Respiratory Outbreak Control Measures
Information Package for Institutions

Introduction

Outbreaks occur when the usual level of disease in a Long-Term Care Home (LTCH) is exceeded over a period of time. Early identification of an outbreak is essential since the implementation of precautions and therapeutic interventions can prevent the spread of infection and decrease the morbidity and mortality of a very frail, compromised population.

This package includes:

Sections

A) Outbreak Definition
B) Case Definition
C) Collection of Laboratory Specimens
D) General Outbreak Control Measures
E) Confirmed Influenza Additional Outbreak Control Measures
F) Communication
G) Declaring the outbreak over

Attachments

- Procedures for Specimen Collection and Submission
- Sample “Stop” Sign
- Sample droplet, contact and airborne signs
- Respiratory Outbreak Checklist (For Institutional Use)
- Sample Transfer and Return Algorithm for use during Outbreaks

To report a suspect outbreak please call York Region Community and Health Services:

During Business Hours: 905-830-4444, ext.73588
After Business Hours & Weekends: 905-953-6478
A) Case Definition

The facility will be placed under Surveillance mode (suspect respiratory infection outbreak) when two residents/staff present with similar respiratory symptoms (see below) in a relatively short period of time (e.g., 24-48 hours). The infection control designate from the Long-Term Care Home must notify York Region Community and Health Services.

Suspect Outbreak Definition

Suspect respiratory infection outbreak:
- Two cases of acute respiratory tract illness occurring within 48 hours in a geographic area (e.g., unit, floor)
  OR
- More than one unit having a case of acute respiratory illness within 48 hours

Suspect influenza outbreak:
- One laboratory-confirmed case of influenza
  OR
- Two cases of acute respiratory tract illness occurring within 48 hours in a geographic area (e.g., unit, floor)
  OR
- More than one unit having a case of acute respiratory illness within 48 hours

Any further progression (additional cases or laboratory confirmations) of the Suspect Outbreak will be considered an outbreak.

An outbreak can be declared at any time by the Medical Officer of Health, or their designate, or the ICP (Infection Control Practitioner) or designate of the LTCH.

Confirmed Outbreak Definition

A case definition will be developed in consultation with the Public Health Investigator (Public Health Inspector or Public Health Nurse) assigned to the outbreak.

Generally, the case will present with a combination of respiratory symptoms (runny nose, sneezing, stuffy nose, sore throat, hoarseness, difficulty swallowing, dry or productive cough, swollen or tender glands in the neck, difficulty breathing, thoracic pain, etc) and general symptoms (malaise, myalgia, loss of appetite, headache, chills, fever/abnormal temperature, etc).

Physical examination findings (rales, rhonchi, wheezes, bronchial breathing), diagnostic procedures (e.g., Chest X-ray) and laboratory tests (e.g., viral cultures) could also be used to develop a working case definition.
Different respiratory viruses often cause similar acute respiratory symptoms. Each respiratory outbreak requires its own case definition. The initial working case definition could be modified if necessary, to ensure that the majority of cases are captured by the definition.

**Confirmed respiratory infection outbreak in a Long-Term Care Home:**
- Two cases of acute respiratory illness within 48 hours, at least one of which must be laboratory-confirmed
  OR
- Three cases of acute respiratory illness (laboratory confirmation not necessary) occurring within 48 hours in a geographic area (e.g., unit, floor)
  OR
- More than two units having a case of acute respiratory tract illness within 48 hours

**Confirmed influenza outbreak in a hospital:**
- Two or more cases of nosocomially acquired influenza-like illness occurring within 48 hours on a specific hospital unit, with at least one case laboratory-confirmed as influenza

**B) Clinical Evidence**

**Clinically compatible signs and symptoms include but are not limited to the following:**
- Upper respiratory tract illness (e.g., common cold, pharyngitis)
  - Runny nose or sneezing
  - Stuffy nose (i.e., congestion)
  - Sore throat or hoarseness or difficulty swallowing
  - Dry cough
  - Swollen or tender glands in the neck (i.e., cervical lymphadenopathy)
  - Fever/abnormal temperature for the resident may be present, but is not required
  - Tiredness (i.e., malaise)
  - Muscle aches (i.e., myalgia)
  - Loss of appetite
  - Headache
  - Chills

**Comments**

Different respiratory viruses often cause similar acute respiratory symptoms. The above case definitions are general; **each respiratory outbreak requires its own definition.** The case definition should be developed for each individual outbreak based on its characteristics, reviewed during the course of the outbreak, and modified if necessary, to ensure that the majority of cases are captured by the definition.

