

Ministry of Health

COVID-19 Outbreak Guidance for Long-Term Care Homes (LTCH)

Version 1 – April 1, 2020

Public health units (PHU) should refer to the 2018 [Recommendations for the Control of Respiratory Infection Outbreaks in Long-Term Care Homes](#) as the foundational document for respiratory outbreak related guidance on the preparedness, prevention and management of COVID-19 related outbreaks.

Emerging information on COVID-19 suggests older adults with underlying health conditions are at increased risk of severe outcomes. Therefore, early identification of cases associated with LTCHs and rapid implementation of outbreak control measures are essential to preventing spread within the home.

As per **section 1.1.1** of the [Recommendations for the Control of Respiratory Infection Outbreaks in Long-Term Care Homes](#) guidance document, COVID-19 is a new, emerging pathogen, and the following information is intended to provide any COVID-19 specific guidance not already addressed in the document.

Additional information on COVID-19 for LTCH and for PHUs:

- [Ontario COVID-19 for Health Care Providers](#)
- Public Health Management of Cases and Contacts of COVID-19 in Ontario (available through the Ministry Emergency Operations Centre – EOCOperations.MOH@ontario.ca)
 - These guidelines for PHUs contain information on exposure classifications (high, medium and low/no risk) and contact management definitions (self-monitoring, self-isolating)
- Public Health Ontario (PHO) [IPAC Recommendations for COVID-19](#)

Definition of “Staff”

This document uses the term “staff” to include anyone conducting activities in the LTCH, including but not limited to, health care workers.

Key Features of LTCH Outbreak Management for COVID-19

Preventing the introduction of COVID-19 into the LTCH and preparedness measures before detection of a case in the LTCH

- All health care workers should follow the Ministry of Health's following recommendation and directives:
 - Directive #3, issued by the Chief Medical Officer of Health
- **Active Screening:** Long-term care homes must immediately implement active screening of all staff, essential visitors and anyone else entering the home for COVID19 except for emergency first responders, who should, in emergency situations, be permitted entry without screening.
- Screening must include twice daily (at the beginning and end of the day) symptom screening, including temperature checks. Anyone showing symptoms of COVID-19 should not be allowed to enter the home and should go home immediately to self-isolate. Staff responsible for occupational health at the home must follow up on all staff who have been advised to self-isolate based on exposure risk.
- **Active Screening of All Residents:** Long-term care homes must conduct active screening of all residents, at least twice daily (at the beginning and end of the day) to identify if any resident has fever, cough or other symptoms of COVID-19. Residents with symptoms (including mild respiratory symptoms) must be isolated and tested for COVID-19.
- **New admissions** and re-admissions should be screened for symptoms and potential exposures to COVID-19.
 - All new residents arriving from the community must be placed in isolation for 14 days on arrival to the facility.

- **Review LTCH's respiratory virus outbreak preparedness** (Section 2 in [Recommendations for the Control of Respiratory Infection Outbreaks in Long-Term Care Homes; CDC Preparedness Checklist](#)).
 - Ensure **sufficient PPE** available and review staff PPE training.
 - Review and summarize **advanced directives** for all residents as part of community planning with local acute care facilities and EMS.
 - Review **communications** protocols.
 - Review **staffing** schedules, staff who work in other locations, availability of alternate staff, emergency contact numbers for staff
 - Review and modify internal activities to promote adherence to **physical distancing** measures.
 - Review **environmental cleaning protocols** and ensure frequent cleaning of high touch surfaces.
 - Develop plans to communicate with staff on COVID-19 updates, including providing information on where staff can get tested if they become symptomatic.

Managing Essential Visitors

- As LTCHs are now closed to visitors, accommodation should be considered for essential visitors who are visiting very ill or palliative residents, or those who are performing essential support care services for the resident (i.e., food delivery, phlebotomy testing, maintenance, and other health care services required to maintain good health).
 - Essential visitors must be screened on entry for illness including temperature checks and not admitted if they show any symptoms.
 - Essential visitors should be limited to one person at a time for a resident.
 - Essential visitors must only visit the one resident they are intending to visit and no other residents.
 - Staff must support the essential visitor in appropriate use of PPE.
 - Essential visitors must wear a mask while visiting a resident that does not have COVID-19.
 - Essential visitors in contact with a resident who has COVID-19, must wear appropriate droplet precaution PPE.

- Paramedics and/or emergency personnel are screened at the beginning of their shifts and do not need to be screened on entry into the facility.
- Other health care service partners, which are deemed critical to maintain the health of residents, such as laboratory services, should be allowed entrance with appropriate PPE.

