RIVERVIEW GARDENS

INFECTION PREVENTION & CONTROL POLICIES & PROCEDURES

POLICY: COVID-19: Outbreak Management		
POLICY CODE: IPAC	Issued: Feb 9, 2022	Revised: April 27, 2022 Edited on July 4, 2022

Outbreak Management

Only the local public health unit can declare an outbreak and declare when it is over. It is not the long-term care home's responsibility to determine whether cases have an epidemiological link. The local Public Health Unit (CKPHU) is responsible for investigating (e.g., determining when cases are epidemiologically (linked), declaring, and managing outbreaks under the HPPA. As such, the local CKPHU directs and coordinates the outbreak response. LTCHs and RHs must adhere to any guidance provided by the local PHU with respect to implementation of any additional measures to reduce the risk of COVID-19 transmission in the setting.

For more information on outbreak management, please refer to the COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, effective June 27, 2022 or as current.

Case and Contact Management

Management of Symptomatic Individuals

- As per Directive #3. All individuals in a home who are exhibiting signs or symptoms consistent with acute respiratory illness including COVID-19 must be advised to go home immediately to self-isolate and must be encouraged get tested for COVID-19 using a laboratory-based PCR or a molecular point-of-care test." This is regardless of the individual's COVID-19 vaccination status.

- **When a resident is symptomatic:** Residents must be self-isolated and placed on Additional Precautions, be medically assessed, and tested, as per Directive #3.

    - **Diagnostic testing:** The list of preferred specimen types for molecular testing is available on the Public Health Ontario website. Swabs should ideally be collected from the residents early in the course of their acute symptoms (onset within the preceding 48 hours). There should be a low threshold to test for COVID-19 in the event of new or worsening symptoms.

- Per Directive #3, all symptomatic residents must be tested for COVID-19, even during non-COVID outbreaks, using a PCR laboratory-based molecular at RVG.
- All symptomatic residents with acute respiratory symptoms, are eligible for testing of other respiratory viruses, using a multiplex respiratory virus panel (MRVP) test. During an outbreak, up to four (4) specimens will be accepted for concurrent MRVP testing by PHO's laboratory.

  - **If the COVID-19 and/or MRVP test results are positive:** see Case Management below.

  - **If both COVID-19 laboratory results and MRVP test results are negative:** may discontinue Additional Precautions if there has not been an exposure to COVID-19 and they are afebrile, and symptoms are improving for at least 24 hours (48 hours for gastrointestinal symptoms). Continue to monitor the symptomatic resident closely for worsening symptoms, and test again if new symptoms develop.

- **When a staff or a visitor is symptomatic:**

  Symptomatic staff or visitors must not be permitted entry into the home, as per Directive #3. If they become symptomatic during their shift or visit, they should be self-isolated until they can safely leave the home's property and/or be asked to leave immediately. They must be instructed to self-isolate, seek medical assessment as required, and be encouraged to get tested for COVID-19, as per Directive #3.
  - See Directive #3 for exceptions where individuals who fail screening may be permitted entry into the home.

Case Management

- Per Directive #3, all individuals who are identified as a confirmed or a probable COVID-19 case must self-isolate as per the Public Health Management of Cases and Contacts of COVID-19 in Ontario. This is regardless of the individuals'COVID-19 vaccination or previously positive status.

- **When a resident test positive for COVID-19 (irrespective of MRVP results):** Residents must be self-isolated and placed on Additional Precautions to prevent the spread of infection to others in the home, as per Directive #3.

  - Individuals requiring self-isolation must be placed in a single room on Additional Precautions. Where this is not possible, individuals may be placed in a room with no more than one (1) other resident who must also be placed in self-isolation on Additional Precautions. For the purposes of self-isolation, there should not be more than two (2) residents placed per room, including 3 or 4 bed ward rooms.

  - Asymptomatic residents living in the same room as the case should be tested and placed on Additional Precautions immediately along with the infected resident under the direction of the local PHU (see Contact Management below).

- **When a staff or a visitor test positive for COVID-19:** Staff and visitors who receive a positive COVID-19 test result while they are at the LTCH/RH must leave the facility immediately and be directed to self-isolate at their own home, as per Directive #3.Staff and visitors who are ill or diagnosed with a confirmed COVID-19infection (by RAT or molecular test) may not be permitted to return to the home until after symptoms resolve and the appropriate self-isolation period has elapsed.