Whenever there are **two cases of acute respiratory tract illness within 48 hours on one unit,** an outbreak should be suspected and tests should be done to determine the causative organism.
C) Outbreak Classifications

Outbreaks generally follow into one of three classifications:

1. **Upper Respiratory Tract Illness** (e.g., common cold, pharyngitis)

   Residents or staff must have at least two of the following (new) symptoms:
   - Runny nose (coryza) or sneezing
   - Stuffy nose (i.e., congestion)
   - Sore throat or hoarseness or difficulty swallowing
   - Dry cough
   - Swollen or tender glands in the neck (cervical lymphadenopathy)
   - Abnormal temperature ($\leq 35.5^\circ C$ or $37.5^\circ C$) or a temperature that is known to be abnormal for the resident. Fever/abnormal temperature may be present, but is not required. This applies particularly to the elderly.

   For suspected influenza outbreaks the following additional symptoms may be considered:
   - Tiredness (malaise)
   - Muscle aches
   - Loss of appetite
   - Headache
   - Chills

2. **Pneumonia**

   All of the following criteria must be met:
   - A chest x-ray interpreted as pneumonia, probable pneumonia, or presence of an infiltrate
   - The resident must have at least two of the signs or symptoms described under lower respiratory infections (see below)
   - Other non-infectious cause of symptoms (i.e., congestive heart failure) must be ruled out.

3. **Lower Respiratory Tract Infections (e.g., bronchitis, tracheobronchitis)**

   The resident/patient must have at least three of the following:
   - New or increased cough
   - New or increased sputum production
   - Abnormal temperature for the resident or an abnormal temperature of $\leq 35.5^\circ C$ or $\geq 37.5^\circ C$
   - Pleuritic chest pain
   - New findings on physical examination (rales, rhonchi, wheezes, bronchial breathing)
• One of the following to indicate change in status or breathing difficulty:
  o New/increased shortness of breath
  o Respiratory rate > 25/minute
  o Worsening functional or mental status (deterioration in resident’s/patient’s ability to perform activities of daily living or lowering of their level of consciousness)

Several other infections of the respiratory tract are distinct in their manifestations and occur in regular association with a single infectious agent. Influenza, psittacosis, hantavirus pulmonary syndrome, chlamydial pneumonia, vesicular pharyngitis (herpangina) and epidemic myalgia (pleurodynia) are examples.

Infectious agents for acute febrile respiratory disease include:
  • Parainfluenza virus
  • Respiratory syncytial virus
  • Adenovirus
  • Rhinoviruses
  • Coronaviruses (certain types)
  • Coxsackieviruses (certain types)
  • Echovirus

**D) Laboratory Evidence**

**Laboratory Confirmation**
Laboratory confirmation is not required to be classified as a confirmed institutional respiratory infection outbreak.

**Approved/Validated Tests**
  • Standard culture for influenza virus, respiratory synctyial virus (RSV) and rhinovirus
  • Influenza, parainfluenza, RSV and adenovirus direct fluorescent antibody (DFA) antigen test
  • Influenza IgG serology tests
  • Nucleic acid amplification test (NAT) for influenza virus, RSV, rhinovirus/enterovirus, parainfluenza virus, adenovirus, human metapneumovirus, corona virus ribonucleic acid (RNA)
  • Rapid enzyme immunoassay (EIA) or immunochromatographic (ICT) test kits for influenza virus and RSV