Detection of a Single Case of Acute Respiratory Infection in the LTCH

As part of active surveillance for residents and staff, new acute respiratory infection symptoms should be rapidly identified, investigated and managed to prevent potential spread in the LTCH, and should be considered a suspect outbreak.

In the context of the pandemic, a single laboratory confirmed case of COVID-19 in a LTCH, in a resident or staff member would trigger an outbreak and would be declared.

Specimens from residents of institutions including LTCHs are prioritized for testing at PHO Laboratory provided "Institution" is clearly marked in the "Patient Setting" section of PHO Laboratory requisition. The designated outbreak number must also be documented once an outbreak has been declared. Specimens may be submitted using the [PHO Laboratory COVID-19 Virus Test Requisition](#) or the [PHO Laboratory General Test Requisition](#).

- **Single case in a resident**

- Determine if there is a *known exposure risk* where only that resident would have been exposed. If so, there is potential to manage as a single case with isolation, management in droplet and contact precautions, and aggressive contact follow-up within the LTCH at the direction of the local PHU.
 - **Staff contacts with high risk exposures** (see Public Health Management of Cases and Contacts of COVID-19 in Ontario) should be in self-isolation. If required to work for continuity of operations in the home, consider "work self-isolation" for others.
 - **Work self-isolation (as of [March 19, 2020](#)):** "If there are particular workers who are deemed critical, by all parties, to continued operations. It is recommended that these workers undergo regular screening, use appropriate Personal Protective

Equipment (PPE) for the 14 days and undertake active self-monitoring, including taking their temperature twice daily to monitor for fever, and immediately self-isolate if symptoms develop and self-identify to their occupational health and safety department." At a minimum, a mask should be worn in common areas and particularly when 2 metres distance cannot be maintained. Appropriate PPE should be worn when providing resident care.

- **Work self-isolation also means** following [self-isolation](#) recommendations outside of the workplace. These health care workers should not work in other homes/facilities.
 - **Staff contacts with medium risk exposures** (as defined in the Public Health Management of Cases and Contacts of COVID-19 in Ontario) should be [self-monitoring](#).
 - **Residents with high risk exposures** should be in self-isolation, if possible, in a single room. Droplet and contact precautions should be used when providing direct care to the resident or when within two metres of the resident.
 - Determination of applying outbreak precautions to the affected area or the entire home should be made by the outbreak management team based on knowledge of the home and staffing.
- **Single case in a Staff Member**
 - If there were exposures at the LTCH during period of communicability, initiate outbreak control measures (as per the [Recommendations for the Control of Respiratory Infection Outbreaks in Long-Term Care Homes](#)) for an outbreak.
 - Even if the exposure was contained to a specific area of the LTCH, consideration should be given to applying supplementary measures to the entire LTCH as well, to avoid spread within the home. Determination of applying outbreak precautions to the affected area or the entire home should be made by the outbreak management team based on knowledge of the home and staffing.
 - **Residents with high risk exposures** should be placed in self-isolation and cared for using droplet and contact precautions.

- **Staff contacts with high risk exposures** should be in self-isolation. If required to work for continuity of operations in the homes, consider “work self-isolation” (see above).
- **Staff contacts with medium risk exposures** should be self-monitoring (see Appendix 1).

Information on Outbreak Data Entry in Provincial Surveillance

- Guidance has been provided to PHUs in the form of an Enhanced Surveillance Directive from PHO which includes instructions on how to report a confirmed COVID-19 outbreak.

Specimen Collection and Testing for Outbreak Management

Note: At this time, usual practices for outbreak specimen testing (up to 4 per outbreak) have been changed to ensure early detection of COVID-19 and outbreak management. The changes are described below:

- [Testing](#) should be conducted for **every symptomatic resident** in the LTCH:
 - This includes testing every resident whether linked to a COVID-19 outbreak or not, including deceased residents who were not previously tested.
 - Health units are responsible for following usual outbreak notification steps to the PHO Laboratory. If submitting specimens from persons being tested during a laboratory confirmed COVID-19 outbreak, this should be documented on the PHO Laboratory requisition.
- **All symptomatic staff should be tested.**

When specimens are submitted for laboratory testing from healthcare workers “Healthcare Worker”, and if relevant, the outbreak number must be documented on the PHO laboratory requisition in order to prioritize and expedite testing.
- At this time, staff who test positive for COVID-19 should follow guidance included in the [COVID-19 Quick Reference Public Health Guidance on Testing and Clearance](#).
- There should be a low threshold to test residents and health care workers within the home for COVID-19; even one compatible symptom should lead to testing. If specimens are submitted to PHO Laboratory for testing before an

outbreak number has been issued clearly indicate on the requisition the setting as “institution”.

