COVID-19 guidance for long-term care homes (LTCH)

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 elderly individuals with underlying health conditions are at increased risk of severe outcomes. Therefore, early identification of cases associated with long-term care homes and rapid implementation of outbreak control measures are essential to preventing spread within the home. PHUs should also refer to Appendix A and B under the Infectious Diseases Protocol, 2018 for management and case definition of respiratory outbreaks in institutions and public hospitals Ontario.

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 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

Prevention of introduction of COVID-19 into the LTCH BEFORE detection of a case in the LTCH

- All health care workers should follow Ministry of Health memo dated March 19, 2020 on “Managing health care worker illness and return to work COVID-19”
- **Active screening** of all staff, essential visitors and anyone else entering the home be actively screened
  - Occupational health follow-up of all staff who have been advised to self-isolate based on exposure risk – return to work to be based on current guidance for healthcare workers and essential service workers
  - Active daily symptom screening of all staff (including temperature checks twice per day) if they have been advised to self-monitor, and if they become symptomatic in the workplace they are to immediately go home, to home isolation.
Managing Essential Visitors

- As LTCH 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., similar to a personal support worker).
  - Essential visitors should be limited to one person at a time for a resident.
  - Essential visitors must be screened on entry for illness including temperature checks
  - Essential visitors must only visit the one resident and no other residents
  - Staff must be support the essential visitor in appropriate use of PPE

Detection of a single case in the LTCH – suspect outbreak

A single laboratory confirmed case in a LTCH in a resident or staff member meets the definition for a ‘suspect outbreak’, and should prompt actions associated with a suspect respiratory infection outbreak.

- 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, I recommend 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 m distance cannot be maintained. And appropriate PPE should be worn when providing patient care.
    - Work self-isolation also means following self-isolation recommendations outside of the workplace. These health care workers should not work in other 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. Staff may continue to work in other facilities if required.
    - 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.
  - 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**
  o 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 a suspect outbreak.
  o 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.
  o **Residents with high risk exposures** should be placed in self-isolation and cared for using droplet and contact precautions.
  o **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. Staff may continue to work in other facilities, if required.

Declaring a confirmed outbreak

• **Two or more cases** among residents or HCW within 48 hours with any common epidemiological link, at least one of which must be laboratory-confirmed for COVID-19.

Information on outbreak data entry in provincial surveillance

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

Specimen collection for Outbreak management

• **Testing** should be conducted for **up to the first 4 symptomatic residents or staff** to establish the presence of the outbreak. After an outbreak is established, additional testing in residents should be discussed with the PHO laboratory ahead of time, and at the direction of the local PHU to manage the outbreak
  o All symptomatic staff should be tested. At this time, staff who test positive should be re-tested for viral clearance on symptom resolution. Viral clearance requires two negative specimens collected at least 24 hours apart.
  o Symptomatic HCWs who test negative can return to work as per usual workplace policies (e.g., shorter of five days or 24 hours after symptom resolution) and continue to self-monitor for the duration of the outbreak
  o Ill residents in affected areas do not need to be tested once an outbreak is established
  o Ill residents in unaffected areas may be tested (~1-2 specimens per new area) to establish if the outbreak has spread.
• Have a low threshold to test residents and health care workers within the home for COVID-19; even one compatible symptom should lead to testing.
• 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, without additional testing.
• Testing of asymptomatic residents or staff is generally not recommended.

Outbreak Control Measures

• 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.

Outbreak Infection Prevention and Control Measures

In addition to the IPAC measures found in the Recommendations for the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, the following IPAC measures should be initiated for a COVID-19 outbreak. Visit the PHO website for the most current recommendations and guidance.

• Accepting new and returning residents should be done on a case by case basis and include consultation with the resident/resident’s family, the resident’s physician, the PHU and the referring organization.
  • Until the outbreak is controlled, new resident admissions should be deferred.
  • Re-admissions should be deferred in areas with active outbreak, but may be considered to other areas.
• Families may take their resident home (from affected or unaffected units), but they cannot be readmitted if the home has a suspect or confirmed outbreak.
  • If the resident has had a high risk exposure, they will need to be in self-isolation in the family home and family care providers need to wear appropriate PPE when providing direct care.
  • For all residents, families should be advised to actively and at least twice daily monitor for symptoms compatible with COVID-19 in the resident.
  • Residents who develop symptoms while out of the LTCH should report to the symptoms to the LTCH to determine if testing is recommended and should be arranged.
• Report any suspected COVID-19 illness in residents or staff to the local PHU.
• 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.).
• 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.
Personal Protective Equipment (PPE), Hand Hygiene and Signage

- Ensure that the right PPE is available and accessible for use by front line healthcare workers and others who require use of PPE based on 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.

Aerosol Generating Medical Procedures

- Ensure appropriate measures are taken when performing aerosol generating medical procedures (AGMPs) in LTC (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.

Activities

- Discontinue all communal activities/gatherings, school programs and on-site day cares or intergenerational programming.
- Discontinue non-essential activities.
- Temporarily cease pet visitation programs to reduce the potential of the animal becoming a fomite and contributing to the spread of COVID-19. Pets residing at the home should be assessed by a veterinarian and housed elsewhere for the duration of the outbreak.

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 HCW, 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;
    - Utilizing respite and palliative beds/rooms to provide additional accommodation; and
    - 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:

- Considering designating staff to either ill residents or well residents;
- Having staff working under “working self-isolation” due to high risk exposures; and
- Having staff who are caring for ill residents in the LTCH not working at other facilities.

**IPAC Measures for Residents**

- Monitor residents for any new respiratory symptoms or fever.
  - Mild respiratory symptoms or changes in level of functioning should be assessed.
- Quickly identify and isolate any resident with symptoms of acute respiratory illness or fever.
- 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.
- Residents should be re-swabbed after symptom resolution to ensure viral clearance with a single negative specimen prior to coming out of isolation and precautions.

**IPAC Measures for Staff, Students and Volunteers**

- Keep staff and residents informed on COVID-19.
- In addition to active screening of staff, remind staff to self-monitor themselves for illness at all times, and to immediately self-isolate if develop symptoms.
- Develop policies for managing staff who may have been exposed to a case of COVID-19.
  - Staff with high risk exposures should ideally be put on self-isolation for 14 days.
    - If required for operational continuity, they may be put on “work self-isolation” where able to work while masked, cannot work in other facilities, and following self-isolation in their home.
  - Staff with medium risk exposures may be allowed to return to work while self-monitoring.
- Ensure signage is clear and that PPE (gowns, gloves, masks and eye protection) for staff are available and accessible for care of residents with acute respiratory illness.
- 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
IPAC Measures for Visitors and Private Companions

- Only allow essential visitors for duration of the outbreak. Essential visitors are those who have a resident who is palliative or very ill.
- For visitors who are exceptions to the visitation policy, assist them with donning and doffing their PPE if they are visiting residents requiring additional precautions.
- 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).

Declaring the outbreak over

- Laboratory clearance of staff cases prior to returning to work (two negative specimens collected at least 24 hours apart).
- Laboratory clearance of residents not required at this time.
- No new cases in residents or staff after 14 days from putting last case into isolation.