**Indications and Limitations**
  • NAT primers and probes should be validated to detect the current strains of influenza, RSV, rhinovirus/enterovirus, parainfluenza virus, adenovirus, human metapneumovirus and coronavirus
  • A proportion of influenza isolates should be typed for strain identification, as appropriate, for epidemiological, public health and control purposes
  • Antigen testing for influenza virus and RSV is indicated only during the influenza season due to low positive predictive value.
E) Collection of Laboratory Specimens

As soon as a respiratory outbreak is suspected, laboratory specimens should be collected to determine the causative organism. Nasopharyngeal (NP) swabs should be collected from the most recently ill cases within 48 hours (if possible) of onset of symptoms.

The Ontario Agency of Health Protection and Promotion-Public Health Laboratories-Toronto Public Health Ontario Laboratories-Toronto will perform the rapid test (direct antigen detection) for influenza A, B and respiratory syncytial virus (RSV) on samples collected as part of an outbreak investigation.

All NP outbreak samples that are submitted for testing will be sent to culture for respiratory viruses.

To ensure that the laboratory does not reject any laboratory samples, ensure the following:

• Check to ensure all NP swabs have not expired. Public Health can deliver new swabs if required
• Specimen containers are properly labelled
• The name on the specimen container and requisition form match
• The requisition form is completed, including collection date and outbreak number
• The specimen container is properly packaged to prevent leakage (ensure the specimen container cap is secure)
• The specimen is stored refrigerated (not frozen) until picked up for delivery to the laboratory

See attached Procedure for Specimen Collection and Submission instructions for more information.

F) Outbreak Control Measures

There are several measures that can be used to control the spread of an outbreak.

1. Hand Hygiene

   Hand hygiene is the single most important procedure for preventing infections. Many viruses and bacteria can be spread through contaminated hands. Hand hygiene is the responsibility of all individuals involved in health care.

   There are two methods of removing/killing microorganisms on hands: washing with soap and running water or using an alcohol-based hand rub. Generally, the focus is on microorganisms that have been picked up by contact with residents/health care provider, contaminated equipment, or the environment (transient or contaminating bacteria).

   Alcohol-based hand rub (ABHR) is the preferred method for decontaminating hands. Using ABHR is better than washing hands (even with an antibacterial soap) when hands are not visibly soiled.
During a respiratory outbreak, handwashing frequency amongst staff and visitors must be increased. Implement use of ABHR in areas where hand sinks are not readily available.

2. Enhanced Cleaning and Disinfecting

- Thorough and frequent cleaning of equipment and environmental surfaces should be reinforced during an outbreak. Areas of concern are, but not limited to, all washrooms, handrails, tables, doorknobs, elevator buttons, call bells, telephones, bed rails, light switches, toilet handles and commodes.
- If equipment is shared with other residents, ensure that the equipment is cleaned and disinfected before and after each use.
- Handle soiled resident care equipment in a manner to prevent exposure of the skin and mucous membranes, and prevent contamination of clothing and the environment.
- Ensure that the chemical concentration of the disinfectant is appropriate and the cleaning solutions containing the chemical disinfectant is changed frequently. Pay special attention to the contact time needed for the disinfectant being used. Follow manufacturer’s recommendations for use. Consult your Infection Control Liaison from the Health Protection Division of York Region Community and Health Services for specific requirements.
- Use disposable equipment when possible (use of disposable dishes and cutlery is not required).

3. Use of Personal Protective Equipment (gloves, masks, eye protection and gowns) - PPE

PPE has to be put on before entering an ill resident’s room.

