

<b>Subject: Respiratory Outbreak Policy</b> (Acute Respiratory Infection, Influenza (A/B), RSV, COVID-19, SARS)	Page: 1 of 21
<b>Manual: INFECTION CONTROL</b> Issue Date: April 2003  Revised Date: January 2014, January 2017, May 2020, May 2022, July 2023, May 2025	Approval Authority: Administrator and Director of Care, IPAC Lead

## Respiratory Outbreak Guidelines

The Gibson Family Healthcare Long Term Care and Lodge has implemented a Respiratory Outbreak Policy that has been developed in accordance with the following documents: Fixing Long Term Care Act (2021), Resident Bill of Rights (2021), MOHLTC, Respiratory Outbreak Guidance Manual (South East Public Health Unit, 2022), Health Protection and Promotion Act (HPPA), Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (2025), Best Practises for the Prevention of Acute Respiratory Infection Transmission in All Health Care Settings (PIDAC, 2024), The OHSA and associated Regulations for Health Care and Residential Facilities (HCRF).

### Definition of terms:

**Acute respiratory infection (ARI):** Any new onset acute respiratory infection that are spread via respiratory particles and typically presents with symptoms of a fever greater than 38° C and a new or worsening cough or shortness of breath. It should be noted that elderly people and people with immunocompromising conditions may not have a febrile response to a respiratory infection

**Point of Care Risk Assessment (PCRA):** A Point of Care Risk Assessment (PCRA) is to be performed by every health care worker before any resident interaction. If a health care worker determines, based on the PCRA, and their professional judgement, that health and safety measures may be required in delivery of care to the resident then health and safety control measures including N95 respirators as needed. The home will not unreasonably deny staff access to the appropriate PPE.

**Additional Precautions:** Precautions (i.e., Contact Precautions, precautions for acute respiratory infection and Airborne Precautions) that are necessary in addition to Routine Practices for certain pathogens or clinical presentations

**Contact Precautions:** Used in addition to Routine Practices to reduce the risk of transmitting infectious agents via contact with an infectious person or their environment, includes gloves, gown and mask.

**Droplet Precautions:** Term traditionally used for precautions in addition to Routine Practices for residents known or suspected of having an infection that can be transmitted by large respiratory particles, includes gloves, gown, mask with face shields or goggles.

**Airborne Precautions:** Used in addition to Routine Practices for patients/residents/clients known or suspected of having an illness transmitted by small infectious respiratory particles that remain suspended in the air and may be inhaled by others. Includes gown, gloves, face shield or goggles and N95 mask.

**Hand hygiene:** A general term referring to any action of hand cleaning. Hand hygiene relates to the removal of visible soil and removal or killing of transient microorganisms from the hands. Hand hygiene may be accomplished using an alcohol-based hand rub or soap and running water.

**Alcohol-based hand rub (ABHR):** A liquid, gel or foam formulation of alcohol (e.g., ethanol, isopropanol) which is used to reduce the number of microorganisms on hands in clinical situations when the hands are not visibly soiled. Alcohol-based hand rubs contain emollients to reduce skin irritation and are less time-consuming to use than washing with soap and water.

**Fit-test:** A qualitative or quantitative method to evaluate the fit of a specific make, model and size of respirator on an individual. Fit-testing is required at least every two years and whenever there is a change in respirator face piece or the user's physical condition that could affect the respirator fit.

**Personal protective equipment (PPE):** Clothing or other equipment worn for protection against hazards

**PCRs:** Polymerase chain reaction test that includes nasal and throat swabs to identify respiratory viruses.

**Epidemiological Link:** An epidemiological link can refer to, but is not limited to,

common unit/floor, common staff, shared activities or dining area, common visitors etc., where there is evidence of transmission within the unit or site.

**A Respiratory Outbreak** is defined as two cases of residents experiencing similar symptoms within 48 hours of each other AND have an established epidemiological link. At least one must be laboratory confirmed. If three or more cases have been established, then no laboratory confirmation is needed to declare an outbreak.

*Each case should have **two** or more of the following symptoms:*

- Abnormal temperature
- Chills
- Runny/stuffy nose, sneezing
- Sore throat, hoarseness
- Cough – dry or productive
- Headache
- Tiredness
- Muscle aches
- Poor appetite
- Swollen or tender glands in neck

### **Preparedness**

The Gibson Family Health Care Long Term Care and Lodge developed a Respiratory outbreak plan (Acute Respiratory Illness (ARI), Influenza, RSV, COVID-19, SARS) that is reviewed and updated annually. Each year, in-services are provided to all staff on personal protective equipment (PPE), influenza and hand washing prior to “flu season” as well as fit testing for N95 NIOSH masks every 2 years. The Gibson Family Healthcare LTC and Lodge’s Joint Health and Safety and Infection Control Team is responsible to ensure that the home is prepared for outbreaks throughout the year.