- **Exception for staff on early return to work:** Staff who test positive for COVID-19 may be required to work on early return to work following the policy and guidance issued by the MLTC and MSAA and the COVID-19 Interim Guidance: Omicron Surge Management of Staffing in Highest Risk Settings, or as current.

- Detailed case management for non-COVID-19 respiratory infection outbreaks are outside the scope of this document. See Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018 for more information.

- For case definition for influenza and other respiratory infection outbreak in institutions and hospitals, refer to the relevant disease specific chapters in Ministry of Health's Appendix A and B to the Infectious Diseases Protocol.

Contact Management

- **Contact management decisions are made by the local PHU.** Accordingly, all individuals who are identified as a close contact of a known case or an outbreak are required to follow the direction of the local PHU.

    - **A high-risk contact (HRC)** is defined as a resident who was in contact with a positive case during their period of communicability (within 48 hours prior to symptom onset if symptomatic or 48 hours prior to the specimen collect date if asymptomatic, and until the positive person started self isolating) AND meet one or more of the following:

        - Received direct care from a staff positive for COVID-19 (unless this interaction meets the definition of a lower-risk exposure below).

        - Close prolonged contact (within 2 metres) with a symptomatic person (e.g., roommates' essential caregivers, visitors) or body fluids of a positive case (e.g., roommates, essential caregivers, visitors) or body fluids of a positive case (e.., cough, sneeze), without the consistent and appropriate use of PPE.

    - **A lower-risk contact** is defined as a resident who was in contact with a positive case during their period of communicability, but the exposure may be lower risk. Examples of lower risk exposures include

        - Receiving direct care from staff who was positive for COVID-19 when the staff had consistent and appropriate use of masking (a well-fitting surgical mask or N95 respirator used for source control)

        - Sharing an indoor space with a person with a positive case or in settings where close interactions occur (e.g., dining room) where public health measures (e.g., masking, physical distancing) are in place and the person does not fit the definition of minimal /no risk and/or high-risk

- When a PHU is conducting a risk assessment, the PHU may deem an exposure high-risk if there were other factors involved that may increase the risk of transmission (e.g., accumulated contact time with the positive case).

- For details on how to identify and manage contacts, refer to Appendix F.

    - All HRCs should be monitored for COVID-19 symptoms and be isolated and tested as per Appendix F

    - HRCs, regardless of their vaccination status, may discontinue isolation on of after day 5 from last exposure, provided they remain asymptomatic and receive a negative PCR or molecular test result taken on or after day 5 from last contact with a positive case.

        - Isolate for 10 days from last contact with positive case if testing is declined. If the individua develops symptoms, then the isolation period would be 10 days form symptom-onset

    - If there is no evidence to suggest a resident was exposed to a case, testing and isolation may not be required, unless symptoms develop.

    - Asymptomatic residents who have been previously infected with COVID-19 (based on a molecular or rapid antigen test) on or after December 20th, 2021 and cleared within the last 90 days are not required to isolate or be tested if they have been in contact with a positive case.

Table 3: Contact Management for LTCH and RH Residents based on Exposure Type

High-risk

Exposure	Contact Management for LTCH and RH Residents
Received direct care from case who did not have appropriate masking	• Isolate until negative molecular test results taken on or after day 5 are received OR for a minimum of 10 days from last contact with case (without testing) • Monitor for symptoms for 10 days • Molecular test on day 5 • If negative: isolation may be discontinued • If positive: treat as a case
Close prolonged contact (<2m) with a symptomatic person (e.g., roommates) of a positive case without the consistent and appropriate use of PPE**	

Lower-risk

Exposure	Contact Management for LTCH and RH Residents
Received direct care from a staff positive with COVID-19 who had consistent and appropriate masking*	• Monitor for symptoms for 10 days. • Isolation not required unless symptoms develop or positive test result
Was in a shared indoor space with a case or in a setting where close interactions occur but with public health measures in place	

** masking for source control is defined as the case wearing well-fitted surgical mask or fit-tested N95 respirator appropriately and consistently

*** PPE in this situation is defined consistent and appropriate use of a fit tested N95 respirator and eye protection

- **COVID-19 contact management** should be done as per Public Health Management of Cases and Contacts of COVID-19 in Ontario

- For contact management for other (non-COVID-19) respiratory viruses, see Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018

    - Contacts of non-COVID-19 respiratory illness cases are not routinely self-isolated.