- Masks (surgical) and eye protection to be used when within 2 metres of an ill resident.
- Gloves are recommended if contact with blood, body fluid, secretions, excretions or touching the resident’s environment is likely to occur.
- Gowns are recommended to protect uncovered skin and clothing, if splashing is probable.
- Gloves, masks and gowns must be changed between residents and/or when contaminated.
- Staff must have completed resident care and be at least 2 metre distance from resident before any PPE is removed. Hand hygiene performed after PPE is removed.
- A sign should be placed on the resident’s door indicating the appropriate PPE to utilize. See attached sample York Region Airborne/Droplet/Contact Precautions signs.
4. **Staff Control Measures**

Note: Staff includes all people who carry on activities in the facility including employees, volunteers, nurses, students, physicians, contract workers and sitters.

a) **Exclusion of Ill Staff:**
   - Staff with respiratory symptoms should not enter the facility.
   - Ill staff should report to infection control and/or occupational health.
   - Ill staff should be excluded from work for 5 days from the date of onset of symptoms or until symptoms have resolved (whichever is shorter).
   - See below for influenza-specific staff control measures.

b) **Staff Working at Other Healthcare Facilities:**
   - Staff with respiratory symptoms should not work in any healthcare facility.
   - Well staff should be discouraged from working in any other healthcare setting until the outbreak has been declared over.

c) **Cohort Staff:**
   - Designate some staff to look after only ill residents and other staff to look after only well residents, if feasible.
   - If staff must move between affected and non-affected areas, staff should start their duties in the non-affected areas.
   - Minimize the movement of staff within the facility, especially if only some areas of the facility are in an outbreak mode.

5. **Resident Control Measures**

a) **Restriction of cases to their rooms:**
   - Restrict cases to their room until 5 days after the onset of acute illness or until symptoms have resolved (whichever is shorter) as long as it does not cause the resident undue stress or agitation, and can be done without applying restraints.
   - No room restrictions required for asymptomatic roommates of cases, but roommates should be confined to affected areas of the facility.

b) **Restriction of residents to their unit:**
   - If cases are confined to one unit of the facility, all residents (well and ill) from that unit should avoid contact with residents from the rest of the facility.

c) **Notification of Community Care Access Centre (CCAC), appropriate healthcare facilities and persons:**

   The facility should advise:
   - York Region Community and Health Services
   - CCAC of their admission status
• Other relevant LTCHs and hospitals
• Compliance advisor from MOHLTC (Ministry of Health and Long-Term Care)
• Resident’s physicians and families
• Other healthcare providers (e.g., physiotherapist)
• Staffing agencies
• Emergency Medical Services, including dispatch
• Coroner’s office, if there are any deaths (cases and non-cases)

d) New admissions:
• Admission of new residents is generally not permitted in any part of the facility during an outbreak.
• Measures may be altered as the outbreak comes under control. Each admission has to be assessed in consultation with Public Health.

e) Re-admission of cases to a healthcare facility (i.e., LTCH) from a hospital
• If the resident meets the case definition of the outbreak, re-admission to the LTCH from a hospital is permitted provided that appropriate accommodation and care can be provided.

f) Re-admission of non-cases to a healthcare facility (i.e., LTCH) from a hospital
• Re-admission to a LTCH from a hospital of residents who are not line listed is generally not permitted.
• Measures may be altered as the outbreak comes under control.
• Each re-admission has to be assessed in consultation with Public Health. The following should be considered:
  • The outbreak is under control
  • The resident’s attending physician at the LTCH has agreed to the admission/readmission based on a review of the current health status of the resident in hospital
  • Adequate staff are available at the facility to care for the resident
  • If the outbreak is due to influenza, the resident is protected by influenza vaccination for the current season and/or antiviral drug.
  • Appropriate accommodation is available for the resident
  • The resident or substitute decision-maker has given informed consent of the return.

See attached Sample Transfer and Return Algorithm for use during Outbreaks

g) Resident discharge from an outbreak facility to a private home:
• A resident can be discharged from an outbreak facility to a private home with no restriction. Ensure that family is aware of the outbreak and symptoms that may develop.

h) Resident transfers from an outbreak facility to a hospital, chronic care or rehabilitation facility
• When transferring any resident from one healthcare facility to a hospital chronic care or rehabilitation facility, a facility must notify the receiving healthcare facility, the
Provincial Transfer Authorization Centre (PTAC), family members and Emergency Medical Services.