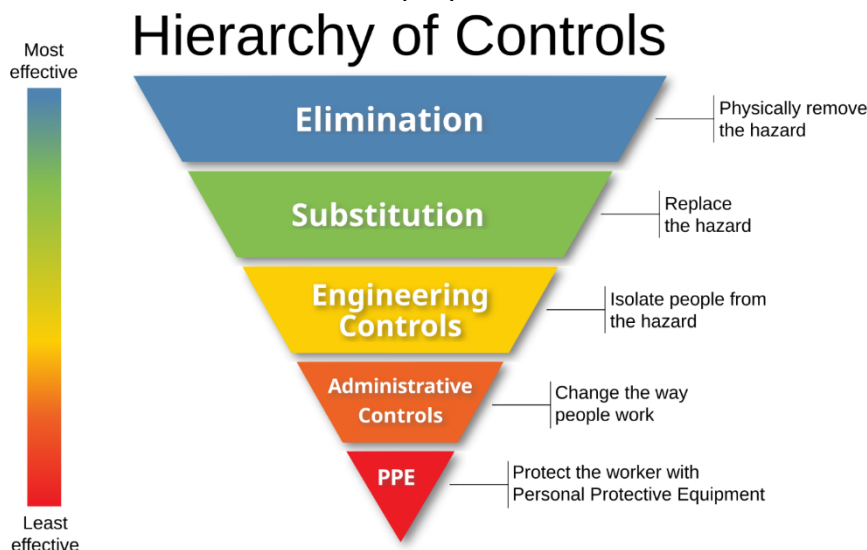
*Preparation includes:*

- Ensuring that there is enough PPE (gowns, masks, face shields, gloves, N95s)
- Training of staff on the use of PPE and best practice handwashing techniques.
- Fit testing for N95 NIOSH masks for all staff every 2 years.
- Staff are offered influenza (October-May) and COVID-19 (October) vaccines annually; Residents are offered Influenza (annually) and COVID-19 (bi-annually) as well as RSV to those residents eligible as a one time dose.

- Ensuring advance directives of residents are reviewed and current.
- Ensuring communication protocols are in place.
- Ensuring alternative internal activities protocols are in place.
- Reviewing environmental cleaning protocols
- Following up to date protocols on managing staff who may be exposed to a respiratory illness.
- IPAC team to complete monthly Self Assessment Audit and weekly if in outbreak situation.
  - Collaboration of the Gibson Family Healthcare LTC and Lodge IPAC team and The IPAC Hub. The Role of the IPAC Hub includes:
  - Support implementation of infection prevention and control (IPAC) best practices in applicable institutions.
  - Educational supports that are offered both remotely (virtually) or onsite and are tailored to the unique types and needs of settings.
  - Deliver education and training.
  - Host communities of practice (CoP) to support information sharing, learning, and networking to congregate living settings.
  - Support the development and implementation of IPAC programs, policy, and procedures within sites/organizations.
  - Support assessments and audits of IPAC programs and practices.

### *Hierarchy of Controls*

As per PIDAC, the application of the hierarchy of hazard controls is fundamental to an OHS framework and is a recognized approach to containment or mitigation of hazards to protect workers, including protection from **infectious diseases**. The hierarchy of controls contains five control levels and are ordered from the highest level to the lowest level in terms of effectiveness to prevent transmission. While personal protective equipment (PPE) is at the bottom of the hierarchy and is not sufficient on its own to protect staff, it is an active control measure that individuals can employ.



## **Heating, Ventilation and Air-conditioning System Installation and Maintenance**

An HVAC system comprises the equipment, distribution systems and terminals that provide, either collectively or individually, heating, ventilating, or air conditioning to a building or part of a building. Most HVAC systems incorporate the processes of air filtration, indoor air recirculation, outdoor air supply and exhaust in varied proportions. To achieve optimal performance, HVAC systems should be designed, constructed, installed, operated and maintained as per the facility engineering recommendations, the manufacturer's instruction for use and in accordance with relevant regulations and standards. HVAC professionals should be consulted to ensure the system is appropriate for the type of setting, nature of activities carried out therein, occupancy rate and operation time. Whenever feasible, IPAC and OHS should work with facility engineers and HVAC experts to optimize the system and ensure its performance meets Canadian Standard Association (CSA) standards. In addition, regular maintenance of the HVAC system is necessary, including filter changes as per the manufacturer's recommendations, to ensure that all vents and fans are clear. Section 19 of the Health Care and Residential Facilities Regulation O. Reg 67/93, under the Occupational Health and Safety Act, requires that the mechanical ventilation system of health care facilities be inspected by a qualified professional every six months to ensure it is in good condition (where applicable). All parts of the air handling unit should be easily accessible for inspection, cleaning and disinfection. Furthermore, there should be clear standard operating procedures, rules and responsibilities for preventive maintenance, as well as documentation of checks.

## **Portable High-Efficiency Particulate Air Filtration Units**

Portable air filtration devices equipped with HEPA filters are effective in capturing IRPs (Infectious Respiratory particle), including some viruses. By ensuring proper placement of the device, airflow being directed from one person to another can be avoided and reduce the potential spread of potentially IRPs. The Gibson Family Healthcare LTC and Lodge follow the manufacturer's recommendations for operating, maintaining and cleaning the unit, including regular filter changes.