- For influenza antiviral prophylaxis, see PHOs at a Glance: Influenza Antiviral Treatment

Table 4: Contact Management for COVID-19 and Other Respiratory Viruses

Case tests positive for	If the high-risk contact is a Resident	If the high-risk contact is a Staff/Visitor
COVID-19	Refer to Table 3 and Appendix F	Test for COVID-19 Self-isolate as applicable
Other respiratory virus (i.e., COVID-19 negative)	Monitor Consider antivirals if influenza	Monitor Consider exclusion/antivirals if influenza and unvaccinated for flu

Declaring an Outbreak

- Surveillance definitions of **COVID-19 outbreaks** in LTCH/RH are as follows:

  - **A suspect outbreak** in a home is defined as:
    - One positive PCR test OR rapid molecular test OR rapid antigen test in a resident

  - **A confirmed outbreak** in a home is defined as:
    - Two or more residents and/or staff/other visitors in a home e.g., (floor/unit) each with a positive PCR test OR rapid molecular test OR rapid antigen test result AND with an epidemiological link*, within a 10-day period.

      *Epidemiological link defined as: reasonable evidence of transmission between residents/staff/other visitors AND there is a risk of transmission of COVID-19 to residents within the home.

  - **NOTE:** the definitions above are for surveillance purposes only. PHUs have the discretion to declare a suspect, or a confirmed outbreak based on the results of their investigation, including when the above definitions are not completely met.

  - For greater clarity, staff cases are those whose COVID-19 infection was deemed due to workplace exposure (i.e., acquisition in the home) by workplace health and safety, the PHU, or the IPAC team.

    - For the purposes of outbreak management, if a staff assessment is not possible to determine the source of acquisition and there is no evidence to support an epidemiological link to the home, the PHU has the discretion to presume staff COVID-19 infections were not acquired in the home during periods of high community transmission.

    - The home's workplace health and safety and/or IPAC team has a duty to report an employee case as per OHSA requirements.

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

- During a suspect or confirmed outbreak, homes should continue to conduct enhanced symptom assessment (minimum twice daily) of all residents to facilitate early identification and management of ill residents.

- Declaring a COVID-19 outbreak may not be necessary in certain scenarios such as:

  - When a resident has tested positive during their self-isolation period following their admission or transfer and has been under Droplet and Contact Precautions for the entirety of this period.

  - When the source of COVID-19 acquisition for staff cases are deemed to have reasonable occurred outside the workplace and there is no evidence of transmission or an epidemiological link to resident cases in the home.

- For greater clarity

  - Declaration of an outbreak (suspected or confirmed) is not required to implement enhanced measures at the discretion of the Outbreak Management Team or as directed by the local public health unit (e.g., enhanced disease surveillance, infection prevention and control measures).

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

  - If a RAT is used for a staff or resident with symptoms or high-risk exposure (e.g., to expedite outbreak management) PCR or rapid molecular diagnostic (e.g., ID NOW) testing should also be performed in parallel.

  - Staff and/or residents are to be managed as a case if a positive RAT or an epidemiological link until PCR (i.e., negative PCR or rapid molecular diagnostic test results are received.

Suspect Outbreak Management

- Suspect outbreak management should include the following steps at minimum:

  - Case and their high-risk of exposure contacts (e.g., roommates, dining/activity cohort, staff who cared for the case without appropriate and consistent PPE) should be tested (PCR or rapid molecular diagnostic, and concurrent RAT if necessary) and managed appropriately as per the section on **Contact Management** below

  - Staff and residents must be cohorted to limit the potential spread of COVID-19

- Increased cleaning and disinfection practices (e.g., at least two times a day and when visibly dirty for high touch surfaces).
- Additional testing at discretion of PHU; and
- Additional control measures at discretion of PHU

