



Regional Influenza Surge Strategy

2018/19



Ontario

Local Health Integration
Network

Réseau local d'intégration
des services de santé

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Background

On an annual basis, the health care system in Erie St. Clair and across the Province of Ontario experiences an increased demand for services, primarily due to respiratory influenza. Other factors such as weather, falls, depression, and population-specific impacts to frail seniors and/or seniors with complex health care needs directly correlate to increased demands. This annual trend, referred to as “seasonal surge,” is experienced between the months of November to April (approximately).

Seasonal Surge, although variable from year-to-year, can significantly stress the health care system causing barriers to access timely care, particularly hospital-based care.

Specifically, seasonal surge pressures have impacted in the following ways:

- 1. Increased hospital occupancy rates that exceed regular capacity*
- 2. Longer Emergency Department wait times and stays, with delayed admissions for those requiring acute care services*
- 3. Cancelled/postponed elective surgeries*
- 4. Delayed access to Long-Term Care and Rest and Retirement services due to “outbreaks”*
- 5. Over-extending of staffing resources due to overtime and increased workload*

The Surge Season experienced in 2016/17 was more significant than in past years. While the Erie St. Clair LHIN and health service providers worked closely to manage the impact of surge with both proactive and reactive strategies, the absence of a region-wide strategy translated into an approach to surge management that lacked standardization, role clarity, and shared expectations among health care providers.

In 2017/18, a draft surge strategy was developed in collaboration with a broad range of health care stakeholders which addressed creating common understanding, definition, and approaches to acknowledging and addressing surge in demands for care.

The experiences of the past two surge seasons has informed the creation of the Erie St. Clair LHIN Regional Influenza Surge Strategy. The strategy will provide a framework to guide the health care system as it responds to another year of expected influenza-related pressures as well as a building point for future planning.

Purpose and Goals

Purpose

The Erie St. Clair LHIN Regional Influenza Surge Strategy is intended to provide a set of common definitions, processes, and protocols to guide hospitals, LTC homes, and other community providers’ response to increase influenza-related demands.

This strategy is informed through engagement with representatives from key health sector organizations and combines provincial best practices and lessons learned in the 2016/17 and 2017/18 surge seasons.

It is important to note that hospitals in the Erie St. Clair LHIN have local surge plans in place. The Erie St. Clair LHIN Regional Influenza Surge Strategy will compliment this work and provide a regional framework for LHIN and system escalation of interventions to mitigate the impacts of surge.

Goals

The goal of the Erie St. Clair LHIN Regional Influenza Surge Strategy will be to create a comprehensive system-wide Surge Strategy that is aligned to provincial best practices and supports a managed and integrated response to seasonal surge that is both proactive and reactive.

In establishing a comprehensive system-wide Influenza Surge Strategy, the Erie St. Clair LHIN and partner agencies aim to:

1. Identify and confirm surge triggers, thresholds, and establish surge scale with appropriate protocols (including monitoring functions).
2. Establish clear roles and responsibilities to guide actions by sector (both proactive and reactive) with a predictive surge timeline based on three-year trend.
3. Use existing data sources and develop new tools to provide informed and evidence-based decisions as a system of health care providers.
4. Develop a capacity plan with prioritization in surge.
5. Develop a broad communication and education strategy that enables:
 - a. Awareness and use of appropriate levels of care during surge to reduce demands on acute care (i.e. through posting holiday access to primary and community care options for public access).
 - b. Maximize uptake on influenza vaccinations to reduce demands on the overall health care system and support the wellness of health care workers.
 - c. Better coordination and planning in preparation for, and in reaction to, surge.
6. Follow guidance from the Ministry of Health and Long-Term Care to implement strategies for improved access to LTC beds during surge and risk mitigation for spread of influenza in LTC (per 'Guide to Respiratory Infections in Long-Term Care Homes' and 'Health Promotion and Protection Act').

Planning Process

The management of surge has been demonstrated through past processes as requiring coordination among multiple agencies to support flow of patients across the continuum to the appropriate level of care and/or avoiding the need for care (particularly within hospital settings) through preventative means. Therefore, a collaborative planning process for the development a Regional Influenza Surge Strategy was put in place.

Planning/Engagement Structure

Phase 1 – 2017/18

Seasonal Surge Planning Committee

The Project Planning provided leadership to set the overall aims of the surge strategy through an after-action-review of the 2016/17 surge season and an environmental scan of provincial best practices.

Co-Chairs:

- Dr. David Ng, LHIN Emergency Department Lead
- Lori Marshall, CEO, Chatham-Kent Health Alliance

Members:

- David Simpson, ED/ALC Lead, ESC LHIN
- Pete Crvenkovski, VP, Performance, Accountability & Finance, ESC LHIN
- Oz Eren, Manager, Decision Support Services, ESC LHIN
- Rashoo Brar, Sub-Region Director, ESC LHIN
- Ron Sheppard, Sub-Region Director, ESC LHIN

Surge Planning Forum

On September 15, 2017, the Erie St. Clair LHIN hosted a Surge Planning Forum which was attended by participants representing the following sectors from all six LHIN sub-regions:

- | | |
|-----------------------------|-------------------------------|
| • Community Support Service | • Long-Term Care |
| • EMS | • Non-Urgent Patient Transfer |
| • Home & Community Care | • Public Health |
| • Hospitals | • Primary Care |

The goal of the forum was to engage leaders and clinicians within key health care sectors impacted by, and able to support, seasonal hospital surge with relevant education on preventative and reactive best practices for preparation and management of seasonal surge, and to receive feedback and direction with respect to a local strategy specific to identifying and gaining consensus on:

1. Thresholds/Triggers for implementing surge escalation protocols; and
2. Roles and Responsibility Matrix for surge events.

Presenters at the forum included:

- **Dr. Kieran Michael Moore** (Medical Officer of Health for the Kingston, Frontenac and Lennox & Addington (KFL&A) Public Health Unit): *Data Driven Collaborative Action to Respond to Surges in Health System Use*
- **Lori Marshall** (President/CEO, Chatham-Kent Health Alliance): *North West LHIN System-Wide Surge Protocol*

- **Dr. Bois Marufov** (Team Lead, Regional Support Team-West in the Infection Prevention and Control Department at Public Health Ontario): *Fifth Season. Outbreak Season. Are you prepared?*
- **Shannon Sasseville** (Director, Communications, Public Affairs, and Community Engagement, ESC LHIN): *The Role of Emergency Management Communication Tool (EMCT) in Surge and Beyond*

Additionally, the event included sub-region break-out groups to receive feedback on specific questions posed on the information presented along with activities designed to determine thresholds/triggers and organizational roles and responsibilities in surge.

The results of the forum were published in a report titled *Erie St. Clair Local Health Integration Network Seasonal Surge Planning Forum, September 15, 2017, Workshop Report*

Sub-Region Working Groups

Building off of the work of the Surge Planning Forum, Sub-Region Working Groups were established with assigned leads from Erie St. Clair LHIN funded health service providers, and other key stakeholders from public health and transportation sectors.

Over a series of meetings, members provided in-depth feedback and recommendations to refine triggers and thresholds with respect to levels of surge and provided a framework for actions to be taken by health service providers as surge escalates.

Finally, sub-region working groups provided final recommendations to the draft Erie St. Clair LHIN Regional Influenza Surge Strategy.

Phase 2 – 2018/19

Surge Planning and After-Action Forum

On June 20, 2018, the Erie St. Clair LHIN hosted its second Surge Planning Forum, similarly attended by participants representing the following sectors from all six LHIN sub-regions:

- | | |
|-----------------------------|------------------|
| • Community Support Service | • Long-Term Care |
| • EMS | • Public Health |
| • Home & Community Care | • Primary Care |
| • Hospitals | |

The forum was provided for a collaborative evaluation of the 2017/18 influenza surge season and the effectiveness of strategy in place to manage system capacity, as well as sharing among members of promising practices and experiences from the prior season.

Most importantly, participants were engaged to help determining strategies for inclusion in the 2018/19 strategy. Specifically, stakeholders assisted in identifying:

- what worked and what did not work in the 2017/18 surge plan
- proactive and reactive mitigations for consideration in the 2018/19 plan
- surge capacity for continuation, to be added, and/or to be removed, in 2018/19 plan

Following the Surge Planning Forum, an additional engagement took place with hospital Chief Nursing Executives for the purpose of reviewing the surge triggers and thresholds and refining the criteria that would be used for determining what constitutes surge and its level of intensity (see pages 9, 10, and 12).

Defining Surge

For the purpose of this plan, surge refers to the impact of increased patient volumes, primarily for hospital services, as a result of respiratory influenza, which affects patient flow across the continuum of care. As noted previously, other factors such as weather, falls, depression, and population-specific impacts to frail seniors and/or seniors with complex health care needs directly correlate to increased demands.

Surge can further be defined and referred to as Seasonal Surge based on the annual trend of increased hospital demands experienced between November to April (approximately). Lastly, within surge season, a period known as the “12 Days of Christmas” is a specific period for which special consideration and planning is required to mitigate its impact (see pg 9).

While efforts necessary to address surge are required across all health sectors, the emphasis for monitoring and protection of access to care is placed upon emergency department, acute care, and surgical services, given the imperative for ensuring life and limb care to patients in need.

It is important to note that the LHIN Regional Influenza Surge Strategy does not take the place of the Critical Care Surge Protocol. This is a well-established, standardized, and province-wide protocol specific to increased demands in hospital Intensive Care and Critical Care units. However, advanced stages of Seasonal Surge will reflect pressures on Critical Care and will require coordination with the Erie St. LHIN Critical Care Lead and the broader provincial Critical Care system.

Surge Levels

In order to provide for the establishment of escalation protocols and action plans, levels of surge will be defined as the following:

Mild

Increased patient volumes that have impact primarily on hospital services and require implementation of internal hospital protocols to manage and mitigate pressures with increased monitoring through partners.

Moderate

Increased and sustained patient volumes that significantly impact upon hospital, community-based, EMS and Long-Term Care services and requires broader system response to manage impacts and mitigate against continued seasonal pressures.

Major

Increased and sustained patient volumes that have significant and broad impacts and are beyond the means of providers to manage through conventional capacity and requires both local and provincial escalation.

Types of Surge

Episodic

Short periods of surge may be experienced within Erie. St. Clair LHIN hospitals that require activation of internal protocols as well support from Erie. Clair LHIN Home and Community Care partners to ensure patient flow continues.

Episodic surge will not trigger an escalation process as per actions set out in this plan.

Episodic surge will be determined as a period of less than three days with increased demand in keeping with the surge triggers and thresholds (see page 12).

Sustained

A sustained surge will be a period of three or more days with increased demand in keeping with the surge triggers and thresholds.

Sustained surge will trigger an escalated systemic response as per the actions set out in this plan.

“12 Days of Christmas”

As Surge Season typically begins to ramp up, we come into the holiday season when it is common practice that health services have decreased their service levels to provide for staff time off. Specifically, service closures and decreasing coverage or operating hours happen in the following sectors with the following results:

- **Primary Care** – impacting access to patients for preventative diagnosis, treatment of conditions, and medication renewals which leads to increased Emergency Department visits and greater acute admissions due to delays in seeking/receiving care.
- **Home and Community Care** – increasing wait times to hospitalized patients for home care services which delays discharges back to community (note: with increased length of stay for hospitalized patients comes the potential loss of muscle and functionality where mobilization/rehab is not taking place, further impacting discharge outcomes and/or health outcomes).
- **Hospital Outpatient Clinics** – decreasing access to follow-up care post-discharge for hospital patients leading to increased hospital readmission rates.
- **Hospital Consultants** - delayed access to diagnostics and treatments with decreased hospitalists and specialists, increasing hospital length of stay.

The 12 Days of Christmas, which is a by-product of a lack of coordinated system planning and resourcing, has been identified as taking place annually between approximately December 21 to January 8.

Longer-term strategies will need to be identified for engagement and partnership with primary care physicians, specialists, and other key providers in order to develop plans to mitigate the effects of the 12 Days of Christmas by increasing access to care throughout the holiday season.

Activation and Cessation Criteria

Past surge events in the Erie St. Clair LHIN have demonstrated that the activation of an escalation protocol and measures to address surge as a system require objective triggers and thresholds. The rationale is that in a true surge situation, health service providers will be called upon to put in place action plans that will support enhanced flow throughout the system and potentially require financial and staffing resources. Objective measures will build trust to support swift action across health care partners.

Also required will be cessation criteria so that the system can safely de-escalate the level of supports being provided to surge and begin the process of moving towards normal operations again. -This Surge Cycle (Figure 1) will be acknowledged and formally communicated to health service providers by the Erie St. Clair LHIN using the established triggers, thresholds, and cessation criteria.

Figure 1: Surge Cycle



Both the Surge Planning Forum and Sub-Region Working Groups provided insights to define a regional algorithm for monitoring and determining surge and its level of severity.

As the status of triggers are not static throughout a 24-hour period, and at certain points of the day a hospital may appear more pressured based on the daily cycle of activities (e.g. daily admission and discharges), the Erie St. Clair LHIN will review and track surge using a time stamp of 3 p.m.

Activation Criteria

The Erie St. Clair LHIN Regional Influenza Surge Strategy will set triggers with assigned thresholds for determining level of surge, and will be officially designated by the Erie St. Clair LHIN and communicated as per established protocols when the triggers and thresholds are consistently observed and sustained for 3 days or greater. Within each of the designated levels of surge, occupancy will be a required trigger with the presence of two or more additional triggers and thresholds met.

That status of surge will be monitored through the soon-to-be launched Oculys Surge Dashboard, which incorporates all available metrics and is coded to identify surge corresponding to the established triggers and thresholds. The portal will be made available to all health care providers for review and monitoring, and will be communicated out via ESC LHIN staff to identify episodic and sustained surge periods.

While the Surge Strategy primarily focuses on influenza-based pressures, hospital flow impacted by other issues will be acknowledged and mitigated against collaboratively (i.e. surge in acute mental health admissions).

Figure 2: Surge Thresholds and Triggers

Mild	Moderate	Major
Total Occupancy (Med/Surg/Critical Care) = 95-102%	Total Occupancy (Med/Surg/Critical Care) = 103-110%	Total Occupancy (Med/Surg/Critical Care) = >110%
Plus 2 or more indicators		
Admit/Discharge Ratio (Acute) = <1:1	Admit/Discharge Ratio (Acute) = >1:1	Admit/Discharge Ratio (Acute) = >1:1
Acute Length of Stay = N/A	Acute Length of Stay = Trending ↑ (above regional average of 5.6 days)	Acute Length of Stay = Trending ↑ (above regional average of 5.6 days)
ED Admissions rate above min-max ranges (by site and region) <ul style="list-style-type: none"> BWH: 6.6% - 9.1% CKHA: 6.6% - 8.1% ESHC WRH - 5.6% - 8.7% ESC LHIN - 9.1% - 11.7% WRH: 12.6%-16.8% 	ED Admissions rate above min-max ranges (by site and region) <ul style="list-style-type: none"> BWH: 6.6% - 9.1% CKHA: 6.6% - 8.1% ESHC WRH - 5.6% - 8.7% ESC LHIN - 9.1% - 11.7% WRH: 12.6%-16.8% 	ED Admissions rate above min-max ranges (by site and region) <ul style="list-style-type: none"> BWH: 6.6% - 9.1% CKHA: 6.6% - 8.1% ESHC WRH - 5.6% - 8.7% ESC LHIN - 9.1% - 11.7% WRH: 12.6%-16.8%
ALC Rate (Acute) = >12.7%	ALC Rate (Acute) = >12.7%	ALC (Acute) = >20%
ALC (Post Acute) = >30% (# of ALC patients/# of beds)	ALC (Post Acute) = >30% (# of ALC patients/# of beds)	ALC (Post Acute) = >50% (# of ALC patients/# of beds)
ILL Trending = Trending ↑ (per Local Health Unit Report for current month)	ILL Trending = ↑ (per Local Health Unit Report for current month)	ILL Trending = ↑ (per Local Health Unit Report for current month)
	Cancelled Elective Surgeries = Yes	Cancelled Elective Surgeries = Yes

Although other triggers were identified by the sub-region working group, the above were confirmed based on analysis of feedback for commonalities across regions, availability and ease of access/tracking of data, and/or proxies for suggested measures. Other triggers identified through sub-region working groups included:

- Increased admit no beds
- Increased primary care/urgent care/clinic visits
- Primary care physicians/clinics open and available
- Increased EMS calls
- Increased EMS offload times

- Increase acute admissions
- Hospital outbreaks
- Code Orange status
- Increase in acuity in acute care patients
- Staff absenteeism/burnout
- Increased influenza cases and/or respiratory illness
- ED re-visits post (admitted and non/admitted patient)

Note: the Erie St. Clair LHIN will review and acknowledge special circumstances/pressures demonstrated outside surge triggers and thresholds if necessary and will designate a surge. Also, surge will be reviewed and designated on a sub-region basis, unless circumstances warrant a region-wide designation with corresponding regional coordination and mitigation.

Cessation Criteria

Cessation and/or downgrading of surge will be designated based on decreasing pressures (below those thresholds noted for the surge category) for a period of more than 3 days.

Surge Capacity Implementation & Coordination

The manifestation of seasonal surge and monitoring of its impacts are primarily focused on hospital emergency department and acute care services. However, an effective response to Seasonal Surge requires a system response that is oriented towards both proactive and reactive mitigations. The Erie St. Clair LHIN Regional Influenza Surge Strategy aims to support a managed and integrated response to seasonal surge that develops and leverages system capacity, promoting flow of patients across the continuum and better access to care despite increased demand.

Health System Roles and Responsibilities

A system response begins with developing a common understanding across health service providers of one another's roles and responsibilities in surge.

Through the Surge Planning Forum and Sub-Region Working Groups, health service providers worked together to acknowledge and document the roles and responsibilities by sector.