## **Hand Hygiene**

*The Fixing Long-Term Care Act, 2021* requires The Gibson Family Healthcare LTC and Lodge to ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing IPAC practices. Gibson Family Healthcare LTC and Lodge educates and trains staff on an annual basis using the "Just Clean Your Hands" program. Hand hygiene agents are accessible at all points of care.

### ***Alcohol-based hand rubs (ABHRs)***

Alcohol-based hand rubs containing 70% alcohol are the preferred method of hand hygiene when hands are not visibly soiled, and soap and water is not readily available. If there is visible soiling, hands must be washed with soap and running water. If soap and running water are not available, cleanse hands first with moistened towelettes to remove visible soil, let hands dry and then use ABHR.

Four Moments for hand hygiene in accordance with the “Just Clean our Hands” program

1. Before initial resident/resident environment contact.
2. Before invasive/aseptic procedures.
3. After body fluid exposure risk and contact with blood, body fluids, secretions and excretions.
4. After resident/ resident environment contact.

All staff, residents, families, and volunteers are educated in the *Four Moments for hand hygiene* in accordance with the “Just Clean our Hands” program on an annual basis and during orientation. Residents and families access the program through the admission process.

### ***Staff Hand Hygiene***

In addition to the four moments for hand hygiene, good staff hand hygiene practices include the following:

- After contact with items known or considered likely to be contaminated with blood, body fluids, secretions, and excretions, including respiratory secretions (e.g. oxygen tubing, masks, used tissues and other items handled by the resident)
- Immediately after removing gloves and other PPE
- Between certain procedures on the same resident to avoid cross-contamination of body sites where soiling of hands is likely; and
- Before and after preparing, handling, serving, or eating food and before feeding a resident
- Before and after staff breaks

### ***Resident Hand Hygiene***

In addition to the four moments for hand hygiene, good resident hand hygiene practices are always necessary, especially during influenza season, and include the following:

- Residents are instructed on (assisted, as necessary) proper hand hygiene
- Care of hand hygiene in residents is always necessary and especially during influenza season
- Resident hands should be washed or sanitized after using the washroom and washed or sanitized frequently before and after meals

- hand hygiene before and after shared activities; and hand hygiene when leaving and returning to their room.

## **Personal Protective Equipment (PPE)**

PPE is used alone or in combination to prevent exposure by placing a barrier between the infectious source and one's mucous membranes, airways, skin, and clothing.

The selection of PPE is based on the nature of the interaction with the resident and/or the likely mode(s) of transmission of infectious agents. Selection of the appropriate PPE is based on the risk assessment (e.g., interaction, status of resident) that dictates what is worn to break the chain of transmission.

The Gibson Family Healthcare LTC and Lodge is responsible to ensure that staff have enough supplies of PPE as required and that they are accessible. Education is provided in the proper selection and use of PPE to all health care providers and other staff who have the potential to be exposed to blood and body fluids.

### *Gloves*

When a resident is placed on contact or droplet-contact precautions, gloves are used when direct care will be provided. In addition, gloves must be worn when it is anticipated that the hands will be in contact with mucous membranes, non-intact skin, tissue, blood, body fluids, secretions, excretions, or equipment and environmental surfaces contaminated with the above. Indiscriminate or improper glove use has been linked to transmission of microorganisms. Gloves are task specific and single use for the task.

### *Appropriate Glove Use:*

- Wear the correct size of gloves.
- Put on gloves immediately before the activity for which they are indicated.
- Perform hand hygiene before putting on gloves for a clean/aseptic procedure.
- Remove carefully and discard gloves immediately after the activity for which they were used.
- Perform hand hygiene immediately after glove removal.
- Change or remove gloves if moving from a contaminated body site to a clean body site with the same resident.
- Change or remove gloves after touching a contaminated site and before touching a clean site or the environment.

- Do not wash or re-use gloves.
- Do not reuse the same pair of gloves for the care of more than one resident.
- Double gloving is not recommended.
- Gloves should be used as an additional measure, not as a substitute for proper hand hygiene.
- Gloves are recommended when providing care involving direct contact with an ill resident.
- Gloves should be put on before entering and removed prior to leaving the resident's room or dedicated bed space.
- Gloves are task-specific and single-use for the task. Gloves should be changed between dirty and cleaner procedures on the same resident, e.g., after open suctioning of a tracheostomy and remainder of care.
- Gloves that fit snugly around the wrist are preferred for use with a gown because they will cover the gown cuff and provide a better barrier for the arms, wrists and hands.

### *Masks*

A mask is used by a health care provider (in addition to eye protection) to protect the mucous membranes of the nose and mouth when it is anticipated that procedure or care activity is likely to generate splashes or sprays of blood, body fluids, secretions or excretions, or when within two meters/6 feet of a coughing/sneezing resident.