- Once an outbreak is established, any additional illness in residents should be managed as a probable case (symptoms and close contact with a confirmed case) and presumed COVID-19, while waiting for their testing results.
- Testing of asymptomatic residents or staff is generally not recommended.

Outbreak Control Measures

- **Steps in an Outbreak:** If an outbreak is declared at the long-term care home, the following measures must be taken:
 - Monitor residents for any new respiratory symptoms or fever;
 - Quickly identify and isolate any resident with symptoms of acute respiratory illness or fever;
 - New resident admissions are not allowed until the outbreak is over;
 - No re-admission of residents until the outbreak is over;
 - If residents are taken by family out of the home, they may not be readmitted until the outbreak is over;
 - For residents that leave the home for an out-patient visit, the home must provide a mask and the resident, if tolerated, wear a mask while out and screened upon their return;
 - Discontinue all non-essential activities. For example, pet visitation programs must be stopped for the duration of the outbreak.
 - If possible, discontinue all communal activities/gatherings, school programs and on-site day cares or intergenerational programming for the duration of the outbreak;
 - Report any suspected COVID-19 illness in residents or staff to the local PHU.
- See [PHO PPE document](#) for guidance on Droplet and Contact Precautions ([Fact Sheets](#)).
- Environmental cleaning is particularly important for COVID19 and should follow Ontario [PIDAC Best Practice Guidance](#).
- Review proper glove use and hand hygiene with kitchen and housekeeping staff as well as resident care staff.

Additional Outbreak Control Measures

In addition to the IPAC measures found in the Recommendations for the Control of Respiratory Infection Outbreaks in LTCHs, the following IPAC measures should be initiated for a COVID-19 outbreak. Visit the [PHO website](#) for the most current recommendations and guidance.

- Residents who develop symptoms while out of the LTCH should report the symptoms to the LTCH to determine if testing is recommended and should be arranged.
- Ensure EMS and hospital is informed when residents are to be transferred.
- Arrange for the use of portable equipment to help avoid unnecessary resident transfers (e.g., portable x rays, dialysis, etc.).
- Maintain ongoing assessment of contingency plans for procurement of essential supplies (e.g., stock rotation, ordering, alternatives, etc.).
- Consider cultural, ethnic and indigenous needs as well as religious practices and determine acceptable alternatives as indicated.
- Consider alternative measures to be taken for residents with cognitive disabilities (e.g. increase one on one programs, use of preventative wandering barriers, dedicate resident time for sensory stimulation activities, take advantage of High Intensity Needs Funding if available).
- Ensure that isolation of residents and restriction of visitors takes into consideration the detrimental physical, emotional and social impacts on the elderly residents. As such, consideration for alternative options for support should be considered (e.g. exercise programs for the room, one on one programs and visits, use of technology to allow visual and auditory contact with family and friends, distracting activities that meet the needs of individual residents). See [PIDAC's Best Practices for Prevention and Control Infections in all Health Care Settings](#) for more details.
- Where possible, encourage visitors to keep in touch with loved ones by phone or video chat or other technologies, as available. Care packages from families/friends are encouraged (but remind family/friends that if they are ill with cough, sneezing, or runny nose they should not prepare/send packages).
- If needed, the facility may recruit and replace staff to support an outbreak.

Personal Protective Equipment (PPE), Hand Hygiene and Signage

- Ensure that the right PPE is available and accessible for use by those who require use of PPE based on Directives and [current recommendations](#).
 - Droplet Contact Precautions require the use of gloves and gown for direct care and the use of a mask and eye protection when within 2 metres of the resident.
- Ensure availability and accessibility of hand hygiene products (e.g. alcohol-based hand rub) throughout the home.
- Ensure signage is clear and that education for staff, visitors and families, outsourced workers and companies is to be provided. Examples include:
 - Non-medical: delivery people, construction, environmental cleaning contracts or,
 - Medical: special care providers, chiropodist, respiratory therapy, physiotherapy.

Aerosol Generating Medical Procedures

- Ensure appropriate measures are taken when performing aerosol generating medical procedures (AGMPs) in LTCH (e.g. tracheotomy care with suctioning). Collection of nasopharyngeal swabs are not aerosol generating procedures.
- The use of an N95 respirator is recommended instead of a mask as part of precautions for AGMPs.

Environmental Cleaning

- At this point, there is no requirement to enhance or change the use of cleaning products and hospital grade disinfectants that are normally used for environmental cleaning in LTCHs.
- Additional environmental cleaning is recommended for frequently touched surfaces, including trolleys and other equipment that move around the home, and consideration given to increasing the frequency of cleaning.
- Policies and procedures regarding staffing in Environmental Services (ES) departments should allow for surge capacity (e.g., additional staff, supervision, supplies, equipment). See [PIDAC's Best Practices for Prevention and Control Infections in all Health Care Settings](#) for more details.