The following accounts for key roles and responsibilities of health service providers with key activities to support surge (note: some activities are not solely dedicated to surge and reflect ongoing roles/initiatives that will also support seasonal surge management):

Health Sector	Response
Erie St. Clair LHIN (Integrated Delivery Systems)	<p>Annual refresh of a system-wide surge plan that includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> • Engagement of health and social service partners to support readiness for surge capacity, coordination of care, and confirm required elements to a surge plan • Identification, support and resourcing of system-wide surge capacity where required proactively and within the context of an escalation event (including engagement with the MOHLTC)

	<ul style="list-style-type: none"> • Monitoring and surveillance to assess the status of seasonal surge based on established triggers and thresholds • Provision of formal designation, re-designation or cessation of surge and corresponding level with communications to stakeholder to implement established action plans • Implement and lead surge calls with designated health service providers and leads to coordinate • Communication to health service providers and public on the status of the health care system (and/or Sub-Region) and reinforce key messages consistent with the Erie St. Clair LHIN Regional Influenza Surge Strategy
Emergency Medical Services (EMS)	<ul style="list-style-type: none"> • Provision of monitoring and preventative care to vulnerable high-user clients through Community Paramedicine Programs • Provision of Influenza vaccination and health clinics to targeted communities of vulnerable clients (where possible) • Collaboration with “circle of care” health care providers (e.g. Home & Community Care, Primary Care and EMS) to support appropriate access to and discharge from hospital for patients • Appropriate staffing during holidays and anticipated periods of peak volumes through seasonal surge • Collaboration with hospital partners, Central Ambulance Communication Centre (CACC) and LHIN to implement diversion protocols and temporary measures to minimize EMS offload delays at Erie St. Clair LHIN Emergency Departments
Acute Care Hospitals	<p>Annual refresh of a hospital-based surge plan that includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> • Engagement of community partners to support readiness for surge capacity and coordination of care • Implement infection control via staff education and influenza vaccination and protocols to identify and prevent the spread of influenza and infectious diseases • Appropriate staffing during holidays and anticipated periods of peak volumes through seasonal surge • Identification and implementing of surge bed capacity (both in conventional and unconventional settings) to absorb impact of increased acute care volumes and length of stay • Collaboration with “circle of care” health care providers to support appropriate access to and discharge from hospital for patients • Adherence to discharge and Home First policies that provide proactive planning and support to patients and families for returning home to receive ongoing care after acute care • Proactive and transparent communication to the Erie St. Clair LHIN and health system partners on current status of hospital services, access, and action plans in place to manage impacts of seasonal surge • Collaboration with EMS partners and LHIN to implement diversion protocols and temporary measures to minimize EMS offload delays at Erie St. Clair LHIN Emergency Departments

Post-Acute Care Hospitals	<ul style="list-style-type: none"> • Implement infection control via staff education and influenza vaccination and protocols to identify and prevent the spread of influenza and infectious diseases • Identification and implementing of targeted surge bed capacity (for rehabilitation levels of care – e.g. activation and restoration, short-term and long-term complex medical) in collaboration with acute care to create flow and enable the transition of patients to home or alternate care setting • Escalation in the level of intake and admissions to support alleviating acute care pressures, including 7-day a week admissions and direct admissions from the community • Collaboration with “circle of care” health care providers to support appropriate access to and discharge from hospital for patients • Appropriate staffing during holidays and anticipated periods of peak volumes through seasonal surge • Proactive and transparent communication to the Erie St. Clair LHIN and health system partners on current status of hospital services, access, and discharge action plans in place to manage impacts of seasonal surge
Home & Community Care	<ul style="list-style-type: none"> • Increased staffing levels as required for holidays and weekends to support greater access to services provided by home and community care and/or navigation to community resources (including continuing to hold complex discharge rounds and ALC reviews) • Responsiveness to clients at risk of hospitalization through screening/assessment and increasing of nursing, personal support, and allied health services • Monitoring of clients to proactively identify changes in care needs • Collaboration with “circle of care” health care providers to support appropriate access to and discharge from hospital for patients • Proactive and transparent communication to health system partners on current status of services, access, and action plans in place to manage impacts of seasonal surge
Long-Term Care	<ul style="list-style-type: none"> • Implement infection control via staff education and influenza vaccination and protocols to identify and prevent the spread of influenza and infectious diseases in collaboration with regional Public Health Units • Identification and implementation of surge capacity as part of long-stay, Interim, and Convalescent Care programs • Collaboration with “circle of care” health care providers to support appropriate access to, and discharge from, hospital for patients • Proactive and transparent communication to the Erie St. Clair LHIN and health system partners on current status of the home, and action plans in place to manage outbreaks and support seasonal surge
Rest & Retirement Homes	<ul style="list-style-type: none"> • Implement infection control via staff education and influenza vaccination and protocols to identify and prevent the spread of influenza and infectious diseases in collaboration with regional Public Health Units. • Identification and implementation of surge capacity in conjunction with home and community care supports (e.g. Care Coordination, Nursing, Personal Support, and allied health care)

	<ul style="list-style-type: none"> • Collaboration with “circle of care” health care providers to support appropriate access to, and discharge from, hospital for patients
Primary Care (Group-based Family Practices, NP-Led Clinics, and CHCs)	<ul style="list-style-type: none"> • Adherence to infection control best practices (e.g. uses of personal protective equipment) • Access to primary care supports during the “12 Days of Christmas” (according to accountability agreements with MOTLC) including consideration of Advance Access clinics • Patient education and dispensing of influenza vaccination • Collaboration with “circle of care” health care providers to support appropriate access to, and discharge from, the hospital for patients • Proactive and transparent communication to the Erie St. Clair LHIN and health system partners on current status of services, and action plans in place to support seasonal surge
Community Support Services	<ul style="list-style-type: none"> • Implement infection control via staff education and influenza vaccination and protocols to identify and prevent the spread of influenza and infectious diseases (especially for services provided in congregate settings) • Provision of preventative services for targeted populations (e.g. frail and elderly) and in congregate settings (e.g. seniors buildings/residences) that focus on maintenance and recovery of physical and mental wellness, including exercise classes, meals on wheels, volunteer checks, etc. • Provision of respite and personal support services to high needs patients at risk of hospitalization or to support safe discharge to home • Screening to identify and refer clients at risk to hospitalization to appropriate service providers • Proactive and transparent communication to the Erie St. Clair LHIN and health system partners on current status of services, and action plans in place to support seasonal surge
Public Health Units	<ul style="list-style-type: none"> • System-wide influenza management and education that minimizes spread and impact • Distribution of publicly-funded influenza vaccine stocks • Conduct surveillance, analyze epidemiological data, and report about diseases of public health importance which would include influenza/respiratory illness • Tracking of influenza vaccine rates of residents and staff in LTC • Designation and cessation of outbreaks for Long-Term Care Homes and Rest & Retirement Homes and engagement of health system partners to manage the safe transition of residents back to their homes after a hospital stay where outbreak or influenza concerns are present
Other	<ul style="list-style-type: none"> • Pharmacy – access points for influenza vaccination and screening for poly-pharmacy issues in complex medical patients

Sector Specific Action Plans

Building off of the identified roles and responsibilities of health care providers across sectors, a comprehensive Erie St. Clair LHIN 2018/19 Regional Influenza Surge Action Plan (Appendix B) has

been developed and vetted with stakeholders. The focus of the action plan is to leverage the totality of system capacity in a coordinated fashion in preparation for the coming surge season featuring tactics specific to each sector.

Hospital Surge Capacity

Over the past two fiscal years (2017/18 and 2018/19), the MOHLTC has made commitments to provide funding to create additional hospital bed capacity in each LHIN with the expectation that the LHINs, hospitals, and the community sector are working together in a partnership that builds on these investments to support a continuum of care that moves patients to the appropriate service destination, as quickly as possible.

With its targeted investments, the MOHLTC is funding surge capacity to address capacity and flow hospital wide, specifically through acute medicine beds as well as acute mental health. Hospitals in the Erie St. Clair LHIN have experienced increased admission rates for mental health patients which coincides with time of year (e.g. holiday season and winter months).

Opportunities exist and consideration should be made if and when surge were to escalate to leverage greater capacity in post-acute care. In doing so, targeted resources to support increasing rehab, restorative geriatric, and complex medical and palliative care.

LHIN Home and Community Care should provide dedicated care coordination services to added hospital surge beds that are opened to ensure capacity and flow and to provide support to patients who might otherwise be designated ALC.

For 2018/19, the following are committed surge capacity resources within Erie St. Clair LHIN hospitals:

Funded Hospital Surge Capacity

Organization	# of Surge Beds 2018/19
Bluewater Health	12 (Acute) 5 (Acute MH)*
Chatham-Kent Health Alliance	5 (Acute)
Erie Shores Health Care	4 (Acute)
Windsor Regional Hospital	28 (Acute) 5 (Acute Mental Health)*

*Funding confirmation pending

Unconventional Hospital Surge Capacity

In preparation for surge, hospitals are required to identify unconventional surge capacity outside of funded beds as a contingency measure. The expectation is that, in the case of an escalation of extreme bed pressures (at Major Surge level), hospitals with operationalized space within clinical and non-clinical spaces where care can be safely delivered to patients. As such, plans should be developed in advance that

identify unconventional space, equipment and amenities required for conversion of space, and a staffing plan to operationalize.

Through daily monitoring and management of surge with the Erie St. Clair LHIN leadership and system partners, decisions to open unconventional space should be vetted with appropriate communication plans and messaging in place to address public and media questions and concerns.

The financial implication of operationalizing surge capacity by hospitals, if and when that should be required, would be assessed on an individual basis toward the end of the surge season. However, hospitals on an annual basis should consider a contingency budget that would offset the cost of a surge event requiring use of Unconventional Surge Capacity.

Community Surge Capacity

Hospitals are encouraged to work with Home and Community Care to review all potential discharge destinations with patients and families, including returning home with the services and supports required to make this transition from hospital to community.

The MOHLTC provided the ESC LHIN with funding to create capacity in hospitals by transitioning Alternate Level of Care (ALC) patients from hospital to community with the services and supports they require to meet their needs. The MOHLTC funded the following programs as a strategy to create capacity prior to surge: Mobile Assisted Living/Neighbourhoods of Care

Mobile Assisted Living supports patients to transition from hospital to community where their needs can be met to live independently in the community. The hub and spoke model allows for flexibility for care provision through both scheduled and unscheduled visits.

Mobile Assisted Living is intended to be a longer term option to support patients with care in intervals throughout a 24-hour period and whom require emergency response available from staff assigned to a neighbourhood of care. Intensive Hospital to Home.

The ESC LHIN provides the Intensive Hospital to Home (IHH) program to patients who have been hospitalized but have the potential to transition home with the appropriate level of care. ESC LHIN care coordinators assess patients in the hospital and provide the patient with a robust service plan to meet their needs in the community.

IHH is available to patients for up to 60 days, allowing them time to make decisions about their next level of care be it remaining at home with reduced service levels or transitioning to another living environment, including long-term care.

In 2018/19, IHH will be considered for supporting discharges to the community where patients are on a community wait list for post-acute in-patient rehabilitation care. Where appropriate, LHIN Home and Community Care will also look to discharge patients from hospital to the community and provide in-home rehabilitation as an alternative to post-acute inpatient care.

Public health and Outbreak Management

The local public health unit plays a key role in the prevention and management of outbreaks. Prompt reporting of an outbreak results in a rapid response in the initiation of infection prevention and control measures. This can help to decrease the length and severity of the outbreak.

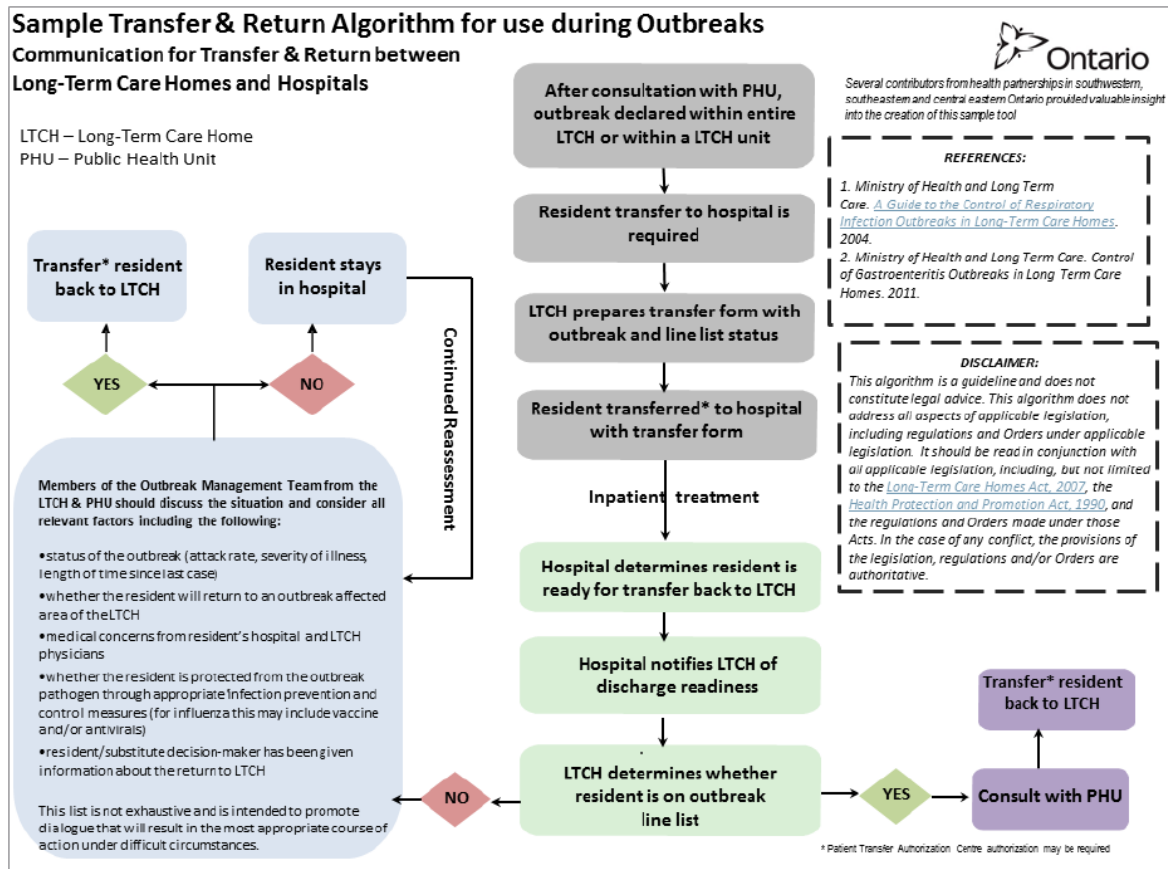
Health care facilities and institutions are legally required to report outbreaks. It is the obligation of each facility to contact the public health unit with any questions or concerns. Public Health provides surveillance, monitoring and declaration when the outbreak is over.

Public Health is an important contributor to the planning process during surge as they will determine the strategies required to address the outbreak and if patients can be discharged from hospital back to their home. ESC LHIN, Hospitals and Public Health will work together to address any issues with respect to patient discharges from hospital to a home that is experiencing outbreak and the parameters around this.

Regular communication between Public Health, Hospitals, Long-Term Care, Community Support Services, and Home and Community Care is essential during the flu season. Figure 2 provides an algorithm that should be considered for use by hospitals, long-term care and public health units for supporting the transfer of patients back to Long-Term Care as taken from A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Home, September 2016.

Figure 2: Sample Transfer & Return Algorithm for use during Outbreaks

Note: A resident in a Long-Term Care or Rest & Retirement home suspected or confirmed as having influenza does not necessarily require hospitalization. Each case should be reviewed independently and seek to include the PHU, hospital clinical staff, and where applicable, the Nurse Led Outreach Team for implementation appropriate protocols and pre-cautions in the context of the homes situation and current hospital pressures. Additionally, where there are concerns with discharge and placement of a resident back to their home, case conferencing with the above partners, and where necessary, LHIN Home and Community Care, should take place to solidify timely and appropriate actions.



The Ministry of Health and Long-Term Care published its most recent best practice guidelines for managing infection control in March of 2018, called 'Recommendations for the Control of Respiratory Infection Outbreaks in Long-Term Care Homes' (Appendix B). LTC administrators and their clinical leaders should review and implement recommendations where feasible as a part of their continued efforts to reduce the impact of influenza.

Sub-Region Accountability Tables

Late 2018/19 will see the launch of Sub-Region Accountability Tables (SRATs) across the Erie St. Clair LHIN geography as smaller geographic planning regions that will help better understand and address patient needs at the local level and bring about a higher level of integration of care across health and social service providers.

The following are the SRATs that will support local planning of health care:

- Windsor
- Tecumseh Lakeshore Amherstburg LaSalle & Essex South Shore
- Chatham City Centre & Rural Kent
- Lambton

As the SRATs are established, their mandate will include annual seasonal influenza surge preparedness planning with a broad focus on preventative and re-active mitigations to minimize the impact of influenza on access to care.

Activities to Support Patient Flow

The LHIN has recognized that there are several strategies that will contribute to patient flow and the creation of capacity during surge, if implemented in every hospital. Some of these strategies are identified as follows:

1. **Weekly Complex Discharge Rounds** – It is anticipated that hospitals and Home and Community Care will hold weekly complex discharge rounds to identify patients that have barriers to discharge and to proactively develop a service plan to support them to transition from hospital to community.
2. **Alternate Level of Care (ALC) Reviews** – Hospitals, Home and Community Care, and Supportive Housing providers will meet weekly/bi-weekly during surge to review all patients either designated ALC or at risk of being designated ALC, should they remain in hospital. All appropriate discharge options should be explored for each patient, including transitioning the patient from hospital to community to receive care and treatment.
3. **Use of Complex Discharge Screening Tool** – Hospitals should use a Complex Discharge Screening Tool to identify those patients who will have a barrier to discharge due to their needs and other factors. The early identification of barriers to discharge will allow discharge planning to begin earlier and progress during the course of the admission.
4. **Identification of “Ready for Discharge”** – Hospitals should review all “ready for discharge” patients at daily rounds/patient care huddles to ensure that the patient is discharged within the “Estimated Date of Discharge” that has informed care, treatment, and discharge planning. The review should also include a review of services available in the community to support the patient to transition from hospital to community, including the use of Intensive Hospital to Home (IHH) and other community support services.
5. **Daily Collaboration between Acute Care, Post-Acute Care, and Home and Community Care** – Daily discussions between acute and post-acute care should occur in order to maximize capacity and bed utilization in Complex Care, Rehabilitative Services and Palliative Care. Patients should be transitioned from acute care to post-acute care as soon as possible to ensure that there is capacity and flow in acute care. The goal should be to ensure that the patient is in the right bed, with the right services and supports at the right time.
6. **Review of Weekend Discharge Processes** – Hospitals should review weekend discharge processes to ensure that timely, safe, and appropriate discharges can occur seven days a week to create capacity and support flow.
7. **Repatriation Process** – Ongoing review of the repatriation process should occur so that patients can be repatriated to their home community as soon as possible to receive services. A well-defined process will ensure that patient flow is maintained and the patient has access to the appropriate level of care they require.