i) LTCH resident transfer to another LTCH:
   - LTCH residents (cases and non-cases) from anywhere in the home should not be transferred to another LTCH until the outbreak has been declared over. Discuss exceptions with Public Health.

j) Resident transfers within an outbreak facility:
   - Resident transfers within an outbreak facility are not permitted until the outbreak is declared over.
   - Discuss exceptions with Public Health.

k) Resident appointments:
   - Non-urgent appointments made before the outbreak should be rescheduled until the outbreak has been declared over.
   - Urgent appointments for residents during respiratory outbreaks (non- influenza) may continue with precautions (resident must wear mask if within 2 metres of symptomatic case, clean hands prior to leaving the facility. EMS and receiving facility must be advised.
   - Discuss urgent appointments for cases with Public Health.
   - Specialist appointments are often made far in advance. All attempts should be made to keep these appointments provided the resident is well enough to attend (e.g. medically-stable) and the specialist agrees to the appointment in light of the resident's status. Otherwise, these appointments must be rescheduled.

l) Communal activities:
   - Discontinue communal activities that mix residents from different units/areas.
   - Activities on individual units may continue if units are not in outbreak.

6. Visitor Control Measures

a) Advise visitors of the outbreak:
   - Post outbreak notification (stop) signs at all entrances to the facility, indicating that the facility is in outbreak. See attached sample York Region Stop sign.
   - Post appropriate droplet/contact/airborne notices on the room doors of ill residents advising visitors to check in at the nursing station before entering the room to reinforce routine practices (hand hygiene, PPE use, etc.)

b) Advise visitors of restrictions:
   - Ill visitors are not permitted in the facility.
   - Encourage visitors to postpone visits if possible during the outbreak.
   - Visitors should have been encouraged to be vaccinated against influenza at least two weeks before visiting the facility during the respiratory/ influenza season by the LTCF during the fall.
• Visitors must follow the appropriate infection prevention and control measures in place.
• Visitors should only visit one resident and exit the facility immediately after the visit.

c) Advise about visiting a well resident:
• Visitors visiting well residents with an ill roommate are not required to wear PPE provided they stay at least 2 metres away from the ill resident at all times and clean their hands as they leave the room.
• There are no restrictions for visiting well residents in private rooms although visitors should not visit other residents during the outbreak.

d) Advise about visiting an ill resident:
• Ill residents should be visited in their room only, by one visitor at a time, if possible.
• Visitors providing direct care (within 2 metres) to an ill resident must wear mask, eye protection and gloves. A gown can be used to protect uncovered skin and clothing if soiling is likely to occur. Barrier precautions should be removed on exiting the room and placed in appropriate receptacle located just inside or outside the room entrance.
• After visiting a resident, the visitor should leave the facility immediately.

e) Advise about visiting by outside groups:
• Visits by outside groups (e.g., entertainers, community groups) are generally not permitted during an outbreak. Exceptions to be discussed with CID Manager.
• Onsite adult/childcare programs may continue if there is no contact between cases and program participants. Program participants should not access the outbreak area.

G) Confirmed Influenza A or B Additional Outbreak Control Measures

a) Influenza vaccine:
• Seasonal influenza vaccine should be offered to all unvaccinated residents, staff and visitors for whom the vaccine is not contraindicated, no matter how late in the influenza season the outbreak occurs.
• The facility is responsible for making arrangements with the York Region Community and Health Services department to have the vaccine delivered to the facility to immunize residents and staff. Staff may otherwise be directed to their family physician.
• Residents who are new admissions and whose immunization information is unavailable or unknown should be considered unvaccinated and vaccine should be offered.
• Facility should maintain an updated record of the immunization status of the staff and residents.
b) Immunized staff:
- A person is considered fully immunized if he/she has been vaccinated for 2 weeks or more prior to lab confirmation of an influenza outbreak. (It takes up to 2 weeks for antibodies to develop post-vaccination).
- Only fully immunized well staff will be working in the outbreak facility.
- Newly immunized staff (those vaccinated for less than 2 weeks at the time of lab confirmation of the outbreak), who wish to continue working at the facility during the outbreak will be required to take antiviral prophylaxis until 2 weeks after the date of vaccination, or until the outbreak is declared over, whichever is shorter.