Cohorting

- LTCHs, in collaboration with local PHU, should consider resident and staff cohorting as a strategy to prevent spread of COVID-19 in the home.
 - Resident cohorting may include:
 - Alternative accommodation to maintain spatial separation of 2 metres;
 - Resident cohorting of the well and unwell;
 - Utilizing respite and palliative beds/rooms to provide additional accommodation;
 - utilizing other rooms as appropriate to help maintain isolation of affected residents (e.g., community and recreation rooms that have call bells).
 - Staff cohorting may include ensuring that they do not care for ill and well residents at the same time. This may include:
 - Designating staff to either ill residents or well residents;
 - Having staff working under “working self-isolation” due to high risk exposures; and
 - Having staff limit the number of work locations to minimize risk to residents.

Units/LTCHs with Resident Mixing

- Units or smaller LTCHs where it is not possible to isolate residents from each other should be considered as a single unit, where all residents are managed as if infected/potentially infected and staff use droplet and contact precautions for all residents and while in the affected area.
- More frequent cleaning of high-touch surfaces, and staff assistance of hand hygiene for residents.

Communications

- Long-term care homes must keep staff, families and residents informed about COVID-19. Staff must always be reminded to monitor themselves for COVID-19 symptoms, and to immediately self-isolate if they develop symptoms.

- Signage in the Long-Term Care home must be clear about COVID-19, including signs and symptoms of COVID-19, and steps that must be taken if COVID-19 is suspected or confirmed in staff or a resident.
- Food and Product Deliveries: Food and product deliveries should be dropped in an identified area and active screening of delivery personnel should be done prior to entering the home.
- Communicate with local acute care hospital regarding outbreak, including number of residents in the facility, and number who may potentially be transferred to hospital if ill based on advanced care directives.
- Communicate with local public health and Ministry of Labour during an outbreak to collaborate and for support in the investigation and response.
- The Ministry of Long-Term Care and/or the Ontario Long Term Care Association will also be in communication with the facility experiencing an outbreak.

Declaring the Outbreak Over

- The outbreak may be considered over when there are no new cases in residents or staff after 14 days from putting last case (resident or staff) into isolation.

Appendix 1 – PPE Recommendations for Staff on Work Self Isolation

All **symptomatic** staff must be tested for COVID-19. When specimens are submitted for laboratory testing from healthcare workers “Healthcare Worker”, and if relevant, the outbreak number must be documented on the PHO laboratory requisition in order to prioritize and expedite testing. Other staff who have had high risk exposures (direct contact with residents in affected area without appropriate PPE) should self-isolate, but may **“work self isolate”** under the following conditions:

Resident/ Cohort	Symptomatic Resident: Confirmed or Suspect Case	Asymptomatic Resident: Contacts of a Case (e.g., roommate, tablemate, friend)	Asymptomatic Resident: Not Exposed to a Case	Comments
Who Should Provide Care? Preferred option	Exposed but asymptomatic staff exposed to ill residents in affected area.	Exposed but asymptomatic staff exposed to ill residents in affected area.	Asymptomatic staff not exposed to ill residents in affected area. Alternate option: Exposed but asymptomatic staff.	
Precautions When Providing Direct Care	Routine Practices plus Droplet/ Contact Precautions.	Routine Practices plus Droplet/ Contact Precautions.	Routine Practices, unless whole area/facility under outbreak precautions use Routine Practices plus Droplet/Contact precautions.	

Resident/ Cohort	Symptomatic Resident: Confirmed or Suspect Case	Asymptomatic Resident: Contacts of a Case (e.g., roommate, tablemate, friend)	Asymptomatic Resident: Not Exposed to a Case	Comments
What PPE is Required?	<p>Procedure Mask at all times.</p> <p>Add eye protection, gloves, and gowns for direct care.</p>	<p>Procedure Mask at all times.</p> <p>Add eye protection, gloves, and gowns for direct care.</p>	<p>Ideally, exposed staff are not providing care to asymptomatic residents outside of the affected area.</p> <p>If required, to wear Procedure Mask at all times* and as per Routine Practices.</p>	<p>In addition to Routine Practices.</p> <p>When PPE is in scarce supply, masks can be worn for extended periods and changed at staff breaks, unless they become moist or soiled in advance.</p> <p>Gloves changed between residents; between soiled and aseptic tasks on same resident. Hand hygiene performed between glove use.</p>
Staff Screening and Monitoring	<p>Screen twice per shift for respiratory symptoms including Temperature checks.</p> <p>This applies to everyone entering and leaving the facility.</p>			<p>All staff who develop symptoms are to immediately report symptoms to their supervisor/occupational health and safety representative and not be in the workplace.</p>