### *Appropriate Mask Use*

- Proper masking applies to all staff, volunteers, visitors who enter or encounter a suspect or confirmed resident illness area.
- Proper masking is required in all instances where contact and/or droplet precautions are being taken.
- Select a mask appropriate to the activity.
- Secure mask over nose and mouth.
- Do not touch mask while wearing it.
- Remove mask correctly immediately after completion of task and discard into an appropriate waste receptacle.
- Do not allow mask to hang or dangle around the neck.
- Clean hands after removing the mask.
- Do not re-use disposable masks.
- Do not fold the mask or put it in a pocket for later use.
- Masks are recommended when providing care involving direct contact with ill residents or when within 2 meters/6 feet of coughing/sneezing residents.
- For the care of a resident with respiratory illness, put a surgical mask on the resident, if tolerated, whenever the resident is not in his/her room (e.g. transfer to hospital). If masks are not available or not tolerated, residents should be

encouraged to use another method to cover their mouth and nose when coughing or sneezing (e.g., tissue).

- Change masks if they become wet or contaminated by secretions.
- Remove mask with clean hands before caring for another resident and when leaving the residents dedicated environment.
- Handle masks only by the strings/ties, to prevent self-contamination.
- Change masks according to the manufacturer's recommendations.
- Perform hand hygiene before and after mask removal.

## **Eye Protection**

Eye protection is used by health care providers (in addition to a mask) to protect the mucous membranes of the eyes when it is anticipated that a procedure or care activity is likely to generate splashes or sprays of blood, body fluids, secretions or excretions, or within two meters/6 feet of a coughing/sneezing resident.

### *Appropriate Use of Eye Protection*

- Remove eye protection immediately after the task for which it was used and discard into waste or place in an appropriate receptacle for cleaning and disinfection.
- Prescription eyeglasses are not acceptable as eye protection.
- Eye protection includes the use of safety glasses, goggles, and face shields. It does not include personal eyeglasses.
- Eye protection should be worn where there is a potential for splattering or spraying of blood, body fluids, secretions, or excretions, including cough/sneeze producing aerosol-generating procedures, while providing direct resident care. Proper eye protection is required in all instances where contact and/or droplet precautions are being taken.
- Safety glasses, goggles and face shields should be removed carefully to prevent self-contamination.
- If re-used, eye protection should be cleaned and disinfected between uses according to the manufacturer's recommendations using a minimum of a low-level disinfectant.
- To prevent self-contamination, staff should not touch their eyes during care of a resident with a respiratory illness.
- Perform hand hygiene before and after removal of eye protection.

### *Gowns*

A gown is recommended when it is anticipated that a procedure or care activity is likely to generate splashes or sprays of blood, body fluids, secretions, or excretions, or a resident is on contact or droplet/contact, airborne precautions. Long-sleeved gowns protect the forearms and clothing of the health care provider from splashing and soiling with body

substances during procedures and resident care activities which are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.

### *Appropriate Gown Use*

- Gowns should only be worn when providing care for residents, as per the above indications.
- When use of a gown is indicated, the gown should be put on immediately before the task and must be worn properly, i.e., tied at the top and around the waist.
- Proper gowning is required in all instances where contact and/or droplet, airborne precautions are being taken.
- Remove the gown immediately after the task for which it has been used in a manner that prevents contamination of clothing or skin and prevents agitation of the gown.
- Discard used gown immediately after removal into appropriate receptacle. Do not hang gowns for later use.
- Do not re-use gowns.
- Gowns should be removed before leaving the residents' room or dedicated space. It is important to remove (doff) PPE correctly (i.e. in the correct order) to prevent cross- contamination and the potential spread of infection from resident to resident. Doffing incorrectly also poses a risk of self-contamination.

### **Resident Care Needs**

Resident care plans are updated every 3 months and as condition changes. Advanced directives are reviewed annually during care conferences and as goals of care change. Plans of Care and Kardex are available on PCC for all staff to access. All resident's assessments are identified on the care plan and updated quarterly as well as any specific needs, such as oxygen usage, etc. These care plans are available via PCC online remote access is available.

### **Immunization**

#### *Influenza Immunization of Residents*

To ensure that protection lasts throughout the influenza season, the recommended time for influenza immunization is as early as possible when the vaccine becomes available as advised by our local Public Health Unit.

Prior to, or upon admission, each resident will be assessed regarding their immunization and medical status. If the influenza immunization status of a resident is not available or if it is unknown, the resident will be considered unvaccinated, and immunization will be

offered. A resident or their substitute decision-maker (SDM) may refuse any treatment/medication. Refusal (and reason for refusal) will be documented in the resident chart. If the resident is admitted after our fall influenza immunization program, but before the influenza season is over, vaccination will be offered, unless the resident has already received the current season's influenza vaccine.

The immunization record of the resident, including their influenza immunization status, will be retained in their Immunization Record within Point Click Care. Upon transfer to another home or hospital setting, the residents' recent immunization status will be shared with the receiving health care facility through the Health Assessment.

#### *Consent for Vaccination and Antiviral Medication*

Resident Immunization - Informed consent from the resident (or if the resident is incapable with respect to treatment, the SDM) must be obtained for influenza, pneumococcal, tetanus-diphtheria vaccines, RSV, COVID-19, and antiviral medications for prophylaxis in the event of an outbreak.