8. Emergency Department Avoidance Framework – Hospitals and Home and Community Care will work collaboratively to provide access to a full array of discharge options for patients from the emergency department, as a way to avoid an unnecessary admission or if the services are available and accessible in the community.
9. Standardized Discharge Time – Patient flow and capacity can be supported by enforcement of a discharge time from hospital (e.g. 11:00 a.m.) as this will facilitate planning, patient transport, completion of discharge orders, and provide the hospital with time to prepare the room/bed for the next admission. A standardized discharge time will allow for some predictability and planning to occur in support of flow.
10. Time to Inpatient Bed – To create capacity and flow in the emergency department it will be essential to monitor the time that it takes for admissions to leave the department and transition to an inpatient bed. Without a strategy to monitor the time to inpatient bed, there is a potential for a bottleneck to occur in the Emergency Department, limiting the ability to see patients, stopping the “flow” through the department. Throughput is essential in supporting surge and increased capacity demands.
11. Ambulance Off-Load Times – During surge it is key to have processes in place that allow for the timely off-load of patients who arrive in the Emergency Department via ambulance. This will allow ambulances to be available to the community for those requiring transport to hospital for emergency and/or acute care. Having an off-load strategy that supports patient flow and transitions in care will assist with effectively managing surge.

Patient Transport

Patient transport is a key partner in the smooth transition of discharged patients from hospital to community. During periods of high demand, capacity challenges, or surge, hospitals should be working collaboratively and communicating with patient transport providers to efficiently transport patients to their discharge destination without causing undue delays in the hospital system. The efficient movement of patients between hospital and community will in and of itself create capacity as beds will become available much earlier in the day.

Communications, Monitoring and Reporting

Communications Strategy

Proactive Communications

Engagement with health system partners through the seasonal surge planning reinforced that a proactive communications plan should aim to:

Public

- Increase access to and up-take of influenza vaccination across general public and targeted populations (e.g. seniors and those with complex medical conditions)
- Improved knowledge of access points for primary care during holidays and seasonal surge periods that reduce demands on hospital services
- Increase knowledge of status and impact of influenza on the health care system

Health Care Provider

- Improve knowledge of the importance of appropriate access to services during holidays to increase operating hours and minimize service closures
- Improve communication and coordination between service providers to support care coordination and flow of patients across the continuum of care

Improved Access to Primary Care

The public should consider ‘urgent’ access or professional consultation on the status of their health through the following resources prior to seeking care at an emergency department:

- Consulting your primary care provider
- Calling Telehealth Ontario: 1-866-797-0000
- Going to a local walk-in clinic
- Visiting your local pharmacy
- Exploring self-care at home

The Erie St. Clair LHIN collaborates with primary care providers to encourage increased ‘urgent’ access during seasonal surge periods, with specific focus on the “12 Days of Christmas.” Advanced Access primary care clinic models for primary care, with scheduled walk-in-based clinic hours established, is one strategy that can be used generally, and/or within seasonal influenza surge periods to address access for patients who may be at risk for experiencing complications as result of influenza.

All health care providers should be encouraged to have a preventive focus and early identification of patients most at risk for complications associated with influenza, including:

- Babies under 6 months old as they are not appropriate for receiving influenza vaccination
- Children under 5 years of age due to their developing immune systems and small airways that are more easily blocked
- People 65+ years old and the frail elderly with weakened immune systems and underlying conditions
- Pregnant women
- People with underlying health conditions, such as asthma, heart disease, or diabetes

Annually, the Erie St. Clair LHIN seeks information from primary care providers regarding their holiday clinic hours. Where information is made available, holiday hours for primary care providers are posted and made available for the public to access on www.eriestclairhealthline.ca.

Reactive Communications

Communication departments in hospitals and the LHIN will work collaboratively to develop responses to media enquiries that reinforce key messages for the appropriate level of surge that is being experienced. Key messages will be reinforced with information about the steps that have been taken to plan for surge, the additional bedded capacity added to the system and the strategies developed by stakeholders to be responsive to the increase in demand for their services, and provide for transparency in acknowledging system demands, trends for influenza rates, and the alignment of system demands relative to surge criteria.

Surge Calls to Support Communication Between Stakeholders

The ESC LHIN will be the lead organization in arranging and hosting surge calls as a way to foster and support communication across the region. The frequency of the calls will be determined by the surge level (mild, moderate, major) as will the participants required to be on the daily or weekly call. Each hospital will delegate the individuals they would like to represent their facility as the “surge contact” person(s) and they or their delegate will attend the surge teleconferences. Surge calls may be LHIN-wide or specific to a sub-region, depending on the nature and location of the surge.

It is anticipated that at “mild surge” the hospitals will activate their own internal and hospital-specific surge plan with a Surge Teleconference being held weekly, as a way to share information, current state, and any trending data that is available.

If the surge level meets the criteria for “moderate surge” the surge teleconferences will be held daily and the individuals required to attend the call to support decision-making and planning will be clearly defined. This will allow for a systemic response to surge with key decision-makers reviewing the efficient and effective mobilization and use of resources across the region. See table below.

A “major surge” will require involvement of the executive leadership from key stakeholders across multiple sectors to be involved. Surge teleconferences will be daily and, if needed, more than once a day during the surge period to effectively manage resources and respond to the demands placed on the system by the surge. This “all hands on deck” approach will support a systemic response and facilitate effective management of the increased demand for capacity. See table below.

System-wide Surge Teleconferences

	MILD	MODERATE	MAJOR
Frequency of Surge Calls – LHIN and Health Sector	Daily	Twice Daily (morning/afternoon)	Daily and as required
Required Attendance on Surge Teleconferences	<ul style="list-style-type: none">• Sub-region Surge Leads• Public Health Unit	<ul style="list-style-type: none">• Hospital Director/ VP/Manager (ED, Acute Care, Post-Acute Care)• LHIN Sub-region Directors• LHIN ED/ALC Lead	<ul style="list-style-type: none">• Hospital CEOs• LHIN CEO• LHIN VP, Home and Community Care and Performance, Accountability & Finance

		<ul style="list-style-type: none"> • LHIN Primary Care and ED Leads • Public Health (Manager of Infectious Disease Prevention) 	<ul style="list-style-type: none"> • LHIN Primary Care and ED Leads • LHIN ED/ALC Lead • LHIN Sub-region Directors • EMS Chief • Public Health, Medical Officers of Health • LTC Administrators • Executive Directors – Community Support Service Providers Organizations
Teleconference Number	1-888-289-4573 Access Code: 8367828		
LHIN Surge Contacts	Ron Sheppard 1-888-310-8881 Ext. 5342 or Cell Phone: 519-358-9572 David Simpson 1-888-310-8881 Ext. 7324 or Cell Phone: (519) 562-7271		

Home and Community Care Service Provider Organization Surge Calls

	MILD	MODERATE	MAJOR
Frequency of Surge Calls – LHIN and Health Sector	Daily	Daily	Daily and as required
Required Attendance on Surge Teleconferences	SPOs <ul style="list-style-type: none"> • Nursing • PSW • Therapy • Equipment • Pharmacy 	SPOs <ul style="list-style-type: none"> • Nursing • PSW • Therapy • Equipment • Pharmacy 	SPOs <ul style="list-style-type: none"> • Nursing • PSW • Therapy • Equipment • Pharmacy
Teleconference Number	1-888-289-4573 Access Code: 8367828	1-888-289-4573 Access Code: 8367828	1-888-289-4573 Access Code: 8367828
LHIN Surge Contacts	Gwendolyn Vanderheyden 310-8881 Ext. 6248 Cell Phone: 226-345-8548 Hollie Rice-Mitchell (Alternate) 1-888-310-8881 Ext. 3325		

	David Simpson 1-888-310-8881 Ext. 7324 Cell Phone: (519) 562-7271
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Monitoring Systems and Tools

During surge it is anticipated that the LHIN, hospitals, and the community sector will be monitoring influenza on a daily basis using a number of tools available to them, including some listed below:

- **Oculys** will assist the health care sector, specifically hospitals, in monitoring a number of data points at both the hospital and system level. Hospitals are encouraged to monitor Oculys throughout the day and to use this information to inform decision-making. The ESC LHIN will be using Oculys to track data points such as ALC rate, occupancy levels, admits to bed, length of stay in emergency departments, and other relevant information that address capacity and flow issues.
- **EMS Situational Awareness Dashboard** is a tool that provides real-time data on the status of deployment of EMS resources in Essex County. The dashboard is and will continue to be used primarily by Essex-Windsor EMS and hospitals to manage day-to-day EMS utilization with the goal of minimizing EMS offload delays and avoiding Code 7s and associated escalations. The Erie St. Clair LHIN will use the dashboard as a monitoring tool and leverage it where escalations are required involving significant offload delays with identified patient/public risk.
- **Public Health Website for Outbreak Information and Flu resources:**
 - Chatham-Kent Public Health Unit: <http://ckphu.com/>
 - Lambton Public Health: <https://lambtonhealth.on.ca/>
 - Windsor-Essex County Health Unit: <https://www.wechu.org/your-environment/outbreaks>
- **ILI Mapper** which provides a map of Ontario where LHIN specific or hospital specific data can be review for trends in influenza-like illness. Click on the “LHIN View” to see the trend for ESC LHIN. Visit the website: <http://mapper.kflaphi.ca/ilimapper/>
- **ESC LHIN Website** will provide information on flu resources and holiday hours for family health teams, community health centres, primary care, and other health sector providers. Visit www.eriestclairlhlin.on.ca
- Alternate Level of Care (ALC) data is available from Access to Care and should be monitored regularly by hospitals to ensure discharge planning discussions continue to occur with all ALC patients throughout their stay in hospital. Access to Care provides ALC rates for both acute care and post-acute care.
- Hospitals can, if granted access, use the Daily Hospital Utilization Tool to gain access to information about occupancy, bed availability, and patient flow. The tool is refreshed daily at 3:30 p.m. for all hospitals in Ontario.

Ministry of Health and Long-term Care Emergency Management Communications Tool (EMCT)

EMCT is a web-based system available online that acts as a communication hub, allowing organizations responsible for responding to emergencies within the health care sector to better coordinate an emergency response. Organizations are using EMCT for influenza reporting.

Per Ministry of Health and Long-Term Care directives, the Erie St. Clair LHIN and health service providers are required to use the EMCT system in seasonal surge situation. It is therefore the responsibility of all providers to ensure that they have active users and accounts and assigned staff to enter tickets when necessary.

EMCT will be used if and when seasonal surge reaches levels at or above ‘moderate’ surge, or where a surge in hospital pressures necessitates cancellation of elective surgeries, transfers of critical care patients to alternate facilities, EMS offload delays resulting in ‘Code Black’ situations (e.g. no available EMS for 911 calls), or other related sentinel events.

It is the responsibility of the organization experiencing the impacts of surge to enter EMCT tickets, unless otherwise coordinated with the ESC LHIN and its system partners.

For more information, please visit the website <https://emct.disasterlan.ca/> or contact the EMCT Support Line at 1-844-668-2628 or EMCT@LHINs.on.ca. Additional training on use of the EMCT system can be coordinated via Shannon Sasseville, Director of Communications, Public Affairs, and Community Engagement, at 1-866-231-5446, x3225 or Shannon.sasseville@lhins.on.ca.

Annual Review and Evaluation

An annual review and evaluation process will need to be conducted by the ESC LHIN in collaboration with system partners with the aims of:

1. Assessing impact of seasonal influenza pressures on the Erie St. Clair health system
2. Determining effectiveness of strategies implemented to support mitigating the impacts of seasonal influenza pressures
3. To determine appropriate revisions to the Regional Influenza Surge Strategy and associated action plans for the coming year.

The evaluation should include the following parameters:

- Involvement of system partners in the assessment and evaluation of the ESC LHIN surge plan.
- Review of data sources to assess impact of surge on the system, the effectiveness of capacity operationalized to deal with demand, and identify innovations that created capacity and flow
- Validation and/or recommended changes to Triggers and Thresholds based on correlating data and updating of the Oculys Regional Dashboard accordingly

- Identification future surge capacity and various reactive and proactive mitigations targeted all health sectors: hospital, home care, primary care, community, and public health

The Erie St. Clair LHIN Regional Influenza Surge Strategy will continue to be an iterative document and strategy, refreshed annually and circulated/posted publicly for all stakeholders to access. More importantly, the work of responding to surge will continue to be collaborative with a high degree of communication and coordination between the Erie St. Clair LHIN and its partners to ensure that access to health care is maintained to the best of our collective efforts.

Appendix A

Erie St. Clair LHIN 2018/19 Regional Influenza Surge Action Plan

Hospital Sector

Goal	Aim	Timeline
Implement surge capacity in hospitals to support increased demand	<ul style="list-style-type: none"> • Assess and provide inventory of overflow and surge beds numbers and locations within hospitals to LHIN and MOHLTC • Appropriately staff and operationalize MOHLTC/LHIN funded surge beds as well as hospital budgeted capacity • Review and implement appropriate staffing during “12 Days of Christmas,” anticipating increased ED and inpatient volumes – including Hospitalist, Utilization and Patient Flow Managers, and outpatient services that will decrease likelihood of readmission rates (December 21 – January 2) • Communicate outpatient hours/closures over the holidays, operating room slowdown hours, and other information that impacts patient access to hospital services (provide to LHIN for posting on Healthline.ca) • Expand role and schedule NLOT as needed to assist and support residents in long-term care to receive care in home during “12 days of Christmas” and surge generally 	<ul style="list-style-type: none"> • September/October • December-March • September/October • November/December • September/October

Establish and launch daily surge status and communication protocols to improve coordination among partners	<ul style="list-style-type: none"> • Designate a primary contact person to liaise with ESC LHIN Surge Leads • Participate in daily surge teleconferences for 2018/19 for December (including PHU) • Designate MRP staff for completion of EMCT for reporting of adverse events, cancellation of elective surgeries, ambulance code blacks, etc. <p><i>(Note: usernames and passwords to be obtained for the EMCT system to enable reporting)</i></p> <ul style="list-style-type: none"> • Provide notification to ESC LHIN when EMCT “tickets” are submitted 	<ul style="list-style-type: none"> • September 30 • December 17 – April 30 • Ongoing • Ongoing
Improve influenza vaccination rates and infection control throughout seasonal surge	<ul style="list-style-type: none"> • Disseminate information and conduct education sessions for staff regarding the benefits of flu shots • Host mobile flu clinics for staff • Offer flu shots to at risk/complex in-patients 	<ul style="list-style-type: none"> • November-December • October-December • Ongoing
Improve access and coordination with Primary Care to divert patients from hospitals during seasonal surge	<ul style="list-style-type: none"> • Coordinate primary care appointments/consults post-discharge from acute/post-acute care • Provide communications to patients regarding access to urgent care and full range of options for care (walk in, follow up visits after ED visit/acute stay) reinforcing the use of Healthline.ca 	<ul style="list-style-type: none"> • Ongoing • November-April
Continue with implementation/execution of proactive discharge planning	<ul style="list-style-type: none"> • Continue discharge planning activities as usual during “12 Days of Christmas” • Hospitals to solidify/renew partnership with PHUs for ongoing 	<ul style="list-style-type: none"> • December/January • October/November

	<p>Infection control support, discharge planning support for patients to LTC/R&R</p> <ul style="list-style-type: none"> • Holding of Complex Discharge Rounds and ALC Reviews (include additional partners - LTC/PHUs/CSS) • HSP discharge coordination calls during outbreaks • (Inclusion of NLOT for residents of LTC homes) • Posting of 'Estimated Date of Discharge' on white boards in patients rooms and discussed with patients/families during care rounds • Collaborate with non-emergent transport providers on availability of vehicles to transport patients on discharge, without delay - provide information to transport services on the anticipated number of discharges per day over the holiday period) 	<ul style="list-style-type: none"> • Ongoing • Ongoing • Ongoing • December-April
Reduce/manage Ambulance Offload pressures	<ul style="list-style-type: none"> • Implement an Ambulance Offload Policy/Guideline 	<ul style="list-style-type: none"> • December

Primary Care

Goal	Aim	Timeline
Improve influenza vaccination rates and infection control throughout seasonal surge	<ul style="list-style-type: none"> • Educate patients and staff regarding the benefits of the flu shots • Provide vaccination to staff • Offer and encourage flu shots to all patients, with emphasis on at risk/complex in-patients 	<ul style="list-style-type: none"> • Ongoing • Ongoing • Ongoing
Improve access and coordination with Primary Care to divert patients from hospitals during seasonal surge	<ul style="list-style-type: none"> • Consider "Advance Access" same day appointments and/or walk-ins during surge season and extension of hours to support patients to receive care proactively with their family practitioner 	<ul style="list-style-type: none"> • December 21 – January 2 • Ongoing

	<ul style="list-style-type: none"> • Provide access to patients for appointments/consults post-discharge from acute/post-acute care (within 7-10 days) • Provide hours of operation to the Erie St. Clair LHIN for communicating on Healthline.ca 	<ul style="list-style-type: none"> • November
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Long-Term Care/Rest and Retirement Homes

Goal	Aim	Timeline
Improve influenza vaccination rates and infection control throughout seasonal surge	<ul style="list-style-type: none"> • Collaborate with PHUs to identify opportunities for infection control improvements and improved vaccination rates • Conduct education sessions for staff and residents regarding the benefits of the flu shots • Host mobile flu clinics and offer influenza vaccinations for all staff and residents 	<ul style="list-style-type: none"> • October-December • October-December • October-December
Continue with implementation/execution of proactive discharge planning	<ul style="list-style-type: none"> • Collaborate with hospitals and PHUs to support repatriation of residents back to their homes, including addressing infection control support needs that would allow for a safe return • Participation in Hospital Complex Discharge Rounds and ALC Reviews where necessary (supporting residents) • Participation in coordination calls during outbreaks • Support admissions with appropriate staffing throughout the “12 Days of Christmas” 	<ul style="list-style-type: none"> • Ongoing • Ongoing • Ongoing • December 21 – January 2
Improve access and coordination with Primary Care to divert patients from hospitals during seasonal surge	<ul style="list-style-type: none"> • Facilitate appropriate access to Medical Director for timely physician consultations throughout the “12 Days of Christmas” and generally through seasonal surge 	<ul style="list-style-type: none"> • December – April • Ongoing

	<ul style="list-style-type: none"> • Where applicable, consult with NLOT team proactively to avoid unnecessary ED visits 	
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Erie St. Clair LHIN