Confirmed Outbreak Management

- Once an outbreak is declared, the local PHU will direct testing and public health management of all those impacted (staff, residents, and visitors) using a risk-based approach. It is important to consider both the COVID-19 risk to residents and the potential harm of resident isolation and testing when implementing public health measures (e.g., facility-wise versus limiting to floors/units where appropriate.)
- Confirmed outbreak management should include the following steps at minimum:
  - Defining the outbreak area of the home (e.g., floor or unit or whole facility) and cohorting based on COVID-19 status (i.e., infected or exposed and potentially incubating),
  - Assessing risk of exposure to residents/staff based on cases' interactions, and in consideration of factors such as exposed resident/staff COVID-19 vaccination status and whether cases are infected with a variant of concern with known immune/vaccine escape potential,
  - Enhanced monitoring for new symptoms in all residents and staff in the outbreak area,
  - Conducting weekly IPAC self-audits as per Directive #3,
  - Facilitate assessment of IPAC and outbreak control measures by health system partners as applicable,
  - Increased cleaning and disinfection practices (e.g., at least two times a day and when visibly dirty for high touch surfaces),
  - The need for staff to follow Additional Precautions for all resident interactions in the outbreak area,
  - Modification of dining and indoor social activities (as applicable),
  - Limiting or restricting new admissions and transfers, and
  - Limiting or restricting visitors, depending on the nature of the outbreak
- At the discretion of the PHU and where operationally feasible for the home:

- Group activities dining, and other social gathering may continue/resume in areas of the home (e.g., floors/units) not affected by the outbreak if residents are able to adhere to public health measures (e.g., masking, physical distancing),

- Group activities/gatherings within an outbreak area of the home (e.g., previously infected with COVID-19). Considerations may include:

    - Appropriate staff cohorting can be maintained,

    - There have been no concerns raised on the IPAC audits of the homes that are unaddressed, or,

    - Residents within the cohort are able to adhere to public health measures (e.g., masking).

- Activities for residents in isolation may continue/resume. For example:

    - 1:1 walks in an empty hallway with HRC or case and staff or essential caregiver, both with appropriate use of PPE

    - Staff or essential caregiver supported visits to a designated room other than the residents' room where others are not occupying or travelling through.

    - At the discretion of the PHU, Adult Day Programs for community members may continue, provided that the outbreak is contained, appropriate cohorting measures are in place to prevent transmission to the Day program participants, and all other public health measures continue to be followed for staff and participants.

Cohorting in an Outbreak Setting

- Cohorting is an important part of an overall IPAC approach within a home to limit the potential transmission throughout the home in the event of an introduction of an infection.

- Best practice is for staff who have worked in an outbreak setting in another facility (e.g., acute care, another LTCH or a RH) should not work in other facilities for the duration of the outbreak, regardless of their COVID-19 vaccination status. This is to limit the risk of COVID-19 transmission across homes/facilities.

- Where this is not possible, staff should be assigned to also work in an outbreak area at the second location, be actively screened every day, and be rapid antigen tested every day.

Diagnostic Testing for Outbreak Management

- Local PHUs are responsible for making recommendations on and facilitating outbreak testing using a risk-based approach based on exposures (e.g., affected outbreak floor /unit).

- When timely PCR results may not be available, RAT may be collected to facilitate timely outbreak management.

- Asymptomatic individuals who initially test negative should be re-tested if they develop symptoms.

- Residents and staff who were previously infected with COVID-19 in the last 90 days (confirmed by molecular or rapid antigen testing) should be excluded from point prevalence testing unless they develop symptoms.

- The use and frequency of point prevalence testing during time of high community transmission should consider the potential for identification of incidental detection of COVID-19 among staff and residents and ongoing testing that may already be occurring among staff.

- In the event of **ongoing transmission** in an outbreak, following the initial testing of the home at the time of the outbreak declaration, repeat testing of all resident and staff who initially tested negative should be conducted within 3-7 days from when the initial testing was conducted. If additional cases or symptomatic individuals are identified, continue repeat testing of residents and staff who tested negative every 3-7 days until no new cases are identified. Testing with PCR is recommended, and when timely access to PCR results is not available consider collecting RAT.

- PHU are responsible for following usual outbreak notification steps to the PHO Laboratory to coordinate/facilitate outbreak testing and ensuring an outbreak number is assigned.