Staff immunization – Informed consent from the staff member must be obtained for influenza, COVID-19 and antiviral medications for prophylaxis in the event of an outbreak. IPAC lead or designate to follow Public health directives with current vaccinations recommendations

#### **Staff /Volunteers Education**

The ongoing annual education of staff, volunteers, residents, residents' families and visitors regarding infection control and outbreak prevention and related strategies is the responsibility of the combined Infection Control/Occupational Health and Safety Committee. This education will occur the time of hiring/placement, during staff/volunteer orientation and annually thereafter. The OSHA and associated Regulations for Health Care and Residential Facilities (HCRF) (O. Reg. 67/93) require annual review of measures and procedures for worker health and safety, and will include infection prevention and control, immunization, and other related topics. Outbreak policies and procedures will be reviewed/revised annually by this committee as required by legislation.

Education/orientation programs for all residents/families, staff and volunteers (as applicable) includes information and review on:

- The effectiveness, benefits, and risks of influenza immunization.
- Information about the respiratory viruses (including influenza, RSV and COVID-19) and its morbidity, mortality, and transmission
- The prevention of influenza, and the requirement for annual influenza vaccination
- The mechanisms to reduce disease transmission, for example respiratory etiquette and hand hygiene
- Respiratory infection outbreak management and exclusion policies of the home:

- policies related to staff and visitor illness recommendations; (any persons experiencing symptoms of a respiratory illness should not be working/visiting the home).
- influenza immunization and exclusion policies for staff/volunteers.
- influenza immunization policies and recommendations for family members and visitors; (any persons experiencing symptoms of a respiratory illness should not be working/visiting the home).

**Respiratory etiquette:**

- All individuals are advised to practice respiratory etiquette when coughing or sneezing: Turn head away from others; cover the nose and mouth with tissue or sneeze into your sleeve; discard tissues immediately after use into waste; and perform hand hygiene immediately after disposal of tissues.
- Use of personal protective equipment (PPE), cleaning and disinfecting requirements and environmental cleaning.
- Four Moments of Hand Hygiene education
- Chain of transmission: modes of infection transmission.
- Outbreak-related policies and procedures: surveillance, early recognition for potential transmission of infectious conditions, and management of an outbreak.

## **Surveillance**

### *Resident Surveillance*

As per MOHLTC, each resident will have a respiratory symptom assessment daily and twice daily when in a respiratory outbreak. The goal of surveillance is to ensure early identification of symptoms in residents that precede a potential outbreak or an outbreak in its early stages. Additionally, during an outbreak, surveillance serves to identify potential symptomatic residents that would otherwise prolong an outbreak. This assessment is recorded in PCC.

### *Staff Surveillance*

Surveillance for ARI among staff is done throughout the year. All staff are aware of early signs and symptoms of ARI. Staff are asked to report their respiratory infection to their manager. The manager must promptly inform the infection control lead or Director of Resident Care/Administrator of cases/clusters of employees/contract staff who are absent from work with respiratory symptoms. The information is also reported without using names to protect the employees' right to confidentiality to our Infection Control/Occupational Health and Safety Committee.

### *Non-staff Surveillance (includes volunteers, private pay caregivers, and visitors)*

All volunteers, private pay caregivers and visitors who conduct activities within Helen Henderson are to self-screen and exclude themselves from entering the home when they have respiratory symptoms (i.e., new cough, new shortness of breath, fever). Screening tools and policies are posted and followed by all persons entering the home as directed by MOHLTC.

## **Outbreak Detection and Management**

Early recognition of cases signaling suspected outbreaks and swift action are essential for effective management. Timely specimen collection, communication and the implementation of appropriate control measures have the potential to make a significant impact during the outbreak that will benefit both residents and staff.

***The following are guidelines only, as recommended by the MOHLTC. Always defer to the instructions of the public health unit.***

**Step 1** - Assess the symptomatic resident, establish two symptoms that are not “normal” or a symptom of a chronic condition.

**Step 2** - Infection control measures are to be implemented as soon as symptoms are assessed and identified by Charge RN. All staff will be notified quickly of the potential outbreak and provided with appropriate supplies (e.g. alcohol-based hand rub, PPE, including gowns, face/eye protection, gloves, surgical masks, etc.) All residents symptomatic with an Acute Respiratory Illness (ARI) will be placed on isolation and droplet/contact precautions as soon as possible after symptoms are identified. Asymptomatic residents should be cared for using routine practices and carefully monitored every shift by registered staff for any change in their symptoms.

**Step 3** - Notify the South East Health Unit of the suspected or confirmed outbreak via email or calling the after hours IPAC manager (# located in Outbreak Management Binders)

**Step 4** – Once outbreak is declared by Public Health, the following steps are mandatory and must be followed in accordance with this policy:

- The Charge RN will start a line list through SharePoint.
- The IPAC Lead or designate will complete the Respiratory outbreak control measures checklist and upload to SharePoint. If the outbreak is a confirmed COVID-19 outbreak, the COVID-19 outbreak control measures checklist will be completed.

