individual being visited can also wear a mask, it is recommended they do so
LTCH staff and essential visitor/caregiver asymptomatic close contact	Does not need to self-isolate if asymptomatic.	Where feasible, additional workplace measures for individuals who are self-monitoring for 10 days from last exposure may include: • Active screening for symptoms ahead of each shift, where possible • Individuals should not remove their mask when in the presence of other staff to

	Self-Isolation Period	Additional Instructions
		reduce exposure to co-workers (i.e., not eating meals/drinking in a shared space such as conference room or lunch room.) • Working in only one facility, where possible; • Ensuring well-fitting source control masking for the staff to reduce the risk of transmission (e.g., a well-fitting medical mask or fit or non-fit tested N95 respirator or KN95)

Education

This policy will be given with orientation to all new employees and reviewed annually via Surge Learning for all staff.

This policy will be reviewed by Resident Council, Family Council and Public Health as required.

References:

Ministry of Health COVID-19 Guidance: Long-Term Care Homes, Retirement Homes and Other Congregate Living Settings for Public Health Units;
Ministry of Long-Term Care COVID-19 guidance document for long-term care homes in Ontario

Ontario. Ministry of Health. Recommendations for outbreak prevention and control in institutions and congregate living settings. Toronto, ON: King's Printer for Ontario; October 2024

Attachments:
Droplet/Contact Precautions for COVID-19 Compatible Symptoms Checklist
COVID-19 Outbreak Form
Personal Protective Equipment Required