Goal	Aim	Timeline
Confirm and Launch ‘Seasonal Influenza Surge Strategy’ with support from partners	<ul style="list-style-type: none"> • Finalize and submit plan to ESC LHIN Executive Team for approval • Provide Open Board Meeting presentation of plan with request for official Board endorsement • Distribute final approved plan to stakeholders and post plan to ESC LHIN web site • Issue formal ESC LHIN CEO letter to HSPs on priorities for surge management (e.g. development of internal surge plans, capacity for “12 days of Christmas,” and promoting the influenza vaccination and related strategies) • Hold education sessions/webinars on Seasonal Surge Plan 	<ul style="list-style-type: none"> • November 2018 • November/December 2018 • November • November • November/December
Implement surge capacity in hospitals to support increased demand	<ul style="list-style-type: none"> • Proactively fund surge beds for all hospitals to allow for proactive staffing and operationalizing of surge capacity and reduce over-time costs (via UPF) • Implement new expanded hours of service and weekend hospital care coordination staffing model • Post outpatient hours/closures over the holidays, operating room slowdown hours and other information that impacts patient access to hospital services on Healthline.ca • Maximize use of Convalescent Care and Respite bed capacity via identification of appropriate clients through HCC Care Coordinators 	<ul style="list-style-type: none"> • October • September • November • December-April

Establish and launch daily surge status and communication protocols to improve coordination among partners	<ul style="list-style-type: none"> • Initiate daily surge teleconferences for 2018/19 for December (including PHU) • Initiate weekly surge teleconferences for 2018/19 with SPOs, equipment, and pharmacy providers, as required. • Provide refresh training to HSPs on use of EMCT system and its purpose • ESC LHIN to establish and implement a protocol and process for providing ongoing email updates and alerts on Sub-region surge status throughout seasonal surge period 	<ul style="list-style-type: none"> • December 17 • December 17 • November • October/November
Improve influenza vaccination rates and infection control throughout seasonal surge	<ul style="list-style-type: none"> • Collaborate with PHUs and hospitals to develop a comprehensive strategy to support improved vaccination rates (targeted at health care workforce and general public) and better tracking of immunization rates • Consider engagement of labour unions to educate on benefits of vaccination • Conduct education sessions for patients and staff regarding the benefits of the flu shots • Host mobile flu clinics for frontline staff and encourage SPO agencies to duplicate a strategy for their staff • Collaborate with PHUs to identify and support LTC homes with infection control improvements 	<ul style="list-style-type: none"> • September/October • October • November-December • November-December • November-December
Improve access and coordination with Primary Care to divert patients from hospitals during seasonal surge	<ul style="list-style-type: none"> • Implement new imbedded Clinical Care Coordinator model in targeted Primary Care clinics • Engage primary care to assess access during surge season, and “Advanced Access” practices generally (FHTs, CHCs, and FHOs) and encourage extension of hours and walk-in based appointments 	<ul style="list-style-type: none"> • October • October/November • November-January

	<ul style="list-style-type: none"> • Provide Public education/communication regarding access to urgent care and full range of options for care (walk in, follow up visits after ED visit/acute stay) • Coordinate primary care appointments/consults post-discharge from acute/post-acute care • Conduct engagement/communications with Urgent Care/Walk-in Clinics to create opportunities for communication/coordination with patient's Primary Care provider to reinforce Medical Home • Continue to leverage and update Healthline.ca with hours of access for Primary Care and drive consumers and health practitioners to the resource to maximize awareness 	<ul style="list-style-type: none"> • Ongoing • TBD • November
Implement Surge Monitoring and Performance Management Processes	<ul style="list-style-type: none"> • Hold joint meeting with Hospitals/Oculys/LHIN to confirm realigned triggers and thresholds and update Seasonal Surge Plan and Oculys Surge Dashboard scoping accordingly • Launch Oculys Surge Dashboard and Reporting Module • Complete Oculys Regional Viewer Updates • Make Oculys accessible to providers • Incorporate outbreak status of LTC within Oculys Surge Dashboard • Engage with PHUs to review current systems and reporting and opportunity to leverage Oculys as a platform for reporting of outbreaks to health care stakeholders 	<ul style="list-style-type: none"> • September • November-January • November • November/December • TBD • September/October
Continue with implementation/execution	<ul style="list-style-type: none"> • Implementation and ongoing use of Complex Discharge Screening Tools for early identification of complex 	<ul style="list-style-type: none"> • Ongoing

of proactive discharge planning	<p>discharges and referrals to ESC LHIN Home and Community Care</p> <ul style="list-style-type: none"> • Coordinate/Participation in Complex Discharge Rounds and ALC Reviews (include additional partners - LTC/PHUs/CSS) • Coordinate/participate in HSP discharge coordination calls during outbreaks (Inclusion of NLOT for residents of LTC homes) • Provide discharge planning Care Coordination activities as usual during “12 Days of Christmas” 	<ul style="list-style-type: none"> • Ongoing • Ongoing • December 21 – January 2
Reduce/manage Ambulance Offload pressures	<ul style="list-style-type: none"> • Support the development and implementation of a region-wide Ambulance Offload Policy 	<ul style="list-style-type: none"> • December
Enhance community support service capacity to provide preventative care and assist with flow and diversion from hospitals	<ul style="list-style-type: none"> • Support the implementation of Mobile Assisted Living capacity for transitional care during surge • Leverage Dementia Strategy to increase community capacity - specifically within respite and Adult Day Programs • Consider opportunities for funding for placement within Rest and Retirement Homes 	<ul style="list-style-type: none"> • November/December • TBD • TBD

Appendix B

**Recommendations for the Control of Respiratory Infection Outbreaks in Long-Term
Care Homes, March 2018**

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Recommendations for the Control of Respiratory Infection Outbreaks in Long-Term Care Homes

Ministry of Health and Long-Term Care

March 2018

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Preamble

This revised document replaces the 2004 *Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes* (the Guide). Due to the extent of the revisions made between the 2004 and current versions of the document, individual changes will not be highlighted within the text.

Changes in the 2014 version of the *Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes* include:

- Notification Procedures for Staff Illness (section 2.1.1)
- Outbreak Case Definitions (section 2.2.4)
- Control Measures for Visitors (section 4.4)
- Use of Influenza Antivirals (section 4.6)
- Influenza Prevention and Surveillance Protocol for Long-Term Care Homes ([Appendix 9](#))

Please note that this list does not encompass all sections of the document which have undergone edits; however, these sections have experienced the most significant alterations. Any policies, procedures, or supporting documents which are based on the 2004 Guide should be updated accordingly.

Changes in the March 2018 version of *Recommendations for the Control of Respiratory Infection Outbreaks in Long-Term Care Homes* are limited to the title change and reference to the Standards.

Definition of ‘Staff’ for non-Long-Term Care Home Facilities

The definition of staff used in this document is taken from the Long-Term Care Homes Act, 2007, and this legislation applies only to long-term care homes.

For facilities other than long-term care homes, it is recommended that facilities other than long-term care homes (e.g. retirement homes) adopt a broader definition of staff to increase prevention and protection opportunities. The recommended definition for staff is taken from PIDAC’s [Routine Practices and Additional Precautions in All Health Care Settings](#), November 2012. They define ‘staff’ as follows:

“[All] persons, except volunteers, who carry on activities in the [facility], including but not limited to employees (permanent, temporary), students, attending physicians and both health care and non-health care contract workers and any other staff, including persons with admitting/clinic privileges (MD, Mid-wives, staff of Hearing Aid Centres); maintenance workers (e.g. janitorial, repair, etc.) or other workers who carry on activities in resident care areas or come into contact with residents (e.g. hairdressers, chiropodists) should follow the same direction as that intended for ‘staff’, as defined above.”

This inclusive use of ‘staff’ also aligns with the definition used by the Ontario Hospital Association for its Communicable Diseases Surveillance Protocols (accessible here: <https://www.oha.com/labour-relations-and-human-resources/health-and-safety/communicable-diseases-surveillance-protocols>), which enforces its protocols on the following parties:

“[All] persons carrying on activities in the hospital, including but not limited to employees, physicians, nurses, contract workers, students, post-graduate medical trainees, researchers and volunteers.”

Disclaimer

This document is a guideline and does not constitute legal advice. This document 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 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.

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Thunder Bay District Health Unit

Toronto Public Health

The assistance of the following organizations in the development of the original 2004 Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes is also gratefully acknowledged:

Belmont House Retirement and LTC Facility

Chester Village Home for the Aged

Durham Health Unit

Kawartha Pine Ridge Public Health Unit

Kingston, Frontenac, Lennox and Addington Public Health Unit

Kingston General Hospital

Mt. Sinai Hospital

Ontario Association of Non-Profit Homes and Services for Seniors

Ottawa Public Health

Perth District Health Unit

Simcoe Health Unit

Sunnybrook and Women's College Hospital

Acronyms

ABHR	Alcohol-Based Hand Rub
ARI	Acute Respiratory Infection
DONPC	Director of Nursing and Personal Care
ES	Environmental Services
HCRF	Healthcare and Residential Facilities Regulation
HCW	Health Care Worker
HH	Hand Hygiene
HPPA	Health Protection and Promotion Act, 1990
ICP	Infection Prevention and Control Professional
IPAC	Infection Prevention and Control
iPHIS	Integrated Public Health Information System
LTCH	Long-Term Care Home
LTCHA	Long-Term Care Homes Act, 2007
MOHLTC	Ministry of Health and Long-Term Care
NACI	National Advisory Committee on Immunization
OHS Act	Occupational Health and Safety Act, 1990
OMT	Outbreak Management Team
O. Reg. 79/10	Ontario Regulation 79/10 (under the LTCHA)
PIDAC	Provincial Infectious Diseases Advisory Committee
PHAC	Public Health Agency of Canada
PHU	Public Health Unit
PHO	Public Health Ontario
PHOL	Public Health Ontario Laboratory
PPE	Personal Protective Equipment
PTAC	Provincial Transfer Authorization Centre
SDM	Substitute Decision-Maker
TIV	Trivalent Inactivated Influenza Vaccine

Glossary

Antiviral Medication - Antiviral medication is medication that is used for preventing or treating viral infection. Two antiviral influenza medications, oseltamivir, zanamivir (both neuraminidase inhibitors) are licensed for use in Canada, for the treatment and prophylaxis of influenza A and B, in adults. Oseltamivir (Tamiflu™) is the recommended antiviral of choice for both treatment and prophylaxis of influenza A & B. Amantadine is in another class of antivirals, known as adamantanes, used for influenza A infections only. Because of the high levels of resistance among circulating influenza A viruses, amantadine is not recommended for antiviral treatment or chemoprophylaxis of currently circulating influenza A virus strains

Acute Respiratory Infection (ARI) - Any new onset acute respiratory infection that could potentially be spread by the droplet route (either upper or lower respiratory tract), which presents with symptoms of a fever greater than 38°C and a new or worsening cough or shortness of breath (also known as febrile respiratory illness, or FRI). It should be noted that elderly people and people who are immunocompromised may not have a febrile response to a respiratory infection.

Case - A person with the particular illness or disease, usually fitting the case definition.

Case definition - A set of criteria for determining who should be classified as a case. The definition is comprised of clinical information and should include epidemiological information related to time, place, and person.

Competent Person - A person who:

- a) is qualified because of knowledge, training and experience to organize the work and its performance,
- b) is familiar with [the Occupational Health and Safety Act] and [any] regulations that apply to the work, and
- c) has knowledge of any potential or actual danger to health or safety in the workplace;

Control Measure - Any action or activity that can be used to prevent, eliminate or reduce a hazard.

Droplet Precautions - Droplet Precautions are used in addition to Routine Practices for residents known or suspected of having an infection that can be transmitted by large infectious droplets.

Hand Hygiene (HH) - A general term referring to any action of hand cleaning. HH relates to the removal of visible soil and removal or killing of transient microorganisms from the hands. HH may be accomplished using soap and running water or an alcohol-based hand rub. HH also includes surgical hand antisepsis.

Health Care Setting - Any location where health care is provided, including settings where emergency care is provided, hospitals, LTCHs, outpatient clinics, community health centres and clinics, physician offices, dental offices, and home health care.

Incubation Period - The time interval between initial contact with an infectious agent and the first appearance of symptoms associated with the infection. For influenza, the incubation period is 1-3 days.

Infected/Infectious Individual - A person who harbours an infectious agent and who has either become symptomatic or is asymptomatic. An infectious person is one from whom the infectious agent can be acquired.

Infection Prevention and Control Professional (ICP) - A health professional designated to be responsible for infection control programs in the LTCH, in accordance with LTCHA, 2007, S.O. 2007, c. 8 and O. Reg. 79/10. The ICP should possess expertise and additional training in infection prevention and control.

Influenza - A viral infection of the respiratory system. Symptoms of influenza include fever, cough, sore throat, muscle ache, extreme fatigue, and headache. Unlike the common cold and most other respiratory viruses commonly called “the flu”, influenza virus infection can result in severe illness, pneumonia and even death. The incubation period of influenza is 1-3 days; duration of infectivity is usually not more than 5 days after onset of symptoms. Influenza can cause epidemics, or outbreaks, which are a cluster of cases occurring within a short period of time in a defined geographic area (e.g., schools or health care institutions) or group of people.

Influenza Vaccine – There are two types of Influenza vaccines authorized for use in Canada. The first type of influenza vaccine is prepared from killed and denatured influenza virus. It stimulates the formation of immunity (e.g. antibodies) against the strains of influenza virus likely to be circulating that season. The second type, FluMist (a product of AstraZeneca Canada), is a live attenuated, influenza vaccine (LAIV) that contains live, but weakened, influenza virus that is sprayed into the nostrils (i.e., intranasal spray). The live attenuated influenza vaccine is not publicly funded in Ontario.

Influenza Vaccine in Pregnancy - During seasonal influenza epidemics, healthy pregnant women with influenza, especially those in the third trimester of pregnancy, experienced rates of hospitalization in excess of those observed in age-matched non-pregnant women with influenza. Moreover, the rates of hospitalization were comparable to those observed in individuals with other recognized co-morbid conditions that increase the risk of influenza-related complications. As a result of such data, pregnancy is now recognized to be a risk factor that warrants annual influenza immunization.

Line Listing - A table that summarizes information about possible, probable or confirmed cases associated with an outbreak. It often includes identifying information, demographics, clinical information and exposure or risk-factor information.

Long-Term Care Home (LTCH) - The term “long-term care home” has the same meaning as under the LTCHA. Subsection 2(1) of the LTCHA defines long-term care home as follows:

“long-term care home” is a place that is licensed under the *Long-Term Care Homes Act, 2007*, Chapter 8, and includes a municipal home, joint home or First Nations home approved under Part VIII of the Act.

Medical Contraindication to Influenza Immunization - Egg allergy is no longer considered a contraindication for receipt of the trivalent influenza vaccine (TIV). After careful review, the National Advisory Committee on Immunization (NACI) concludes that egg-allergic individuals may be vaccinated against influenza using TIV, without a prior influenza vaccine skin test, based on an assessment of risk for a severe allergic reaction to guide the method of vaccination ([NACI, Statement on Seasonal Influenza Vaccine](#)).

Influenza vaccine should not be given to people who have had an anaphylactic reaction to a previous dose or any of the vaccine components (<http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/13vol39/acs-dcc-4/index-eng.php>).

Private pay caregiver - A person who is hired directly or indirectly by a resident, or a person acting on behalf of a resident as the case may be, to provide care or companionship to the resident.

Recommended Recipients - People at high risk for influenza-related complications. High risk groups are defined by the NACI ([NACI, Statement on Seasonal Influenza Vaccine](#)).

Resident - The term “resident” has the same meaning as under the LTCHA. Subsection 2(1) of the LTCHA defines resident as follows:

“resident” means an individual who is admitted to and living in a LTCH

Respiratory etiquette – Practices that should be observed when coughing or sneezing:

Turning head away from others; Covering the nose and mouth with tissue; or sneeze into your sleeve; Discarding tissues immediately after use into waste; and performing hand hygiene (HH) immediately after disposal of tissues.

Routine Practices - The system of infection prevention and control (IPAC) practices recommended by the Public Health Agency of Canada (PHAC) to be used with all residents during all care to prevent and control transmission of microorganisms in health care settings

(http://www.publichealthontario.ca/en/BrowseByTopic/InfectiousDiseases/PIDAC/Pages/PIDAC_Documents.aspx).

Sentinel events - Sentinel Event: A colonization/infection in which the occurrence of perhaps even a single case may signal the need to re-examine preventive practices (http://www.publichealthontario.ca/en/BrowseByTopic/InfectiousDiseases/PIDAC/Pages/PIDAC_Documents.aspx).

Staff – The term “staff” has the same meaning as under the *Long-Term Care Homes Act, 2007*

(LTCHA). Subsection 2(1) of the LTCHA defines staff as follows:

“staff”, in relation to a long-term care home, means persons who work at the home,

- a) as employees of the licensee,
- b) pursuant to a contract or agreement with the licensee, or
- c) pursuant to a contract or agreement between the licensee and an employment agency or other third party”

Surveillance of Disease - The continuous scrutiny of all aspects of occurrence and spread of a disease that are pertinent to effective control. Included are the systematic collection and evaluation of: data on individual cases; laboratory test results; information about immunity or vaccination status; use of medications; other relevant data.

Transmission of Influenza - Influenza is spread from person to person by inhalation of tiny droplets produced by the cough or sneeze of a person infected with influenza. It can also be spread by contact with infected respiratory secretions through articles such as bedrails, facial tissue, or (unwashed) utensils.

Visitor - Person who attends at a LTCH but who is not staff or a volunteer.

Volunteer - A person who is part of the organized volunteer program of the LTCH, but does not receive a wage or salary for the services or work provided for that program.

1 Introduction

Respiratory infection outbreaks occur in long-term care homes (LTCHs) throughout the year but are more common from the fall to early spring. These can lead to substantial morbidity and mortality and are disruptive and costly for LTCHs. Respiratory tract infections are commonly diagnosed infections in LTCH residents. In Ontario, based on data from the Public Health Ontario Laboratory (PHOL), the most common respiratory viruses causing respiratory infection outbreaks are influenza A and B, entero-rhinovirus, coronavirus, RSV, parainfluenza, and metapneumovirus.¹ Occasionally, not only one, but two or more infectious agents are identified in an outbreak.

LTCH residents are predisposed to Acute Respiratory Infections (ARIs) in part because they may be elderly, may have chronic illnesses which weaken their immune system, and may have chronic lung or neurological diseases which impair their ability to clear secretions from their lungs and airways. However, residents are also at risk because many viral and bacterial respiratory pathogens are easily transmitted in an institutional environment.²

Early detection together with the timely implementation of outbreak control measures that are carefully adhered to, can effectively minimize transmission of infection, thereby preventing or more quickly bringing an outbreak under control.