- The IPAC Lead or designate will place signage at the Front Entrance and retirement Home/LTC Doors to indicate Outbreak. Additional signage may be placed at entrances or exits of receptions at the discretion of Public Health.
- The Administrator or designate will notify family and staff via email. Social Media pages and official website will also be updated.
- The Activation Manager or designate will notify volunteers via call or email.
- The IPAC Lead or DOC/ADOC will Notify the MOHLTC through the Critical Incident System and/or by contacting the local service area office (pursuant to section 107 of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007).
- Provide the health unit with the name of the primary infection control contact for the home.
- The health unit will provide the home with an 11-digit outbreak number.
- Confirm the number of laboratory specimens (maximum four (4) specimens) to be taken during the initial outbreak investigation. These specimens will have both FLUVID and MULTIPLEX results completed.
- Additional testing is permitted but will only receive FLUVID results.
- Staff can be tested ONLY in an outbreak. Test will only be processed if there is an outbreak number on the requisition.
- All specimen containers (vials, tubes, etc.) must include the resident's name and date of collection and health card number. Specimen containers should be checked to ensure they have not expired prior to use.
- The laboratory requisition must include LTC/Lodge's name and address, the Outbreak Investigation Number, resident name, resident health card number, resident date of birth, date on which the specimen was collected and sufficient test request information as indicated by the relevant specimen collection instructions. The requisition should be printed on coloured paper to indicate to the laboratory that this specimen is from an outbreak facility.
- An outbreak can be declared at any time by the Medical Officer of Health (or their designate), the Medical Director or the Director of Nursing.

For influenza outbreaks, confirm the implementation of the exclusion policy, review and implement the staffing contingency plan. Determine if additional influenza immunization clinics are required for non-immunized staff, and if so, take steps to ensure that it is implemented (noting that newly vaccinated staff will still need to take anti-viral medication to be able to continue to work).

Ensure Creatinine Clearance rates for residents are up to date and to be sent to pharmacy for dispensation of anti-viral medications.

- Identify and notify any additional persons/institutions that require notification of the outbreak:
- Residents' physicians
- Other health care providers, e.g. physiotherapists
- Families of ill residents or families of all residents in the home
- Emergency services, including dispatch

- Ministry of Labour
- Joint Health and Safety Committee/Infection Control, and/or trade union if there are occupational illnesses

**Step 5** - Monitor the Outbreak on an Ongoing Basis

Outbreak monitoring will include:

- Ongoing surveillance to identify new cases.
- Monitoring the status of ill residents and staff.
- Updating line listings daily via SharePoint.
- Ongoing monitoring of precautions and control measures.
- Ongoing monitoring of enough staffing to support the outbreak.
- Reporting any significant changes in the nature of the outbreak (e.g. hospitalizations, deaths, changes in clinical picture).
- In case of resident death during outbreak, Death notice form to be completed and uploaded to SharePoint as per Public Health
- weekly IPAC audits

Resident Line Listing Surveillance will include:

- New cases, with all appropriate information
- Names of residents who have recovered/recovery date.
- The status of ill residents and noting any issues, such as worsening symptoms or complications.
- Adverse reaction to any prescribed antiviral prophylactic medication, or discontinuation of antiviral prophylactic medication, as relevant to the resident.
- Transfers to/returns from acute-care hospitals.
- Deaths (among cases where they are believed to be as a result of infection with the causative organism and met the case definition).

Staff Line Listing Surveillance will include:

- New staff cases, together with all appropriate information
- Initials of staff who have recovered.
- Last day worked and return-to-work dates as determined in collaboration with the health unit.

**Step 6** - Declare the Outbreak Over

South East Public Health together with the IPAC lead or designate will determine when to declare an outbreak over, taking into consideration the etiologic agent and the epidemiology of the outbreak.

In practice, the time before which an outbreak can be declared over is dependent on:

- The causative organism, if known (contributes to the communicability, incubation period calculation).
- The epidemiology of the outbreak: how aggressive transmission has been, how severe illness has been, mortality profile, the number of hospitalizations, etc.
- Whether the last case was a resident or staff member.

Once the outbreak has been declared over, all individuals notified of the outbreak at the beginning of the investigation are to be notified that the outbreak is over. Refer to Step 4 for a listing of individuals to be notified of the end of the outbreak.

South East Public Health will send an Outbreak Summary Report to IPAC Lead for review.

### **New Admissions and Return of Non-cases**

From the perspective of susceptibility to disease transmission, the admission of new residents and return of residents who have not been line-listed in the outbreak (i.e. are not known cases) is generally not advised during an outbreak. Members of the OMT, the HCC and the health unit will discuss the situation and consider all relevant factors to assess if new admissions and/or return of non-cases should be considered.

#### *Return of Cases*

The return of residents, including those from hospital, who were line-listed and were part of the outbreak, are permitted to return provided appropriate accommodation and care can be provided; the working assumption is that the resident has been exposed to the causative organism and is now immune. If, however, the outbreak is laboratory-confirmed influenza, returning residents should be placed on antiviral prophylaxis medication in line with other residents. However, in the event that a resident cannot return to the home because of an outbreak of disease in the home, the licensee of the home is not permitted to discharge the resident and the resident will return to the home when the outbreak is declared over.