c) Unimmunized staff:
- Unimmunized well staff may work as soon as they start taking an antiviral. Antiviral prophylaxis should be started as soon as possible after lab confirmation of influenza and should continue until the outbreak is declared over.
- Unimmunized well staff should also be offered influenza vaccine and if vaccinated, will continue taking antiviral prophylaxis for 2 weeks after the date of vaccination or until the outbreak is declared over, whichever is shorter.
- During an influenza outbreak, immunized staff have no restrictions on their ability to work at other facilities, provided the individual changes their uniform between facilities. However, non-immunized staff not receiving prophylactic therapy must wait one incubation period (3 days) from the last day that they worked at the outbreak facility/unit prior to working in a non-outbreak facility, to ensure that they are not incubating influenza.

d) Ill staff:
- Ill staff should be excluded from work for 5 days from the onset of symptoms or until symptoms have resolved (whichever is shorter). This also applies to ill staff who are taking antiviral medication for treatment.

e) Well residents:
- Start antiviral prophylaxis for all well residents, regardless of vaccination status, as soon as possible and continue until outbreak is declared over.

f) Ill residents:
- Antiviral treatment should be started for ill residents as soon as possible and no later than 48 hours after the onset of symptoms and should continue for a total of 5 days.
- Ill residents who are being treated with an antiviral are to remain in their room for the duration of antiviral treatment (5 days).

g) Communication
- The facility will provide the Public Health Investigator with daily updates by noon of the line list. If there is a significant change in severity of illness, hospitalizations and/or deaths, contact Public Health immediately.
- The phone number for on-call staff outside normal office hours is 905-953-6478.
- The facility will ensure the Coroner is advised immediately of any deaths (case or non-case) that occur during the outbreak.
H) Declaring the outbreak over

Criteria for declaring the outbreak over will be established in consultation with York Region Community and Health Services. As a general rule, viral respiratory outbreaks can be declared over if no new cases have occurred in 8 days from the onset of symptoms of the last resident case. The rationale for this definition is, if the outbreak were continuing, given active surveillance, new cases would have been identified within 8 days, since 8 days is the outer limit of the period of communicability of influenza (5 days) plus one incubation period (3 days).

Note: If symptoms in the last resident case resolve sooner than 5 days, or if the last case is a staff member who should stay at home during the period of communicability, the time until the outbreak is declared over can be shortened accordingly.

The facility will advise the appropriate health care organizations and persons when the outbreak has been declared over (e.g., CCAC).
PROCEDURES FOR SPECIMEN COLLECTION AND SUBMISSION

Nasopharyngeal Swab Technique:
Equipment needed:
• Swab with fibre tip
• Sterile water
• Viral culture media
• Gloves and mask
• Scissors
• Test requisition form

Procedure: Taking Nasopharyngeal Swabs

1. Position the patient with the bed raised to 45° or to a comfortable position.
2. Wash and glove hands and put on mask.
3. Clean the patient’s nares with the stiff sterile cotton swab provided in kit.

Note: Using sterile water to wet the swab first often makes it easier to clean the nares. However, this isn’t a requirement; a dry swab is often just as effective.

4. Bend the wire swab (while in the sterile package) to give it a slight arc-like appearance; this will allow for easier insertion into the posterior nasal region.
5. Measure the distance from the tip of the earlobe to the tip of the nose and mark the swab with your finger (while in the sterile package).
6. Gently, tilt the patient’s head back (about 70°) and insert the swab to the previously determined mark.
7. Rotate the swab a minimum of 3 times if the patient is tolerating the procedure well.
8. Once the sample is collected, carefully remove the nasopharyngeal swab and place the swab into the transport medium provided with the kit.
9. Cut the wire so the swab specimen will fit in the vial (this helps prevent leaks). Discard the swab handle.
10. Agitate the transporting container several times.
11. Mark the outbreak number on all specimens associated with the outbreak.
NASOPHARYNGEAL SWAB SPECIMEN COLLECTION TECHNIQUE

Figure 1: Nasopharyngeal Swab Insertion

Figure 2: Anatomy of the Nasopharynx
A. **Ensure lid is secure:** Place the container in the zip-lock bag provided.