1.1 Purpose of the Document

This document replaces “A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes”, Ontario Ministry of Health and Long-Term Care, October 2004.

The purpose of this document is to assist LTCHs and public health units (PHUs) with prevention, detection and management of respiratory infection outbreaks which arise from the transmission of common viral pathogens, through droplet exposure.

The recommendations in this document have been developed specifically for implementation in LTCHs. Recommendations regarding outbreak control can however, be implemented in principle, in other institutional settings, including complex continuing care or retirement homes, among others. Attention should be given to the guiding infection control principles; the management of outbreaks may be different in LTCHs, as compared with other settings, but the principles remain the same.

The specific management of influenza outbreaks will be referenced throughout this document.

The reason for referring specifically to influenza outbreaks is that secondary complications of influenza virus infection are more frequent and severe, contributing to the greatest proportion of morbidity and mortality as compared to other respiratory viruses.

It is important to note that while the majority of the recommended infection prevention and control measures for management of influenza outbreaks are the same for all respiratory

infection outbreaks caused by spread through droplet exposure, with influenza outbreaks the use of vaccines and antivirals is an important component of outbreak management.

The recommendations contained in this document are based on current evidence and best practice at the time of writing.

It is also important to note that the recommendations contained in this document are intended to protect the health of the resident/patient populations, as required under the Health Protection and Promotion Act, (HPPA). Recommendations are made in the interest of the resident populations at risk. LTCH licensees are also required to fully respect and promote the individual resident rights set out in the Residents' Bill of Rights in s.3 under the Long-Term Care Homes Act, 2007 (LTCHA). The LTCH and PHU should work together to ensure that residents' rights under the LTCHA are fully respected and promoted, while implementing outbreak control measures that are protective to the resident populations and that are appropriate and proportional to the risk profile of the outbreak. Strategies will be presented in this document to address these issues. Users of this document should also ensure that they are complying with any other legislation or regulations relevant to their workplace(s) that may not be addressed within these recommendations.

1.1.1 Special Circumstances

During an outbreak caused by **new, emerging pathogens**, (e.g. MERS-CoV, avian influenza A (H7N9)) LTCHs should follow recommendations developed specific to that emerging pathogen. This information will be available from the MOHLTC's Emergency Management Branch online at <http://www.health.gov.on.ca/en/public/programs/emu/>.

During an **influenza pandemic**, recommendations for management and control may be altered and LTCHs should use guidance documents specific to pandemic outbreak management. This information will be available from the MOHLTC's Emergency Management Branch online at <http://www.health.gov.on.ca/en/pro/programs/emb/>.

1.1.2 Out of Scope

Outbreaks caused by organisms that are spread via other mechanisms, e.g., airborne, require additional outbreak control measures and are out of scope for this document. As well, management of outbreaks caused by bacterial pathogens (e.g. *Legionella* and Tuberculosis) and fungal respiratory pathogens (e.g. *Aspergillus*), are out of scope for this document.

This document can be used in conjunction with:

- *Influenza Prevention and Surveillance Protocol for Long-Term Care Homes*, September 2014 (see [Appendix 9](#))
- PIDAC Best Practice documents (see [Appendix 13 – Resources and Useful Links](#))

1.2 The Role of Local PHUs

PHUs act under the authority of the *Health Protection and Promotion Act* (HPPA) and in accordance with the Ontario Public Health Standards (including the protocols) (OPHS, 2008).

For Board of Health requirements please see: [Ontario Public Health Standards: Requirements for Programs, Services, and Accountability, Infectious Diseases Protocol](#), 2018 (or as current).

Box 1: Outbreak

Outbreak Document: Purpose
<p>This document will provide a comprehensive outline for PHUs regarding their requirements under the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (including the protocols) 2018, Ontario Reg. 559/91 in the HPPA, with respect to:</p> <ul style="list-style-type: none"> • Helping LTCH staff to understand the parameters for establishing a surveillance program to detect and monitor respiratory illness. This will facilitate the early identification of outbreaks. • Providing guidance and recommendations to LTCH and PHU staff in order to investigate and manage outbreaks of respiratory infections, including: • identifying symptoms to form a case definition for the specific outbreak • consulting promptly with PHUs when there is suspicion of an outbreak • activating an Outbreak Management Team (OMT) • ensuring that OMT members understand their roles and responsibilities • outlining outbreak control measures • ensuring that staff collect appropriate specimens in a timely manner to verify diagnosis • updating information regarding changes to procedures, laboratory guidelines, etc. • specifically addressing the use of antiviral medications for the prevention and treatment of influenza <p>In line with Board of Health requirements, PHUs are committed to providing support to all LTCHs, including:</p> <ul style="list-style-type: none"> • Annual promotion of influenza vaccination to staff of LTCHs. • Provision of annual in-service education for staff on infectious diseases. • Collaboration on the development of infection control policies and an outbreak contingency plan. • Ongoing consultation about communicable disease surveillance program, including the collection, analysis and appropriate management of infections. • Assistance in the investigation, confirmation and management of the outbreak, when notified of a suspect or confirmed respiratory outbreak. • Provision of specimen kits, and transport of the same to the laboratory. • Notifying nursing staffing agencies of LTCHs in outbreak. It is the responsibility of the agencies to notify public health of the appropriate contact numbers.

2 Respiratory Outbreaks: Prevention and Preparation

This section focuses on practices aimed at preventing outbreaks as well as those practices that ensure LTCHs are prepared to manage outbreaks. This section includes specific recommendations in the areas of immunization, education and the development of surveillance and outbreak control policies and procedures.

2.1 Prevention

2.1.1 Immunization

Effective infection prevention and control (IPAC) efforts for preventing respiratory infections are comprised of numerous strategies, the main strategy being seasonal influenza immunization of residents and staff. The MOHLTC supports annual influenza immunization as the primary strategy to minimize the impact of influenza on residents of LTCHs in Ontario.³

Influenza and pneumococcal immunization of LTCH residents, along with appropriate infection prevention and control practices, reduces the impact of these vaccine-preventable diseases.

Residents who provide informed consent (or, if the resident is incapable, informed consent is provided by the resident's substitute decision maker) should receive annual influenza vaccination, unless contraindicated. The Canadian Immunization Guide indicates that one dose of polysaccharide pneumococcal vaccine is recommended for all adults 65 years of age and older, and for adults less than 65 years of age in LTCHs or who have conditions putting them at increased risk of pneumococcal disease ([The Canadian Immunization Guide](#)). Individuals with unknown immunization histories for pneumococcal vaccine should receive the vaccine.⁴

LTCHs must have a resident and staff immunization program in place which should include policy for influenza and pneumococcal disease. Pursuant to s.229 (10) of Ontario Regulation 79/10 under the LTCHA, LTCHs are responsible for offering residents immunization against influenza, pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the MOHLTC website.⁵ LTCHs should ensure their immunization policies are updated and clearly communicated each year.

Box 2: Immunization: LTCHs Roles and Responsibilities

Immunization: LTCHs Roles and Responsibilities
<p>Pursuant to s.229 (10) of Ontario Regulation 79/10 under the LTCHA, LTCHs should:</p> <ul style="list-style-type: none"> • Ensure that all staff members are provided with information annually regarding the influenza vaccine and the home's immunization and exclusion policies. • Promote and implement accessible influenza vaccination clinics. • Keep an updated record of all staff influenza immunizations. • Advise outside agencies that provide staff to the LTCH of the home's immunization/exclusion policy. • Develop a staffing contingency plan based on immunization rates in their own home. • Ensure that consenting residents receive annual influenza vaccination. • Ensure that residents have been offered immunization against pneumococcus, tetanus, and diphtheria.

Influenza Immunization

"Vaccination is recognized as the cornerstone for preventing or attenuating influenza for those at high risk of serious illness or death from influenza infection and its complications. Health care workers (HCWs) and their employers should actively promote, implement and comply with influenza immunization recommendations in order to decrease the risk of infection and complications among the vulnerable populations for whom they care".⁶ For immunization recommendations, please refer to the current season's NACI statement on seasonal influenza vaccine.

"HCWs involved in direct resident care should consider it their responsibility to provide the highest standard of care, which includes undergoing annual influenza vaccination. In the absence of contraindications, refusal of HCWs who have direct patient (resident) contact to be immunized against influenza implies failure in their duty of care to their patients".⁶

LTCH immunization policies should address influenza immunization requirements for residents, staff*, volunteers, private pay caregivers and visitors, who conduct activities within the home.

Each home should have policies and procedures related to annual staff immunization as well as resident influenza and pneumococcal immunization.³

Medical contraindications to influenza vaccination

There are few valid medical contraindications to the influenza vaccination. Egg allergy is no longer considered a contraindication for trivalent inactivated influenza vaccine (TIV). After careful review, NACI concludes that egg-allergic individuals may be vaccinated against influenza using TIV, without a prior influenza vaccine skin test and irrespective of a past severe reaction to egg, with the following conditions: those with mild reactions

* Under the *Occupational Health and Safety Act*, (OHSA), immunization cannot be mandated for HCWs.⁸

such as hives, or those who tolerate eggs in baked goods may be vaccinated in regular vaccination clinics, while those who have suffered from anaphylaxis with respiratory or cardiovascular symptoms should be vaccinated in a medical clinic, allergy office or hospital where appropriate expertise is present. These individuals should always be kept under observation for 30 minutes.⁶ Medical contraindications must be documented as a reason for not receiving influenza vaccination. For medical contraindications, please refer to the current NACI statement on influenza vaccination, PIDAC's *Prevention of Transmission of Acute Respiratory Infection*, as well as to each vaccine's product monograph.⁷

Role of the LTCH regarding visitor immunization status

Visitors, including family members/substitute decision-makers (SDMs) and friends to the home, should be encouraged to receive their annual influenza immunization.⁷ However, it is not the responsibility of the home to verify the immunization status of visitors and family members/SDMs beyond providing information on the importance and role of vaccination and where they may get vaccinated.

Influenza vaccine administration

Availability of on-site vaccination clinics for all staff is recommended to provide optimal access to immunization services.⁷ Staff can, of course, also obtain their seasonal influenza immunization from their regular care provider or other source in the community. All staff members who receive the influenza vaccine from a source other than the LTCH must provide proof of influenza immunization.

Proof of Immunization

Only the following should be accepted as proof of influenza immunization:³

- A personal immunization record (e.g., Ontario Yellow Card) documenting receipt of the current season's influenza vaccine
- A record of immunization from a health care provider (e.g., pharmacist, physician or public health unit immunization clinic) documenting receipt of the current season's influenza vaccine
- Note: for persons that work in multiple LTCHs or health care facilities, it is prudent to retain proof of immunization obtained for other LTCHs or institutions

If documentation is not available, the LTCH should consider the staff member unimmunized, and the employer must offer influenza immunization to the individual.

Staff Exclusion Policy

A staff exclusion policy is a protective measure for residents and patients. Employers may send employees home, or enact other practices as contained within the LTCH's own policy, in the event of an influenza outbreak when the worker has not received the influenza vaccine or is not taking antiviral medication.

Currently, this is common practice in Ontario LTCHs and is an important strategy for minimizing the impact of influenza on residents of LTCHs. See [Appendix 9 – Influenza Prevention and Surveillance Protocol for Long-Term Care Homes](#) for further details.

LTCHs should have an exclusion policy for staff and volunteers who choose not to be immunized and/or take antiviral drugs. Staff with influenza, an ARI, and staff that have not been immunized **and** are not taking antiviral prophylaxis, should be excluded from work.⁶ This measure is reasonable to protect vulnerable patients/residents during an outbreak. (See [Appendix 8](#) regarding suggestions for exclusion policy content).

Notification Procedures for Staff Illness

In accordance with the OHSA and its regulations, the following are required steps for communicating staff illness.

Reporting to the LTCH's Infection Prevention and Control – IPAC/ICP/designate

Should clinical staff become aware of any case(s) or cluster(s) of respiratory infection in residents and/or staff, or if daily ARI surveillance identifies such cases, the LTCH's ICP or designate must be promptly notified.⁷ Should occupational health and safety (OHS) become aware of a case or cluster of respiratory infections in staff, they must notify the ICP or designate.⁷

Reporting to Occupational Health and Safety

Should staff develop any symptoms of respiratory infection, they must report their condition to OHS or delegate.

Should IPAC staff become aware of a case or cluster of respiratory infections in staff, they will notify OHS.⁷

Reporting to the Ministry of Labour

An employer must provide written notice within 4 days of being advised that a worker has an occupational illness, including an occupationally-acquired infection, or has filed a claim with the WSIB with respect to an occupational illness, to:

- the Ministry of Labour,
- the joint health and safety committee (or health and safety representative), and
- the trade union, if any.^{8,9}

Reporting to the Workplace Safety and Insurance Board

Any instances of occupationally-acquired infection shall be reported to the WSIB within 72 hours of the LTCH receiving notification of said illness.⁸

Influenza Immunization of Residents

Immunity after influenza immunization usually lasts less than one year. However, in the elderly, antibody levels may fall below protective levels in four to six months. To ensure that protection lasts throughout the influenza season, the recommended time for influenza

immunization is from October to mid-November unless otherwise advised by your local PHU. If the resident is admitted after the LTCH's fall influenza immunization program, but before the influenza season is over, vaccination must be offered, unless the person has already received the current season's influenza vaccine.³

Prior to, or upon admission, each resident should be assessed regarding immunization and medical status. If the influenza immunization status of a resident is not available or if it is unknown, the resident should be considered unvaccinated and immunization should be offered.³ A resident or their substitute decision-maker (SDM) may refuse any treatment/medication.

Refusal (and reason for refusal) should be documented in the resident's health record.

The immunization record of the resident, including their influenza immunization status, should be retained in a readily accessible part of their health record. Upon transfer to another LTCH, Acute Care or Chronic Care facility, the residents' recent immunization status should be shared with the receiving health care facility.

Consent for Vaccination and Antiviral Medication

Informed consent from the resident/SDM must be obtained for influenza and pneumococcal vaccines, and antiviral drugs for influenza prophylaxis in the event of an influenza outbreak.

Pneumococcal Immunization

There is considerable overlap in the indications for the influenza and pneumococcal vaccines. Consequently, the LTCHs annual influenza immunization program presents an excellent opportunity to immunize residents who have not yet received one dose of pneumococcal polysaccharide vaccine as per the [Canadian Immunization Guide](#).⁴

The pneumococcal vaccine may be administered concurrently with influenza vaccine, but at a separate anatomic site, using a separate needle and syringe. For more information and recommendations related to pneumococcal vaccination, please refer to the [Canadian Immunization Guide](#), and the [NACI Recommended Immunization Schedule](#).^{4, 6}

2.1.2 Education

The ongoing education of staff, volunteers, residents, residents' families and visitors about infection and outbreak prevention and related strategies is part of a robust infection prevention and control (IPAC) program.

The OHSA and associated Regulations for Health Care and Residential Facilities (HCRF) (O. Reg. 67/93) require annual review of health and safety, and may include infection prevention and control, immunization and other related topics. Under the HCRF, every employer in consultation with the joint health and safety committee or health and safety representative, if any, and upon consideration of the recommendation thereof, shall develop, establish and put into effect measures and procedures for the health and safety

of workers, which may include measures and procedures on the control of infections, immunization and inoculation against infectious diseases. Section 9 of the HCRF requires that the measures and procedures be reviewed at least once a year and revised in the light of current knowledge and practice. Further, that the employer, in consultation with and in consideration of the recommendation of the joint health and safety committee or health and safety representative, if any, shall develop, establish and provide training and educational programs in health and safety measures and procedures for workers that are relevant to the workers' work. Clause 25(2)(a) of the OHS Act requires the employer to provide information, instruction and supervision to a worker to protect the health and safety of the worker.^{8, 9}

Education of Staff and Volunteers

At the time of hiring/placement, during staff/volunteer orientation and as appropriate annually thereafter, educational information about influenza as well as policy information related to influenza should be provided.

Box 3: Education for all Staff and Volunteers

Education for all Staff and Volunteers
<p>Education/orientation programs for all staff and volunteers (as applicable) should include information on:</p> <ul style="list-style-type: none"> • The effectiveness, benefits and risks of influenza immunization. • Information about respiratory virus (including influenza) morbidity, mortality, transmission, as well as: • Prevention of influenza, and the requirement for annual influenza vaccination • Mechanisms to reduce disease transmission, for example respiratory etiquette and hand hygiene • Respiratory infection outbreak management and exclusion policies of the home: • A review of policies related to staff and visitor illness recommendations (persons experiencing symptoms of respiratory illness should not be working/visiting the home). • A review of influenza immunization and exclusion policies for staff. • A review of influenza immunization policies and recommendations for family members and visitors (i.e. those experiencing symptoms of respiratory illness should not be visiting the LTCH). • Respiratory etiquette. • A review of IPAC core competencies and resources: • Routine Practices and Additional Precautions, including use of personal protective equipment (PPE), cleaning and disinfecting requirements and environmental cleaning, as per PIDAC documents. • Just Clean Your Hands, including your Four Moments for Hand Hygiene (HH). • Chain of transmission: modes of infection transmission.

Education of Residents, Residents' Families, Private Pay Caregivers and Visitors

Topics to include in education programs for all residents, residents' families, private pay caregivers, and visitors:

- A review of influenza immunization policies and recommendations for residents' families, private pay caregivers, and visitors (i.e. those experiencing symptoms of respiratory illness should not be visiting the LTCH).
- Respiratory etiquette:
 - All individuals are advised to practice respiratory etiquette when coughing or sneezing:
 - I. Turn head away from others;
 - II. Cover the nose and mouth with tissue; or sneeze into your sleeve;
 - III. Discard tissues immediately after use into waste; and
 - IV. Perform hand hygiene (HH) immediately after disposal of tissues.

These are minimum requirements for education; the LTCH can provide more information, at their discretion.

2.1.3 Policy and Procedure Preparation

Each home should have a comprehensive set of policies and procedures related to respiratory infection outbreaks. This includes policies and procedures related to respiratory disease surveillance, staff and resident education, immunization requirements, exclusion policies, among others, related to outbreak management.³ For additional information please see [Appendix 9 – Influenza Prevention and Surveillance Protocol for Long-Term Care Homes, September 2014](#).

The LTCH may seek to provide education for their staff in conjunction with the local PHU as well as the LTCH IPAC committee.

Policies and procedures should address the following topics:

Education and related policies and procedures:

- Annual review of IPAC policy.
- Annual review of policies and procedures related to outbreak prevention and control.