### **Restriction of symptomatic residents to their room**

Ill residents will be isolated in their room and will be on droplet and contact precautions until 5 days after the onset of acute illness or until symptoms have resolved (whichever is shorter). For some pathogens, the period of communicability may be longer than 5 days, but for practical reasons, this can be applied to outbreaks caused by respiratory viruses other than influenza or in the case of outbreaks when the pathogen is not known. There

may be some respiratory outbreaks for which longer isolation periods are required. Restriction of ill residents to their room is recommended if it does not cause the resident undue stress or agitation. If, however, restriction causes undue stress or agitation, alternative measures can be considered, including the use of a surgical mask and compliance with hand hygiene, at the discretion of the home in consultation with the health unit.

Residents with an ARI who are not in single room accommodation can be managed in their bed space using droplet and contact precautions with privacy curtains drawn where these accommodations are available. However, residents may leave their room if they are able to comply with hand hygiene requirements and with the use of a surgical mask. This strategy may not work with all populations and its application is left to the discretion of the home in consultation with the health unit.

### **Restriction of Residents to Their Unit**

If ill residents cannot be contained in one geographical area of the home, then the outbreak must be considered home wide. If cases are confined to one unit, all residents and staff from that unit must avoid contact with residents and staff in the remainder of the home. Additional recreational activities/resources will be made available. The outbreak may be confined to one or more units without declaring a facility-wide outbreak, however, this will depend on several factors (e.g. design of the facility, causative organism, speed of spread, proximity of cases, staffing resources).

### **Communal Meetings and Other Activities**

As much as possible, symptomatic residents will be required to stay within their own units within the home. It is always important to balance the rights of residents with the need to manage the outbreak. Previously scheduled events, (e.g. holiday events) will need to be rescheduled. The IPAC lead or designate together with Public Health will discuss restriction of activities, revisiting the issue as the outbreak progresses. If possible, consideration will be given to planning events in such a way as to permit well residents to participate, according to geographical areas.

### **Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018**

The following will be implemented during an outbreak, based on OMT and local decision making:

- Reschedule communal meetings on the affected unit. However, other meetings or activities may proceed in non-affected areas
- Discontinue group outings from the affected unit

- The IPAC lead or designate together with Public Health will discuss restricting meetings or activities in the entire home if the outbreak spreads to two or more units
- Restrict visits by outside groups, such as entertainers, volunteer organizations and community groups
- Conduct on-site programs such as physiotherapy and foot care for residents in their rooms, if possible. Proper precautions should be taken for ill residents

### **Medical Appointments**

At the discretion of and after consultation with the treating physician, non-urgent appointments may be rescheduled, with the consent of the resident/SDM.

### **Transfer to Hospital**

Before sending an ill resident to hospital, the home will notify the receiving healthcare facility that the home is experiencing an outbreak. The hospital will be provided with the details of the outbreak to ensure control measures are in place when the resident arrives at the hospital. The hospital will be informed of whether or not the resident to be transferred has been identified as a case. The goal is to protect sending and receiving facilities, paramedic and private transfer companies and the public by ensuring appropriate personal protective measures are taken thus containing any risk of spreading. In addition, notifying the receiving hospital whether the transferred resident was or was not on the line list, allows the hospital to start discharge planning.

### **Transfer to another Long-Term Care Home**

Symptomatic resident transfers (from anywhere in the home) to another home are not recommended during an outbreak. This will be discussed on a case by case basis in consultation with health unit and Ontario Health at Home.