Declaring the Outbreak Over

- The outbreak may be declared over by the PHU when there are no new cases in residents or staff linked to exposures in the home after 10 days (maximum incubation period) from the latest of:

    - Date of self-isolation of the last resident case, OR

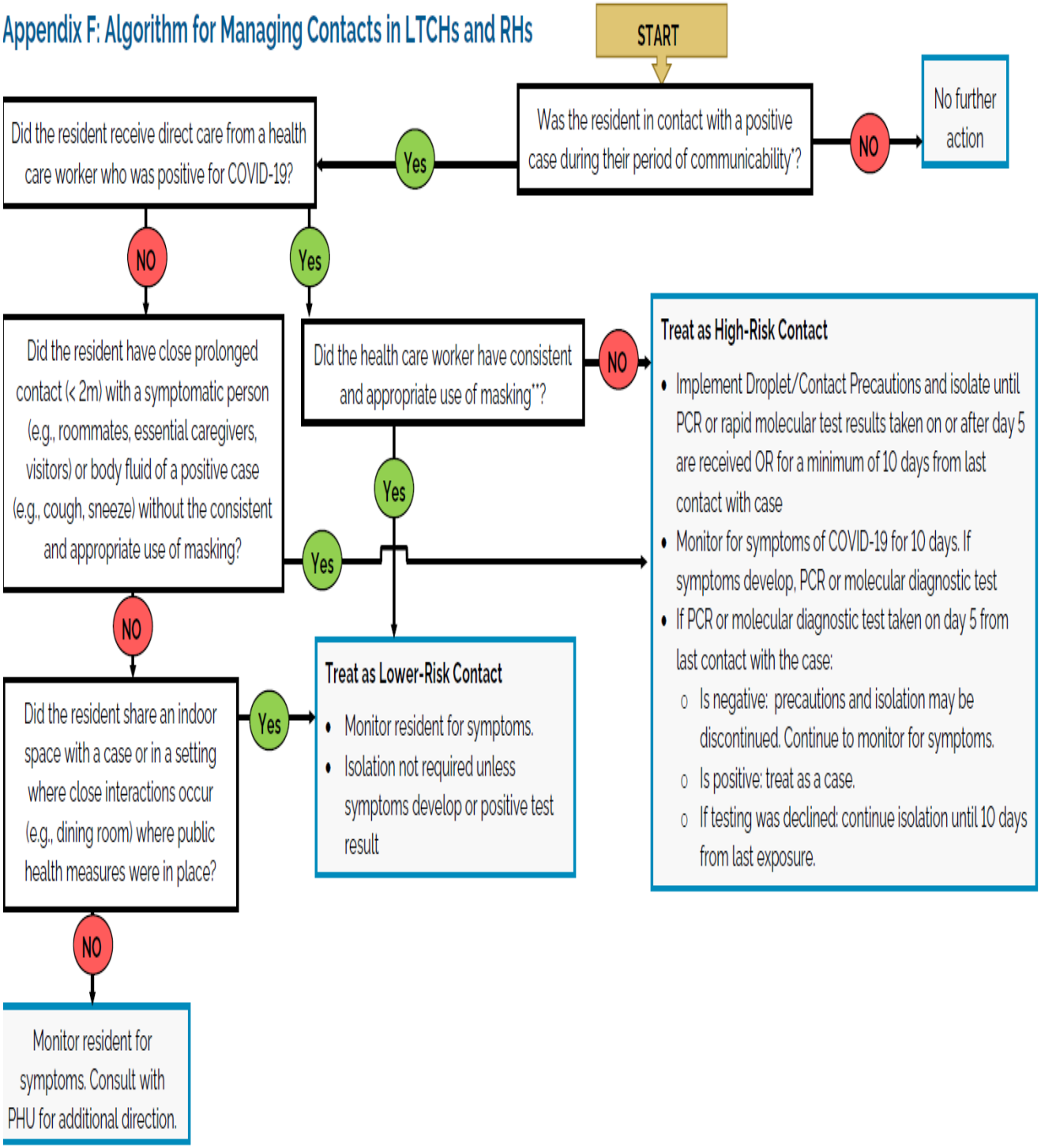
    - Date of illness onset of the last resident case, OR

    - Date of last shift at work for last staff case.

- For greater clarity, if staff continue to test positive for COVID-19 (i.e., a staff presumed or linked to a community exposure), the outbreak may be declared over at the discretion of the PHU, provided there is not evidence of transmission to residents.

- In homes with ongoing transmission and/or evidence of increased severity of illness, the PHU may require 14 days to elapse before the outbreak is declared over.
- Following the end of an outbreak, please see PHOs guidance document on De-escalation of COVID-19 Control Measure in Long-Term Care Homes and Retirement Home

Appendix F: Algorithm for Managing Contacts in LTCHs and RHs



References:

COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units (gov.on.ca)