Outbreak-related policies and procedures:

- Procedures for surveillance, early recognition for potential transmission of infectious conditions, and management of an outbreak including the composition and mandate of the OMT.

Immunization-related policies and procedures:

- Annual staff immunization.
- Resident influenza and pneumococcal immunization.
- Annual reporting of staff and resident immunization to the local MOH. A policy

and procedure on exclusion:

- Staff exclusion policies, including refusal of immunization and refusal of antiviral medication in the event of an influenza outbreak.
- Staff exclusion policies in regards to other respiratory virus outbreaks (e.g. when ill with any ARI)

Staffing plans and related policies and procedures:

- A staffing contingency plan addressing varying levels of available staff during outbreaks due to illness, refusal or inability to immunize, unwillingness or contraindication to antiviral agents.
- A staffing plan to address adequate staff to patient ratios: as workload increases during an outbreak, staffing plans need to address continued provision of care and full implementation of infection control measures.

Antiviral use related policies and procedures:

- A policy on antiviral use, including: appropriate use, obtaining informed consent from residents or substitute decision-makers, obtaining medical directive signed by Medical Director for antiviral prophylaxis, payment and reimbursement processes, as well as indications for oseltamivir (Tamiflu™) and zanamivir (Relenza™).
- A policy on staff antiviral use.

Specimen collection, laboratory testing and related policies and procedures:

- Process to rapidly access specimen kits, testing facilities, and results of laboratory tests in the event of a suspected outbreak.
- Policy requiring availability of staff with competencies related to correct technique for the collection of nasopharyngeal specimens.

Communication related policies and procedures:

- A policy related to communication requirements and processes between the home, local PHU, laboratory, and other regulators (e.g. MOL, WSIB, JHSC, trade union), as appropriate and ensuring staff on all shifts are aware of these lines of communication.
- A policy related to ongoing and effective communication with residents, families of residents, staff and the media.

2.2 Surveillance

2.2.1 Definition and Goal

Surveillance is an essential component of any effective IPAC program. LTCHs are required to have an ongoing surveillance program to detect the presence of infections in residents.³ A well-functioning respiratory infection surveillance system provides the means to establish the endemic, or baseline rate of respiratory infections in a health care setting.

Moreover, surveillance can assist in the detection of respiratory infection outbreaks in LTCHs by identifying significant deviations from the baseline rate.¹⁰ Pursuant to s. 229 (7) of O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007*, licensees of LTCHs are required to implement the PIDAC “Best Practices for Surveillance of Health Care Associated Infections in Patient and Resident Populations” protocol given to them by the Director under the LTCHA, currently the Director of the Performance Improvement and Compliance Branch of the MOHLTC.

Definition

Surveillance is defined as “the ongoing systematic collection, analysis, interpretation and evaluation of health data closely integrated with timely dissemination of this data to those who need it”.¹⁰ There are two key aspects of surveillance systems: surveillance is an organized, ongoing component of a program to improve a specific area of population health and surveillance systems go beyond the collection of information; knowledge gained through surveillance must reach those who can use it to direct resources where needed to improve health.¹⁰

Goal of Surveillance

An important goal of surveillance is to ensure early identification of symptoms in residents and staff that precede a potential outbreak or an outbreak in its early stages so that control measures can be implemented as soon as possible.

Personnel Requirement

Pursuant to subsection 229 (3) of O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007*, a designated, trained ICP is responsible to co-ordinate the IPAC program, which includes surveillance and outbreak management activities. In their absence, a competent person (see glossary) must be designated to continue these functions, including on weekends and during holiday periods. Moreover, staff at all levels of the organization should be trained to monitor for signs and symptoms of acute respiratory illness in residents and staff as well as who they should contact with this information.

2.2.2 Target Groups for Surveillance

Surveillance should be done for both resident and staff populations. Although resource implications may impact the LTCHs ability to conduct year round staff surveillance, this remains an essential component of the infection prevention and control program.

Resident Surveillance

Continuous home-wide surveillance is required to establish baseline levels of infection throughout the year. Suspect outbreaks are recognized when infection rates increase above the baseline. It is expected that LTCHs will ensure they have the capacity to recognize and respond to infection rate increases above the baseline indicative of outbreaks during off-hours (weekends, holidays) as well. Targeted surveillance for respiratory symptoms should be implemented during influenza season (typically

November to April) and when influenza-like illness activity has been reported in the local community, which can start as early as September for some common respiratory viruses, such as rhinoviruses. All staff must be aware of the symptoms of respiratory illness, the criteria for a suspected outbreak and the procedures for reporting to the ICP.

LTCHs are required to have ongoing surveillance programs to determine the presence of infections. Key features of these programs include:

- A sufficiently sensitive surveillance program to identify sentinel events and trends.
- Analysis of surveillance data by the ICP in order to trigger actions designed to reduce or eliminate disease transmission and influence policy and practice.
- Sharing of surveillance data with administration, IPAC team and PHU as necessary.

Staff Surveillance

Surveillance for ARI among staff should be done throughout the year. All staff should be aware of early signs and symptoms of ARI. Ill staff should be asked to report their respiratory infection to their manager or to Employee Health/Occupational Health and Safety.⁷ The manager or Employee Health/Occupational Health designate must promptly inform the ICP of cases/clusters of employees/contract staff who are absent from work with ARI.⁷ The information should be reported non-nominally (without using names) to protect the employees' right to confidentiality, but should include the location of the case.

Under the OHSA, if an employer is advised that a worker has an occupational illness or that a claim in respect of an occupational illness has been filed with the WSIB, the employer must notify a Director of the Ministry of Labour, the joint health and safety committee (or health and safety representative) and the union, if any, within four days of being advised. This notice must be in writing and must contain any prescribed information. Occupational illness includes occupationally-acquired infections of workers.⁸

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

- All volunteers, private pay caregivers and visitors who conduct activities within the home should self-screen based on the signage posted (required when an outbreak has been declared, see section 3) and exclude themselves from entering the home when they have respiratory symptoms (i.e., new cough, new shortness of breath, fever).
- Screening tools and policies are to be posted, and followed by all persons entering the LTCH.

2.2.3 Methods of Data Collection for Surveillance

Daily surveillance is the most effective way to detect respiratory infections. There are two methods to conduct daily surveillance: active and passive.

Passive Surveillance

Passive surveillance involves the identification of infections by staff whose primary responsibility is resident care, while providing routine daily care or activities. Residents

with respiratory and other symptoms should be noted on the daily surveillance form (refer to [Appendix 3 - Sample Respiratory Outbreak Line Listing Form](#)). This form should be easy to use and include patient identification and location, date of onset, a checklist of relevant signs and symptoms, including fever, diagnostic tests and results when available. The completed form should be forwarded to the ICP on a daily basis. Any suspected outbreak should be reported immediately to the ICP (see Step #3 of Outbreak Detection and Management). It is important to maintain a high index of suspicion for respiratory infections, especially during influenza season.

Active Surveillance

Active surveillance involves actively seeking out infections on a regular basis by individuals trained in surveillance, usually ICPs.⁷ Several strategies may be used including:

- Conducting unit rounds.
- Reviewing unit reports, which may include elevated temperature reports.
- Reviewing physician/staff communication books.
- Reviewing medical and/or nursing progress notes in resident charts.
- Reviewing pharmacy antibiotic utilization records.
- Reviewing laboratory reports.
- Verbal report from unit staff, based on clinical observations.

All available sources of information within the home may contribute to the surveillance activities. The method used by each home should be practical in that setting.

Analysis

The ICP or designate reviews the surveillance data for both staff and residents and consults with their local PHU to determine whether the findings meet the criteria for infection in each resident and staff and if a suspected outbreak exists.

For more information related to surveillance programs, including tools and templates, see [PIDAC, Best Practices for Surveillance of Health Care – associated Infections in Patient and Resident Populations, July 2014](#).¹⁰

Reporting:

LTCH Outbreak Reporting Requirements

Confirmed and suspected outbreaks shall be reported as soon as identified to the Medical Officer of Health by persons required to do so under the HPPA.¹¹ LTCHs are also responsible for immediately reporting outbreaks of reportable or communicable disease as defined in the HPPA to the Director under the LTCHA (O. Reg. 79/10, s.107(1)5).¹²

PHU Outbreak Reporting Requirements

PHUs are required to only report outbreaks as specified in the provincial case definition.¹³ Preliminary report of outbreaks shall be made using the integrated Public Health Information System (iPHIS), or any other method specified by the MOHLTC within one

(1) business day of receipt of initial notification as per *iPHIS Bulletin Number 17: Timely Entry of Cases*.¹⁴ The final outbreak report shall be submitted within 15 business days of the outbreak being declared over.

In addition, as outlined in section 2.2.2 of this document (staff surveillance), “Under the OHSA, if an employer is advised that a worker has an occupational illness or that a claim in respect of an occupational illness has been filed with the WSIB, the employer must notify a Director of the Ministry of Labour, the joint health and safety committee (or health and safety representative) and the union, if any, within four days of being advised. This notice must be in writing and must contain any prescribed information. Occupational illness includes occupationally-acquired infections of workers.”⁸

The minimum data elements to be reported for each case and outbreak are specified in the following:

- Ontario Regulation 569 (Reports) under the HPPA;
- The disease-specific User Guides published by Public Health Ontario; and
- Bulletins and directives issued by PHO and the MOHLTC.

2.2.4 Clinical Presentation: Respiratory Tract Infections

The clinical presentation of influenza in an elderly, fully immunized population can differ from the usual clinical presentation of influenza. Because influenza in the elderly often causes tiredness (malaise), muscle aches (myalgia), loss of appetite, headache, and chills, the incorporation of these symptoms into the case definition, if they occur, may be useful. In the elderly, fever could be absent or manifest as follows: abnormal temperature for the resident or a temperature $\leq 35.5^{\circ}\text{C}$ or $\geq 37.5^{\circ}\text{C}$.¹⁵

See [Box 4](#), [Box 5](#), and [Box 6](#) which outline similar acute respiratory symptoms for different respiratory outbreak-associated viruses:

Box 4: Upper Respiratory Tract Illness (includes common cold, pharyngitis)

Upper Respiratory Tract Illness (includes common cold, pharyngitis)
<p>Signs and symptoms may include:¹³</p> <ul style="list-style-type: none"> • Runny nose or sneezing; • Stuffy nose (i.e. congestion); • Sore throat, hoarseness or difficulty swallowing; • Dry cough; • Swollen or tender glands in the neck (cervical lymphadenopathy); • Fever/abnormal temperature for the resident may be present, but is not required; • Tiredness (malaise); • Muscle aches (myalgia); • Loss of appetite; • Headache; and • Chills.

Box 5: Lower Respiratory Tract Infection (bronchitis, tracheobronchitis)

Lower Respiratory Tract Infection (bronchitis, tracheobronchitis)
<p>The resident must have at least three of the following:</p> <ul style="list-style-type: none"> • New or increased cough; • New or increased sputum production; • Abnormal temperature for the resident, or a temperature of $\leq 35.5^{\circ}\text{C}$ or $\geq 37.5^{\circ}\text{C}$; • Pleuritic chest pain; • New physical findings on examination (rales, rhonchi, wheezes, bronchial breathing); • One of the following to indicate change in status or breathing difficulty: <ul style="list-style-type: none"> • new /increased shortness of breath; • respiratory rate $>25/\text{minute}$; • Worsening functional or mental status (deterioration in resident's ability to perform activities of daily living or lowering of their level of consciousness).

Box 6: Pneumonia (e.g. *Streptococcus Pneumonia*)

Pneumonia (e.g. <i>Streptococcus Pneumonia</i>)
<p>All of the following criteria must be met:</p> <ul style="list-style-type: none"> • Interpretation of a chest x-ray as pneumonia, probable pneumonia, or presence of infiltrate. • The resident must have at least two of the signs and symptoms described under lower respiratory tract infection. • Other non-infectious causes of symptoms, in particular congestive heart failure, must be ruled out.

If a cluster of pneumonia or lower respiratory infection cases is suspected, steps must be taken to determine a common causative agent (nasopharyngeal (NP) swabs, serology, chest x-ray, urine for *Legionella* antigen or respiratory specimen for *Legionella* polymerase chain reaction (PCR), sputum smear/culture, etc.) A full discussion of *Legionella* case or outbreak management is out of scope for this document.

Outbreak Case Definitions

Different respiratory viruses can cause similar acute respiratory symptoms; however, each virus and/or outbreak will have unique characteristics. As such, outbreak case definitions should be developed for each specific outbreak; each respiratory outbreak requires its own definition. A case definition should be developed for each individual outbreak and modified if necessary to ensure that the majority of cases are captured by the definition (MOHLTC, Infectious Diseases Protocol, Appendix B -Provincial Case Definition for Reportable Diseases, Respiratory Infection Outbreaks in Institutions, 2014).¹³

Outbreak case definitions differ from provincial MOHLTC surveillance outbreak

definitions, which provide a standard for determining when outbreaks become reportable to the MOHLTC.

MOHLTC Surveillance Outbreak Definitions for Respiratory Infection Outbreaks in Institutions (Appendix B, Respiratory Infection Outbreaks in Institutions, 2014. Case definitions are subject to periodic review as scheduled by the ministry).

1. Confirmed outbreak definitions:¹³

Confirmed Outbreak Definition

Confirmed respiratory infection outbreak in a LTCH:

- Two cases of ARI within 48 hours, at least one of which must be laboratory-confirmed
- OR**
- Three cases of ARI (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 ARI within 48 hours

Confirmed influenza outbreak in a hospital:

- Two or more cases of nosocomially-acquired ARI (i.e., influenza) occurring within 48 hours on a specific hospital unit, with at least one case laboratory-confirmed as influenza

2. Suspect Outbreak Definition¹³

Suspect respiratory infection outbreak:

- Two cases of ARI occurring within 48 hours in a geographic area (e.g., unit, floor)
- OR**
- More than one unit having a case of ARI within 48 hours

Suspect influenza outbreak:

- One laboratory-confirmed case of influenza
- OR**
- Two cases of ARI occurring within 48 hours in a geographic area (e.g., unit, floor)
- OR**
- More than one unit having a case of ARI within 48 hours

Laboratory Confirmation

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

3 Outbreak Detection and Management

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

The steps outlined below are the **responsibility of the LTCH**, unless otherwise noted. The roles and responsibilities of the PHU (Medical Officer of Health or designate) should be clarified at the first OMT meeting, to which the public health representative is always invited.

The following steps should not be taken as a prescriptive approach to outbreak management; many of these steps may be performed concurrently. Every effort was made to ensure a flow that aligns with the course of an outbreak, but LTCHs will have to exercise judgment regarding the specific actions required at each stage of the outbreak, and may look to PHUs for guidance.

Step 1 - Assess the Suspect or Confirmed Outbreak, Establish a Preliminary Outbreak Case Definition, and Begin a Line-list.

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.¹³

When the LTCH suspects an outbreak, or has declared an outbreak, the LTCH should establish a preliminary case definition. This helps to guide the detection of persons potentially associated with the suspect or confirmed outbreak. The case definition should include clinical signs and symptoms, time of onset of illness, and location of resident/staff in the home.¹³

An example of a case definition: a resident or staff member on any unit of the home with illness onset from (date) who is experiencing any two of the following symptoms: cough, fever, headache, chills, lethargy or muscle ache.

Begin a line listing of residents who are ill with respiratory symptoms, based on information collected through the LTCH's surveillance program. (See [Appendix 3](#) for example of a line listing). The line listing provides for rapid assessment of the extent and nature of the suspected outbreak. It may be expanded to include other relevant data beyond what is recommended here as the investigation proceeds. Residents and staff are line-listed when they exhibit symptoms consistent with the outbreak case definition; ***laboratory confirmation of illness is not required to line-list individuals.***

A separate line listing should be completed for staff who present with signs and symptoms that are consistent with respiratory illness.

Confirm the population at risk in the home. This includes:

- The total number of residents, staff, including casual workers and non-resident

care staff, and volunteers at the home.

- If the outbreak is restricted to specific unit(s)/floor(s), the number of staff at risk in the outbreak unit/floor should be identified by the OMT.
- For large LTCHs, keeping a separate line listing for each unit affected by the outbreak may be useful.

The following information should be included on the line listing for all residents/staff that meet the outbreak case definition:

Box 7: Line listing: Resident and Staff Surveillance

Line listing: Resident and Staff Surveillance

Resident Surveillance:

- Name of resident.
- Age.
- Location in home such as unit, room, bed number.
- Date of onset of symptoms.
- Case defining signs and symptoms.
- Treatment given such as antibiotics or antiviral medications.
- Diagnostic tests such as x-rays.
- Samples taken including date and results if known (e.g. nasopharyngeal swab).
- Immunization history for influenza and pneumococcal vaccine.
- If the resident was hospitalized – date and location of hospitalization.
- If deceased, (include date and cause of death).
- If the resident was isolated, the start date of isolation.
- Date illness resolved.
- Date on which antiviral prophylaxis was initiated (if applicable).
- Complications (e.g. pneumonia).

Staff Surveillance

- Initials of staff.
- Work assignments in the home including notation of assigned wards/units.
- Date of onset.
- Case defining symptoms and signs.
- Antiviral medication given for treatment.
- Influenza immunization history.
- Any diagnostic tests including results if available.
- Last day of work of ill staff member.
- Whether they work at another facility.
- Ill household contacts.
- Date of recovery.
- Date returned to work.

Step 2 - Implement General Infection Control Measures.

Control measures are to be implemented as soon as an outbreak is suspected. All staff shall be notified quickly of the outbreak and supplies (e.g. alcohol based hand rub, PPE, including gowns, face protection, gloves, surgical masks, etc.) should be made available as necessary. All residents symptomatic with an ARI should be placed on Droplet/Contact Precautions in addition to Routine Practices **as soon as possible after symptoms are identified**. Asymptomatic residents should be cared for using Routine Practices and carefully monitored for any change in their symptoms.⁷ See *section 4.0 for Respiratory Outbreak Control Measures*.

Step 3 - Declare an Outbreak in your LTCH and Notify the Local Medical Officer of Health or Designate at your Health Unit of the Suspect or Confirmed Outbreak.

- Notify the local Medical Officer of Health or designate.
- There should be a discussion between the Medical Officer of Health or designate and the LTCH regarding whether to declare a facility-wide outbreak or unit specific outbreak when the cases are on one unit/floor and can be confined to that unit.
- ***Laboratory confirmation of an organism is not required to declare an outbreak.*** Once an outbreak is confirmed and declared in the LTCH, the home should start assembling the OMT, with appropriate representation from the LTCH (see below, Step 4) as well as the PHU.
- Notify the MOHLTC through the Critical Incident System and/or by contacting the local service area office (pursuant to section 107 of O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007*).