B. **FILL OUT THE “GENERAL TEST REQUISITION” SUBMISSION FORM (F-SD-SCG-1000)**

   as follows:

   1. **Submitter:**
      - Provide return address: **York Region Community and Health Services**
        **Infectious Diseases Control**
        **17250 Yonge Street, Box 147**
        **Newmarket, ON, L3Y 6Z1**
      - Clinician Initial/Surname and OHIP/ CPSO Number:
        Dr. Karim Kurji - MOH       OHIP Billing N/A
      - Tel: 905-895-4511, ext. 7XXXX
        **Note:** Indicate the extension of the Public Health Investigator (i.e., NOT Dr. Kurji’s extension number)
      - If not available, ext. 73588
      - Fax: 905-898-5213

   **Note:** When the outbreak is declared and the investigation is started outside regular business hours (after-hours, weekends, holidays) by an on- call Public Health Investigator and a stool specimen is submitted to the lab, fill out this section as follows:

   - Dr. Karim Kurji - MOH
   - OHIP Billing N/A
   - Telephone:
      - After hours: 905-953-6478
      - Business hours: 905-895-4511, ext. 73588
   - Fax: 905-898-5213

The next day, after the weekend or after the holidays, the outbreak investigation will be taken over from the on-call investigator by the regular, day-time investigator. At this time, the regular investigator will contact you and provide you with his/ her name and phone number.

When submitting subsequent stool specimens to the lab, use the daytime investigator’s contact information when filling out lab requisition forms.

   - **CC Doctor Information:**
     If you require PHOL to send a copy of the test results to another healthcare provider, enter the clinician’s complete return address, full name, postal code, telephone number and fax number.
2. Patient Information:
   - Health No.
   - Sex
   - Date of Birth
   - Medical Record No.
   - Patient’s Last Name (per OHIP card)
   - First Name (per OHIP card)
   - Patient address: Name, Address, City & Province of the Institution
   - Postal Code: of the Institution
   - Public Health Unit Outbreak No.

Public Health Investigator Information:
   - Name
   - Health Unit: York Region Community and Health Services
   - Tel: 905-895-4511, ext. 7XXXX. If not available, ext. 73588
   - Fax: 905-898-5213

Patient Setting:
   - Institution (check box)

3. Test (s) Requested:
   - Respiratory Outbreak Virus Detection Panel

4. Specimen type and site:
   - Nasopharyngeal (check box)

5. Reason for Test:
   - Diagnostic (check box)
   - Date Collected:
   - Onset Date:
   - Clinical Information: Check box as appropriate (respiratory symptoms, fever, etc.)

C. On the SPECIMEN CONTAINER (e.g., Starswab™ Multitrans™ System)
   - Name (first and last)
   - Date and Time of collection
   - Test
   - Also indicate: Date of Birth and/or Health Insurance Number! (new lab requirement)

THE INFORMATION ON THE SPECIMEN CONTAINER MUST BE THE SAME AS THE INFORMATION ON THE LABORATORY TEST REQUISITION FORM
D. SPECIMEN SUBMISSION

Send specimen(s) to Public Health Ontario Laboratories in Toronto by courier as soon as possible.