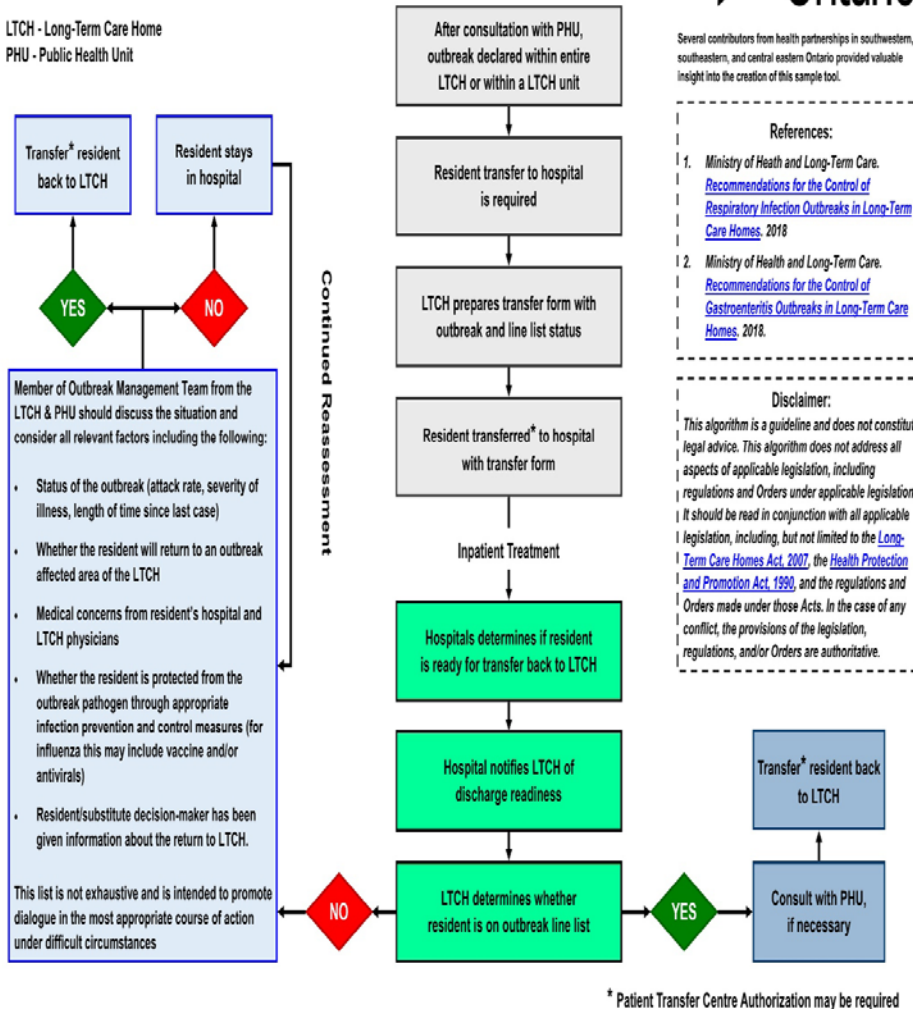
# Sample Transfer & Return Algorithm for use during Outbreaks

## Communication for Transfer & Return between Long-Term Care Homes and Hospitals



Several contributors from health partnerships in southwestern, southeastern, and central eastern Ontario provided valuable insight into the creation of this sample tool.

LTCH - Long-Term Care Home  
PHU - Public Health Unit



## Environmental Cleaning and Disinfection

During an outbreak there will be a requirement for additional and enhanced environmental cleaning in order to contain the spread of the microorganism causing the outbreak. Policies and procedures regarding staffing in Environmental Services (ES) departments allows for surge capacity (e.g., additional staff, supervision, supplies, equipment) during outbreaks as determined by the outbreak management committee. In addition, procedures for assigning responsibility and accountability of routine cleaning of all environmental surfaces and non-critical resident care items are established.

## Managing Essential Visitors

The home is closed to general visitors while in outbreak, but is available to essential support service visitors eq. food and supply delivery, phlebotomy test service, health care

services required for residents and staff to maintain good health or a person visiting a very ill or palliative resident. If an essential visitor enters the building the following steps must be taken:

- the essential visitor must be screened on entry for symptoms of ARI including temperature checks and not admitted if they show any signs of ARI.
- the essential visitor must attest to not be experiencing any of the typical and atypical signs/symptoms.
- the essential visitor must only visit the one resident they are intending to visit and go to no other areas of the building or visit with any other residents.
- the essential visitor must wear a mask while visiting a resident that does not have an ARI.
- the essential visitor must wear full PPE (gown, gloves, face shield and mask) if visiting a resident with an ARI.

## Incubation Periods of Acute Respiratory Viral Infections

Additional resources regarding the incubation range, shedding/potential infectious period include: Public Health Agency of Canada pathogen safety data sheets, Red Book, Control of Communicable Diseases Manual and the Centre for Disease Control.

<b>Table 1: Incubation Periods of Acute Respiratory Viral Infections Virus</b>	<b>Incubation (range)</b>	<b>Shedding/potential infectious period</b>	<b>Comments</b>
Influenza	1-4 days	Usually 5 to 10 days, peak at 24 to 48hrs	The immunocompromised may shed virus for months.
RSV	3-7 days	Usually 3 to 8 days; up to 3-4 weeks in children and immunocompromised	Acute phase of illness 3 to 10 days.
Human Metapneumovirus	Not known (4-9 days?)	Shed for 1 to 2 weeks	Similar to RSV; the immunocompromised may shed virus for months
Rhinovirus	2-4 days	1 to 3 weeks; peak days 2 to 3 of illness	Immunocompromised may shed for months.

Adenovirus	4-8 days	Days to weeks	Immunocompromised may shed for months.
Parainfluenza virus	2-6 days	Up to 10 days in children	Shorter duration of shedding in elderly
Bocavirus	Not established	Duration of shedding variable: 50% <1 week, 25% over one month (1 record of 402 days).	Not firmly established as a respiratory pathogen. Role in respiratory infection remains under investigation
Human Coronaviruses (229E, OC43, HKU1, NL63)	2-5 days		Peak shedding occurs during days 2 to 3 of illness
SARS Coronavirus	2-10 days	Peak shedding and transmission occurs during week 2 of illness. Maximum communicability is less than 21 days.	May be detectable week 3 to months after illness onset

**OUTBREAK MANAGEMENT QUICK REFERENCE - RESIDENTS**