In addition, the LTCH staff should:

- Provide the Medical Officer of Health or designate with an updated line list daily. Do not wait until the line list is completed to notify the Medical Officer of Health.
- Provide the Medical Officer of Health or designate with the name of the primary ICP or the person responsible for IPAC that is responsible for the outbreak investigation along with the person's contact information. The LTCH should designate a staff person to be responsible for the management of the outbreak at all times including weekends, holidays and vacation. Contact names and appropriate numbers shall be provided to the Medical Officer of Health or designate.
- Report the initial control measures that have been implemented.
- Obtain an 11 digit outbreak number from the local health unit investigator supporting the outbreak.
 - Health units are responsible for notifying the PHOL of the investigation and providing the laboratory with the particulars of the suspected outbreak.
 - The [PHOL Outbreak Notification Report](#) is to be completed and faxed to the laboratory by the health unit.¹⁶ It is suggested that the health unit follows up the

fax with a telephone call, especially prior to the weekend or when there are special concerns such as severity of illness, extent of illness in facility/community, suspicion of unusual agent or other special testing considerations.

LTCHs should discuss with the health unit how specimens will be collected, stored and submitted to the laboratory, using as reference current [PHOL specimen collection instructions](#) on the PHO website including [Lababstracts](#).^{17, 18} This will ensure that the most up-to-date instructions, proper laboratory requisitions and appropriate collection kits are used.

- Confirm the number of laboratory specimens (maximum four (4) specimens) to be taken during the initial outbreak investigation.
- Clarify which residents should be tested and establish which residents should not be tested. Nasopharyngeal swabs for respiratory outbreaks should ideally be taken from residents with acute symptoms (onset within the preceding 24 or 48 hours); however specimen submission can be considered up to the fourth day of symptom onset. Swabs should be taken for residents with typical and atypical presentations. The reason for this is that older residents may not mount typical response, but may also be ill with an ARI. Consider, as well, taking NP swabs from ill staff and ensure a process to convey results to the staff's physician.
- All specimen containers (vials, tubes, etc.) must include the patient's name and date of birth, and should be checked to ensure they have not expired.
- When possible, the health unit should use themselves as the return addressee on the laboratory requisition, and include a phone number and contact name (if different, the investigator's name may also be included).
- The laboratory requisition must also include the name and address of the affected LTCH, the Outbreak Investigation Number, client name, Health Insurance Number (HIN), date of birth, date on which the specimen was collected and sufficient test request information as indicated by the relevant specimen collection instructions (see above).
- Investigation specimens are not generally processed as STAT, i.e. immediately.
- **The PHOL will not process specimens with incomplete labeling or information, leaking specimens or specimens collected in improper or expired kits.**
- For more information please refer to [PHOL laboratory submissions](#) or call the PHOL Customer Service Centre at 416-235-6556/1-877-604-4567.¹⁹
- Review the preliminary case definition for the potential outbreak and make changes as necessary to the clinical signs and symptoms, time frame of onset of illness, location in the home, etc.

An outbreak can be declared at any time by the Medical Officer of Health (or their designate), the Medical Director of the LTCH or the Director of Nursing and Personal Care (DONPC) of the LTCH.

Step 4 - Notify Appropriate Individuals Associated with the LTCH of the Outbreak and Establish OMT Membership.

In addition to notifying the local Medical Officer of Health or designate, the LTCH's ICP, who declared the outbreak and must be a member of the OMT, should consider notifying the following individuals, as appropriate, in order to enlist their collaboration in helping to bring the outbreak under control. These may or may not be individuals that form the OMT.

- Medical director
- DONPC
- Administrator
- Licensee and/or Board of Directors
- Chair of the Infection Prevention and Control Committee
- Employee health nurse
- Director of food services
- Director of volunteer services
- Director of housekeeping/maintenance
- Director or manager of OT/PT services of the home
- Resident representatives
- Pharmacist
- Staff members
- Community volunteers (family members/SDMs/caregivers)
- Attending physician
- Nurse representative from affected unit or other relevant staff members
- Community Care Access Centre (CCAC)
- Ministry of Labour Director, Joint Health and Safety Committee, and/or trade union as applicable

Step 5 - Call an initial OMT Meeting.

At this point, the LTCH should assemble an OMT and hold an OMT meeting.

The OMT directs and oversees the management of all aspects of an outbreak. It should include representatives who have decision making authority within the home as well as a representative from the health unit. Public health representation on infection prevention and control committees will establish good two-way communication between the health unit and the home about all aspects of their infection prevention and control program.

The OMT can include any or all persons identified in the notification list above, but must include the LTCH's ICP.

Box 8: The Outbreak Management Team (OMT)

The Outbreak Management Team (OMT)

At a minimum, the following roles and responsibilities should be assigned to members of the OMT:

Chairperson

- Coordinates the outbreak control meetings.
- Sets the meeting time and agenda.
- Delegates tasks.

Outbreak Coordinator (often the ICP)

- Ensures all OMT decisions are carried out.
- Coordinates all activities required to investigate/manage the outbreak.

Secretary (Administrative Support)

- Sets meeting times, location, and notifies committee members of any changes.
- Records and distributes minutes of meetings.

Media Spokesperson

- Only the representative(s) identified by the OMT as the spokesperson(s) should give information to the news media. The media spokesperson can be a representative from the LTCH, the PHU or a representative from each organization.

The Outbreak Management Team should:

Review the line-listing information to confirm an outbreak exists and ensure that all members of the team have a common understanding of the situation.

- Develop a working case definition for the outbreak. A case definition is the criteria that will be used throughout the outbreak to consider a resident or staff member as an outbreak-associated case. The case definition developed for residents may be different from that developed for staff. Residents/staff who meet this case definition will be considered a case regardless of the results of laboratory testing unless another diagnosis is confirmed or the case definition is changed to include the laboratory diagnosis.
- Review the outbreak control measures necessary to prevent the outbreak from spreading. See Section 4.0 of this document for Respiratory Outbreak Control Measures. Confirm the ICP or designate of the home is responsible for ensuring that agreed upon control measures are in place and enforced.
- Determine the signage requirements for the outbreak and take steps to ensure it is placed where appropriate.
- For influenza outbreaks, confirm the use of antiviral medications for treatment of cases and/or prophylaxis of well residents and non-immunized staff. In the event of vaccine drift, direction will be provided by the local health unit.
- For influenza outbreaks, confirm the implementation of the exclusion policy, review

and implement the staffing contingency plan.

- For non-influenza outbreaks with other laboratory confirmed respiratory viruses, determine the key prevention/control measures to be implemented and the decision rules in terms of terminating the outbreak. Determine if additional influenza immunization clinics are required for non-immunized staff, and if so, take steps to ensure that it is implemented.
- Confirm the process and logistics for the collection and submission of specimens for laboratory analysis.
- Identify and notify any additional persons/institutions that require notification of the outbreak:
 - Residents' physicians
 - Other health care providers, e.g. physiotherapists
 - Acute care hospitals (infection control practitioner, admitting, emergency)
 - Families of ill residents or families of all residents in the home
 - Representative from the MOHLTC (through the Critical Incident System report)/CCAC/other LTCHs
 - Staffing agencies
 - Emergency services, including dispatch
 - Provincial Transfer Authorization Centre (PTAC)
 - Ministry of Labour Director, Joint Health and Safety Committee, and/or trade union as applicable

Note 1

Note
<p>In addition, PHUs should notify, as appropriate:</p> <ul style="list-style-type: none"> • Physicians in the community • Adjacent health units • EMS • Other LTCHs and institutions in the community • PTAC <p>The Medical Officer of Health may release as much information (including the name of the home) as is necessary to the media or others in order to decrease the risk of disease transmission to the community and to other homes within the health unit's jurisdiction.</p>

- Prepare a communication plan, including a media release as necessary.
- Prepare internal communications for resident, family members, staff groups and volunteers. Determine if education sessions are required for staff members and confirm who will conduct them.
- Confirm who will be responsible for the ongoing monitoring of the outbreak in both residents and staff members.
- Confirm that the PHOL will phone results directly to the health unit, in addition

to notifying the submitting physician. Health unit staff is responsible for informing the home's ICP. Review the process for discussing laboratory results and control measures with health unit staff and the home's ICP, or designate.

- Confirm how and when daily communications will take place between the home and the health unit. Ensure that contact information is available for both the health unit and LTCH at all times.
- Decide how frequently the OMT will meet and set next meeting(s).

Step 6 - Communicate the Results of Laboratory Tests.

Health units will be notified by phone about rapid influenza A/B test results, as well as influenza molecular tests that do not match rapid test results. Health unit staff is responsible for informing the home's ICP. Direction will be provided at that time regarding any additional control, treatment or prophylaxis measures to be implemented.

The PHOL will send a hard copy of all results (negative and positive) to the health unit and submitting physician indicated on the data sheet.

Step 7 - Monitor the Outbreak on an Ongoing Basis.

Outbreak monitoring must include:

- Ongoing surveillance to identify new cases.
- Monitoring the status of ill residents and staff.
- Updating line listings.
- Ongoing monitoring of precautions and control measures.
- Reporting any significant changes in the nature of the outbreak (e.g. hospitalizations, deaths, changes in clinical picture).

The ICP or designate of the LTCH must update the line listing with new information and communicate this to the health unit contact on a daily basis or as previously arranged. The review of the updated information should examine: issues of ongoing transmission, and the effectiveness of control measures and prophylaxis.

Changes to the outbreak control measures may be indicated from a review of the data. Some control measures may be lifted as the outbreak comes under control or alternatively other measures may be added if the outbreak is not being controlled successfully. If new cases continue to be identified during an outbreak, prophylaxis failure or a new causative organism must be considered; additional laboratory testing may be indicated.

Box 9: Updated Line Listing: Resident and Staff Surveillance

Updated Line Listing: Resident and Staff Surveillance	
Resident Surveillance:	
<ul style="list-style-type: none"> • New cases, with all appropriate information (see Step 1, Resident Line Listing Information). • Names of residents who have recovered/recovery date. • The status of ill residents and noting any issues, such as worsening symptoms or complications. • Adverse reaction to any prescribed antiviral prophylactic medication, or discontinuation of antiviral prophylactic medication, as relevant to the resident. • Transfers to/returns from acute-care hospitals. • Deaths. 	
Staff Surveillance:	
<ul style="list-style-type: none"> • New staff cases, together with all appropriate information (see Step 1, Staff Line Listing Information). • Initials of staff who have recovered. • Expected return-to-work dates as determined in collaboration with the PHU. 	

Step 8 - Declare the Outbreak Over.

Consider declaring an outbreak over when the outbreak is coming under control. This can be determined by a decline in the number of new cases and sustained adherence to infection control outbreak measures through PPE, HH, environmental, and equipment cleaning audit results.

The medical officer of health or designate in collaboration with the OMT shall determine when to declare an outbreak over, taking into consideration the etiologic agent and the epidemiology of the outbreak.

Please note that the medical officer of health retains the final authority to determine if an outbreak is over.

Large LTCHs tend to have some sporadic influenza or respiratory infection cases in non-outbreak situations, as expected during the influenza season when influenza-like-illness is occurring in the community. The OMT needs to differentiate between these sporadic cases and outbreak-associated cases when identifying the last outbreak-related resident and staff case.

To declare an outbreak over, the LTCH must not have had any new cases of infection in either residents or staff, which meet the case definition for the period of time established by the OMT i.e., predetermined decision rules that the OMT has decided to use to declare the outbreak over. Commonly these decision rules are based on the period of communicability + the incubation period. However, depending on the organism, this can equate to a very long and disruptive period of time for the residents of a LTCH.

Hence, 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 or 3 days from last day of work of an ill staff, whichever is longer.

This “8 day rule” is based on the period of communicability and the incubation period for influenza and in general applies to many other respiratory viruses associated with respiratory infection outbreaks as well. Consider: if the outbreak were ongoing and the LTCH was performing active surveillance, new cases would be identified within this 8 day period, since 8 days is the outer limit of the period of communicability of influenza (5 days) plus one incubation period (3 days). Please refer to [Appendix 1](#) for additional information on incubation periods for other respiratory viruses.

If symptoms in the last resident case resolve sooner than 5 days, or if the last case is a staff member who was away from work (according to exclusion policy) throughout their period of communicability, the time until the outbreak can be declared over can be shortened accordingly.

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

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

Generally however, as mentioned, for practical reasons related to the impact on residents’ quality of life, the “8 days from the onset of symptoms of the last case” rule for declaring outbreaks over can be applied to outbreaks caused by other respiratory pathogens, at the discretion of the PHU. The rationale for applying the 8-day rule is that outbreaks caused by influenza tend to be of greater concern; complications of influenza have a greater impact on the elderly than other organisms.

The specific “formula” used to declare an outbreak over, will depend on these factors. PHUs can take a more conservative approach to declaring outbreaks over, depending on the profile of the outbreak.

For novel viruses, where the period of infectivity is unknown, the PHU may consider using two incubation periods to declare the outbreak over.

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

Step 9 - Complete the Outbreak Investigation File.

The outbreak file shall be reviewed to ensure that it contains the following:

- Copies of laboratory and other results.
- Copies of all minutes and other communications.
- Any other documentation specific to the investigation and management of the outbreak.
- A summary report.

Completion of the Final Report of an Institutional Respiratory Outbreak is to be done jointly by the LTCH and the health unit. Copies of all documents related to the outbreak are to be kept on file by the IPAC staff at the LTCH.

This could be an opportunity to review the outbreak, with all members of the OMT present. At this point, The OMT may make decisions about ongoing surveillance needs after declaring the outbreak over. Included are the following:

- Maintenance of general infection prevention and control measures as outlined in Step 2.
- Monitoring the status of ill residents, updating the line-listing and communicating with the health unit representative.
- Noting the number of deaths, if any, that occurred, including whether they had been a case, and informing the health unit representative.
- Noting spread among staff.

As well, following the outbreak, the LTCH should arrange a meeting with health unit staff to review the course and management of the outbreak. The purpose of this meeting is to review what was handled well and what could be improved for managing future outbreaks. A copy of this report should be provided to the infection control committee and a copy should be kept by the LTCH administration. As always, staff from a Regional Infection Control Network of Public Health Ontario (PHO) is also available to consult with LTC staff regarding improvements in IPAC programming.

4 Respiratory Outbreak Control Measures

Daily surveillance will help to identify symptomatic individuals and quickly detect patterns of spread that may indicate the start of respiratory outbreaks. Promptly declaring an outbreak will expedite the implementation of outbreak control measures that may help to bring the outbreak under control more quickly.

This section will cover respiratory infection outbreak control measures, excluding the use of antiviral medication. For antiviral treatment and prophylaxis recommendations during an influenza outbreak, please refer to section 4.6.

4.1 General Control Measures

4.1.1 Background

It is recognized that respiratory viruses, such as influenza, respiratory syncytial virus (RSV), parainfluenza, rhinovirus, adenovirus, etc. are primarily transmitted by large respiratory droplets. Some organisms can remain viable for up to 24 hours, after landing on hard surfaces. General control measures including environmental cleaning, wearing appropriate PPE, and HH will interrupt this mode of disease transmission.²⁰

The following recommendations regarding HH and use of PPE are taken from PIDAC documents:

- The Best Practices for [Hand Hygiene](#), April 2014.²¹
- [Routine Practices and Additional Precautions in All Health Care Settings](#), November 2012.²²
- Annex B, [Prevention of Transmission of Acute Respiratory Infection, March 2013](#).⁷
- Appendix D – Just Clean Your Hands, Best Practices for Hand Hygiene in All Health Care Settings, April 2014.²¹
- [Best Practices for Environmental Cleaning for Prevention and Control of Infections](#), May 2012.²³

For ease of use and convenience, *excerpts from the related PIDAC documents are included* here with reference to the source. The most current PIDAC documents are available at:

(http://www.publichealthontario.ca/en/BrowseByTopic/InfectiousDiseases/PIDAC/Pages/PIDAC_Documents.aspx).

4.1.2 Hand Hygiene

“The hands of health care providers are the most common vehicle for the transmission of microorganisms from [resident-to-resident], from [resident] to equipment and the environment, and from the environment to the [resident]. During the delivery of health care, the health care provider’s hands continuously touch surfaces and substances including inanimate objects, resident’s intact or non-intact skin, mucous membranes, food, waste, body fluids and the health care provider’s own body. The total number of hand exposures in a [LTCH] might reach as many as several tens of thousands per day. With each hand-to-surface exposure a bidirectional exchange of microorganisms between hands and the touched object occurs and the transient hand carried flora is thus continuously changing. In the way, microorganisms can spread throughout a health care environment within a few hours”.²¹

In LTCHs, retirement homes or other shared living facilities, health care associated infections have a significant impact on residents’ health and quality of life. In LTCHs and other health care settings, adherence to HH recommendations is the single most important practice for preventing the transmission of pathogens and directly contributes

to resident safety.²² Section 229 (9) of O. Reg. 79/10 of the *Long-Term Care Homes Act, 2007* requires licensees to ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents.

Alcohol-based hand rubs (ABHRs)

Alcohol-based hand rubs containing 70% alcohol are the preferred method of HH when hands are not visibly soiled. If there is visible soiling, hands must be washed with soap and running water. If soap and running water are not available, cleanse hands first with detergent-containing towelettes to remove visible soil, let hands dry and then use ABHR.²¹

Four Moments for HH:²¹

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

Box 10: Staff Hand Hygiene

Staff Hand Hygiene
<p>In addition to the four moments for HH, good staff HH practices include the following:</p> <ul style="list-style-type: none"> • HH after contact with items known or considered likely to be contaminated with blood, body fluids, secretions and excretions, including respiratory secretions (e.g. oxygen tubing, masks, used tissues and other items handled by the resident). • HH immediately after removing gloves and other PPE. • HH between certain procedures on the same resident where soiling of hands is likely, to avoid cross-contamination of body sites. • HH before preparing, handling, serving or eating food and before feeding a resident. • Avoid touching one's face and mucous membranes (including eyes) with hands.

If at all possible, HCWs should not wash their hands in a resident's washroom. If a resident's washroom is used, care must be taken to avoid hand contamination from the environment .e.g. taps. Using an ABHR after hand washing in this circumstance is recommended.