1. Request courier information from your Public Health Investigator:
   - The name and phone number of the courier service
   - The York Region Community and Health Services Department account name and number

2. Call courier and inform them of the following:
   - The time the specimen(s) will be ready for pick-up from your facility
   - The address of the Public Health Ontario Laboratories in Toronto: 81 Resources Road, Toronto, Ontario.
   - York Region Community and Health Services Department account name and number

3. Ensure shipment requirements are met:
   - Ensure that the courier driver has an insulated container (blue transport cooler bag) for the transportation of the specimen to the laboratory.
   - The cooler bag must carry the marking Biological Substance Category B, to indicate the nasopharyngeal specimen’s classification according to the Transportation of Dangerous Goods Regulations. Please see attached sample.
   - Observe that the courier places the specimen in the cooler.
   - If you have any concerns please do not submit the specimen and call your public health investigator immediately. Call the on call number if outside of regular business hours.
ATTENTION
VISITORS

We are experiencing an outbreak!
Please speak to the nursing staff prior to your visit
You may be at risk of becoming ill within the facility
Visitors Report to Nursing Station

Airborne Precautions

Use With Routine Practices
Visitors Report to Nursing Station

Droplet/Contact Precautions

Use With Routine Practices
Dedicate or Wipe Shared Equipment
Visitors Report to Nursing Station

Droplet Precautions

Use With Routine Practices
Dedicate or Wipe Shared Equipment
Sample Transfer & Return Algorithm for use during Outbreaks
Communication for Transfer & Return between Long-Term Care Homes and Hospitals

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

Transfer* resident back to LTCH

NO

YES

Resident stays in hospital

Members of the Outbreak Management Team from the LTCH & PHU should discuss the situation and consider all relevant factors including the following:
- status of the outbreak (attack rate, severity of illness, length of time since last case)
- whether the resident will return to an outbreak affected area of the LTCH
- medical concerns from resident’s hospital and LTCH physicians
- whether the resident is protected from the outbreak pathogen through appropriate infection prevention and control measures (for influenza this may include vaccine and/or antivirals)
- resident/substitute decision-maker has been given information about the return to LTCH

This list is not exhaustive and is intended to promote dialogue that will result in the most appropriate course of action under difficult circumstances.

After consultation with PHU, outbreak declared within entire LTCH or within a LTCH unit

Resident transfer to hospital is required

LTCH prepares transfer form with outbreak and line list status

Resident transferred* to hospital with transfer form

Inpatient Treatment

Hospital determines resident is ready for transfer back to LTCH

Hospital notifies LTCH of discharge readiness

LTCH determines whether resident is on outbreak line list

Transfer* Resident back to LTCH

Consult with PHU

References:
1. Ministry of Health and Long-Term Care, A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2004.
2. Ministry of Health and Long-Term Care, Control of Gastroenteritis Outbreaks in Long-Term Care Homes, 2011.

Disclaimer:
This algorithm is a guideline and does not constitute legal advice. This algorithm does not address all aspects of applicable legislation, including regulations and Orders under applicable legislation. It should be read in conjunction with all applicable legislation, including, but not limited to the Long-Term Care Homes Act, 2007, the Health Protection and Promotion Act, 1990 and the regulations and Orders made under those Acts. In the case of any conflict, the provisions of the legislation, regulations and/or Orders are authoritative.

* Patient Transfer Authorization Centre authorization may be required

Source: Ministry of Health and Long-Term Care, Public Health Division, October 2013, Control of Gastroenteritis Outbreaks in Long-Term Care Homes. A Guide for Long-Term Care Homes and Public Health Unit Staff, page 87
Respiratory Outbreak Checklist (For Institutional Use)

- Assess the suspected or confirmed outbreak
- Implement general infection control measures
- Notify the local Medical Officer of Health or Designate of the suspected or confirmed outbreak
- Declare an outbreak in consultation with Public Health
- Obtain an outbreak number
- Hold the Outbreak Management team meeting within 24 hours of an outbreak being declared by Public Health
- Notify appropriate health care organizations and persons of the outbreak
- Collect and submit specimens for lab analysis
- Review communication of laboratory results
- Implement specific control measures for Influenza A or B, if appropriate
- Monitor the outbreak on an ongoing basis
- Public Health will declare the outbreak over
- Notify appropriate health care organizations and persons that the outbreak has been declared over
- Set a post outbreak review meeting to review outbreak management with public health
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BIOLOGICAL SUBSTANCE
CATEGORY B