Box 11: Resident Hand Hygiene

Resident Hand Hygiene
<p>In addition to the four moments for HH, good resident HH practices include the following:</p> <ul style="list-style-type: none"> • Residents should be instructed in proper HH and assisted, as necessary. • Care of HH in residents is necessary at all times and especially during influenza season. • Resident hands should be washed after using the washroom and washed or sanitized frequently before and after meals. • HH before and after shared activities.

4.1.3 Personal Protective Equipment

PPE is used alone or in combination to prevent exposure, by placing a barrier between the infectious source and one's own mucous membranes, airways, skin and clothing. The selection of PPE is based on the nature of the interaction with the resident and/or the likely mode(s) of transmission of infectious agents. Selection of the appropriate PPE is based on the risk assessment (e.g., interaction, status of resident) that dictates what is worn to break the chain of transmission.²²

The selection of controls should be based on a hierarchy of controls approach. PPE ranks lowest in the hierarchy of controls. PPE is a last line of defense for workers against hazards related to infectious agents that cannot otherwise be eliminated or controlled.

LTCHs must ensure that staff has sufficient supplies of, and quick, easy access to, the PPE required. As well, LTCHs should provide education in the proper use of PPE to all health care providers and other staff who have the potential to be exposed to blood and body fluids.²²

LTCHs should also consider the requirement of the HCRF Regulation 67/93 section 10 in this regard, which states that:

10. (1) A worker who is required by his or her employer or by this Regulation to wear or use any protective clothing, equipment or device shall be instructed and trained in its care, use and limitations before wearing or using it for the first time and at regular intervals thereafter and the worker shall participate in such instruction and training.
- (2) Personal protective equipment that is to be provided, worn or used shall,
 - (a) be properly used and maintained;
 - (b) be a proper fit;
 - (c) be inspected for damage or deterioration; and
 - (d) be stored in a convenient, clean and sanitary location when not in use.

A. Gloves

When a resident is placed on Contact or Droplet-Contact precautions, gloves are used when direct care will be provided. In addition, gloves must be worn when it is anticipated that the hands will be in contact with mucous membranes, non-intact skin, tissue, blood, body fluids, secretions, excretions, or equipment and environmental surfaces contaminated with the above.²²

Indiscriminate or improper glove use has been linked to transmission of pathogens.

Gloves are task specific and single-use for the task.²²

Box 12: Appropriate Glove Use

Appropriate Glove Use
<p>Appropriate Glove Use²²</p> <ul style="list-style-type: none"> • Wear the correct size of gloves. • Gloves should be put on immediately before the activity for which they are indicated. • Clean hands before putting on gloves for a clean/aseptic procedure. • Gloves must be carefully removed and discarded immediately after the activity for which they were used. • HH must be performed immediately after glove removal. • Change or remove gloves if moving from a contaminated body site to a clean body site with the same resident. • Change or remove gloves after touching a contaminated site and before touching a clean site or the environment. • Do not wash or re-use gloves. • The same pair of gloves must not be used for the care of more than one resident. <p>PIDAC, Routine Practices and Additional Precautions in All Health Care Settings, November 2012.</p> <p>Additional considerations:</p> <ul style="list-style-type: none"> • Gloves should be used as an additional measure, not as a substitute for HH. • Gloves are recommended when providing care involving direct contact with an ill

Appropriate Glove Use

- resident.
- Gloves should fit the wearer properly.
- Gloves should be put on before entering and removed prior to leaving the resident's room or dedicated bed space.
- Gloves are task-specific and single-use for the task. Gloves should be changed between dirty and cleaner procedures on the same resident, e.g., after open suctioning of a tracheostomy and remainder of care.
- HH must be performed immediately after removing gloves.
- Gloves that fit snugly around the wrist are preferred for use with a gown because they will cover the gown cuff and provide a better barrier for the arms, wrists and hands.
- Single-use gloves must not be reused or washed.

B. Masks

A mask is used by a health care provider (*in addition to eye protection*) to protect the mucous membranes of the nose and mouth when it is anticipated that procedure or care activity is likely to generate splashes or sprays of blood, body fluids, secretions or excretions, or within two metres of a coughing resident.²²

Box 13: Appropriate Mask

Appropriate Mask Use

Appropriate Mask Use:²²

- Select a mask appropriate to the activity.
- Mask should securely cover the nose and mouth.
- Change mask if it becomes wet.
- Do not touch mask while wearing it.
- Remove mask correctly immediately after completion of task and discard into an appropriate waste receptacle.
- Do not allow mask to hang or dangle around the neck.
- Clean hands after removing the mask.
- Do not re-use disposable masks.
- Do not fold the mask or put it in a pocket for later use.

Additional Considerations:

- Masks are recommended when providing care involving direct contact with ill residents or when within 2 metres of coughing residents.
- For the care of a resident with respiratory illness, put a surgical mask on the resident, if tolerated, whenever the resident is not in his/her room (e.g. transfer to hospital). If masks are not available or not tolerated, residents should be encouraged to use another method to cover their mouth and nose when coughing or sneezing (e.g., tissue).
- Masks should be changed if they become wet, or contaminated by secretions.
- Staff wearing masks must remove their mask with clean hands before caring for another resident, and when leaving the residents dedicated environment.
- Masks should be handled only by the strings/ ties, to prevent self-contamination.

Appropriate Mask Use

- Masks should be changed according to the manufacturer's recommendations.
- HH should be performed before and after mask removal.

C. Eye Protection

Eye protection is used by health care providers (*in addition to a mask*) to protect the mucous membranes of the eyes when it is anticipated that a procedure or care activity is likely to generate splashes or sprays of blood, body fluids, secretions or excretions, or within two meters of a coughing resident.²²

Box 14: Appropriate Use of Eye Protection

Appropriate Use of Eye Protection

Appropriate Use of Eye Protection:²²

- Eye protection must be removed immediately after the task for which it was used and discarded into waste or placed in an appropriate receptacle for cleaning.
- Prescription eye glasses are not acceptable as eye protection.
- Select a mask appropriate to the activity.

Additional Considerations:

- If using a mask, eye protection is needed. However, if a face shield is being used, a mask is not required.
- Eye protection includes the use of safety glasses, goggles, and face shields. It does not include personal eye glasses.
- Eye protection should be worn where there is a potential for splattering or spraying of blood, body fluids, secretions or excretions, including cough producing aerosol-generating procedures, while providing direct resident care.
- Safety glasses, goggles and face shields should be removed carefully to prevent self-contamination.
- If re-used, eye protection should be cleaned in a manner that will not lead to contamination. The safety glasses, goggles, or face shields should be cleaned between uses according to the manufacturer's recommendations using a minimum of a low level disinfectant.
- To prevent self-contamination, HCWs should not touch their eyes during care of a resident with a respiratory illness.
- HH should be performed before and after removal of eye protection. Masks are recommended when providing care involving direct contact with ill residents or when within 2 metres of coughing residents

D. Gowns

A gown is recommended when it is anticipated that a procedure or care activity is likely to generate splashes or sprays of blood, body fluids, secretions, or excretions, or a resident is on contact or droplet/contact precautions and direct care will be provided.²²

Long-sleeved gowns protect the forearms and clothing of the health care provider from splashing and soiling with body substances during procedures and resident care activities which are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.²²

Box 15: Appropriate Gown Use

Appropriate Gown Use
<p>Appropriate Gown Use:²²</p> <ul style="list-style-type: none"> Gowns should only be worn when providing care for residents, as per the above indications. When use of a gown is indicated, the gown should be put on immediately before the task and must be worn properly, i.e., tied at the top and around the waist. Remove the gown immediately after the task for which it has been used in a manner that prevents contamination of clothing or skin and prevents agitation of the gown. Discard used gown immediately after removal into appropriate receptacle. Do not hang gowns for later use. Do not re-use gown. Do not go from patient-to-patient wearing the same gown. <p>Additional Considerations:</p> <ul style="list-style-type: none"> Gowns should be removed before leaving the residents' room or dedicated space.

It is important to remove (doff) PPE correctly (i.e. in the correct order) to prevent cross- contamination and the potential spread of infection from resident to resident. Doffing incorrectly also poses a risk of self-contamination.

4.2 Control Measures for Residents

As mentioned in the introduction, the recommendations contained in this document are intended to protect the health of resident populations. Recommendations are made in the interest of resident populations at risk. LTCH licensees are also required to fully respect and promote the individual resident rights as set out in the Bill of Rights under the LTCHA. The LTCH and PHU should work together to ensure that residents' rights under the LTCHA are fully respected and promoted, while implementing outbreak control measures that are protective to the resident populations and that are appropriate and proportional to the risk profile of the outbreak.

Consideration for *individual resident's* rights has always been important to PHU staff when providing outbreak management recommendations; however, health units, under the authority of the HPPA, make recommendations aimed at protecting the health of *resident populations* in LTCHs.

When communicating outbreak control measures and recommendations to the LTCH, health unit staff will need to emphasize the need for adherence to IPAC principles with respect to exceptional visit requests; LTCH staff should be advised to call the

local health unit on how to proceed, if there are any concerns regarding how to mitigate the infection control risks of a particular request from a resident/resident's family members /SDM. Examples include a request for allowing children to visit during an outbreak because they don't have child sized PPE or if a visitor wishes to visit numerous residents.

The LTCH infection control practitioner or the most responsible person should contact the local health unit in order to balance the needs of the resident against the risk to the health of the other residents; at this point, a discussion around if/how the request can be accommodated can take place.

When providing outbreak management recommendations, health units will have to assess the risk of non-compliance to outbreak control measures on the general resident population.

Generally, LTCHs and PHUs discuss with OMT members the respiratory infection outbreak control measures and decide jointly on appropriate measures to implement. The extent to which outbreak control measures can be implemented and what is considered reasonable throughout the course of each outbreak will vary. Examples of reasonable and appropriate measures during the course of an outbreak include:

- limiting visiting hours
- limiting the number of residents with whom the visitor has contact
- requiring anyone providing direct care (including visitors, other residents, etc.) to wear the necessary PPE
- requiring visitors or other residents to wear gowns, masks or other PPE, if they have an ARI and/or are leaving their room and/or are within 2 metres of others who are not wearing PPE;
- posting signs at entrances of LTCHs and/or affected unit/area, discouraging visitors during the outbreak period; and
- notifying persons of the outbreak.

However, under outbreak conditions that present a greater risk to the resident population of the LTCH, more restrictive control measures may be required and occasionally there may be a conflict relating to health unit recommended outbreak control measures. If the health unit assesses the risk of not complying with outbreak control recommendations to be high- that is, the probability of adverse health events to other residents, such as disease transmission, is high - the health unit may have to consider a written order from the Medical Officer of Health to the licensee of the LTCH to ensure compliance with outbreak control measures. Under these circumstances, it is reasonable and necessary for the Medical Officer of Health to issue an order under the HPPA to the licensee of the LTCH, to:

- stop admissions to the LTCH
- restrict resident movement to and from the home, or

- bar visitors from the home

These are fairly significant measures, and presumably lesser measures would be discussed and implemented before admissions would be banned or visitors barred completely from the LTCH.

4.2.1 Admissions and Returns from Absences

Generally, as an outbreak control measure, a health unit would advise against admission of new residents to a LTCH or unit/floor experiencing an outbreak. Furthermore, health units will need to be vigilant regarding admissions and those residents returning after absences to ensure that due diligence has been exercised by the LTCH in order to protect these residents and/or the residents with whom they may come into contact. Admissions and return from absence decisions should be made in consultation with the health unit. See below for factors to consider.

A comprehensive approach to new admissions or return of residents from hospitals back to the LTCH requires consideration of a number of factors and careful judgment with respect to risk to individual residents as well as patients in the larger context of health care. Restricting admissions to a LTCH in outbreak may create a backlog in emergency departments or acute care, with a risk to patients in that system. On the other hand, admission of an unexposed resident into a LTCH may put them at risk and may lengthen the duration of the outbreak, with an impact to the larger resident population. **Depending on the causative organism, the severity of the illness, the extent of the outbreak and the physical layout of the building, admission restrictions may or may not be** applied to one floor, one wing or the entire LTCH.²⁴ Therefore a measured and considered approach is required in consultation with the Medical Officer of Health.

An applicant to a LTCH cannot be removed from a waitlist for a LTCH where an outbreak of disease prevents the applicant from moving into the LTCH at the time that the CCAC offers to authorize the applicant's admission to the LTCH (*O. Reg. 79/10 s. 167*).

New Admissions and Return of Non-cases

From the perspective of susceptibility to disease transmission, the admission of new residents and return of residents who have not been line-listed in the outbreak (i.e. are not known cases) is *generally* not advised by a public health unit during an outbreak (see above discussion). If required, this recommended measure may be altered as the outbreak comes under control.

Changes in this recommended outbreak control measure must be considered carefully with respect to resident safety and quality of life, as well as system capacity. (See [Appendix 11 -Transfer and Return Algorithm for Use During Outbreaks](#)). Members of the OMT from the LTCH and PHU should discuss the situation and carefully consider

all relevant factors to assess if new admissions and/or return of non-cases are being considered, such as:

- What is the current status of the outbreak at the LTCH?
- Does the resident's attending physician at the hospital agree to the admission/return based on a review of the current health status of the resident? And are they aware of the outbreak?
- Is the resident protected from the outbreak pathogen through appropriate infection prevention and control measures? If the outbreak is due to influenza, is the resident protected by immunization and/or an antiviral drug?
- Are appropriate accommodations available for the returning resident? Will the resident return to an outbreak affected area of the LTCH?
- Has the resident or their substitute decision-maker been given information about the return to the LTCH?

Return of Cases

The return of residents, including those from hospital, who were line-listed and were part of the outbreak, is permitted provided appropriate accommodation and care can be provided; the working assumption is that the resident has been exposed to the causative organism and is now immune. If, however, the outbreak is laboratory-confirmed influenza, returning residents should be placed on antiviral prophylaxis medication in line with other residents.⁶

Absences from the LTCH in Excess of the Maximum Allowable Days Due to an Outbreak and Re-admissions

A resident who is away from the LTCH on a medical absence will have their bed held for them as long as the length of the medical absence does not exceed 30 days. In the case of a psychiatric absence, the bed will be held for up to 60 days.

If the resident's medical or psychiatric leave exceeds the maximum length identified above the resident will be discharged by the LTCH; they will then be placed in the re-admission category to return to that home which will give the resident priority for re-admission to the home when the resident is well enough to return. However, in the event that a resident cannot return to the LTCH because of an outbreak of disease in the home, the licensee of the LTCH is not permitted to discharge the resident and the resident will return to the home when the outbreak is declared over (O. Reg. 79/10 s. 146).

4.2.2 Restriction of Symptomatic Residents to Their Room

Cases (ill residents) should be encouraged to stay in their room, and should be on droplet and contact precautions until 5 days after the onset of acute illness or until symptoms have resolved (whichever is shorter). For some pathogens the period of communicability may be longer than 5 days, but for practical reasons, this could be

applied to outbreaks caused by respiratory viruses other than influenza. There may be some respiratory outbreaks for which longer isolation periods are required. This would occur in consultation with the OMT. For influenza, the recommendation to isolate residents to their rooms is due to the increased viral shedding that occurs when patients are symptomatic; restriction of ill residents to their room is recommended as long as it does not cause the resident undue stress or agitation. If, however, restriction causes undue stress or agitation, alternative control measures can be considered, including the use of a surgical mask and compliance with HH, at the discretion of the LTCH in consultation with the health unit.

Residents with an ARI who are not in single room accommodation can be managed in their bed space using Droplet and Contact Precautions with privacy curtains drawn, where these accommodations are available.²² However, residents may leave their room if they are able to comply with HH requirements and with the use of a surgical mask. This strategy may not work with all populations and its application is left to the discretion of the LTCH in consultation with the health unit.

4.2.3 Restriction of Residents to Their Unit

In some LTCHs, if ill residents cannot be contained in one geographical area of the LTCH, then the outbreak must be considered facility-wide. If cases are confined to one unit, all residents and staff from that unit should avoid contact with residents and staff in the remainder of the LTCH.²² Additional recreational activities/resources should be made available.

4.2.4 Communal Meetings

As much as possible, encourage symptomatic residents to stay within their own units within the home. It is always important to balance the rights of residents with the need to manage the outbreak. Previously scheduled events, (e.g. holiday events) may have to be rescheduled. The OMT should discuss restriction of activities, revisiting the issue as the outbreak progresses.

If possible, consideration should be given to planning events in such a way, e.g. to permit well residents to participate, according to geographical areas.

4.2.5 Medical Appointments

Non-urgent appointments made before the outbreak may be rescheduled at the discretion of the treating physician, with the consent of the resident/SDM, as long as the resident is not symptomatic.

4.2.6 Transfer to Hospital

It is the policy of the MOHLTC that no inter-facility patient transfer takes place without the sending facility first obtaining a Medical Transfer (MT) authorization number from the Provincial Transfer Authorization Centre (PTAC). This policy also applies to patients being transported from a healthcare facility to and from a private doctors' or

dentists' office for treatment. Of course, the policy does not apply to life threatening emergencies which DO NOT require authorization to transfer.

Before sending an ill resident to acute care, the facility should notify the receiving healthcare facility and the PTAC that the home is experiencing an outbreak.

To contact PTAC:

- call 1-866-869-PTAC(7822)
- <https://www.hospitaltransfers.com/transfer/>

If approved, an authorization number will be issued immediately and either sent on-line or by fax depending on the method used to obtain the MT authorization number from PTAC.

The goal is to protect sending and receiving facilities, paramedic and private transfer companies and the public by ensuring appropriate personal protective measures are taken thus containing any risk of spreading.

The hospital ICP must be provided with the details of the outbreak to ensure control measures are in place when the resident arrives at the hospital. The hospital ICP shall be informed of whether or not the resident to be transferred has been identified as a case. The outbreak transfer letter attached in [Appendix 10](#) can be used to provide the required information.

In addition, notifying the receiving hospital whether the transferred resident was or was not on the line list, allows the hospital to start discharge planning.

4.2.7 Transfer to another Long-Term Care Home

Symptomatic resident transfers (from anywhere in the home) to another LTCH are not recommended during an outbreak. The OMT should discuss exceptions to this recommendation and make decision on a case by case basis. All transfers must go through PTAC. Refer to the PTAC approval process above.

4.3 Control Measures for Staff and Volunteers

4.3.1 Reporting of Respiratory Illness

Staff, volunteers or contracted service workers with an ARI should not enter the LTCH; they should report any respiratory illness to their supervisor who shall report to the employee health nurse or the ICP.³

4.3.2 Exclusion of Staff, Students, and Volunteers, with an Acute Respiratory Infection

Staff, students, or volunteers with any respiratory infection symptoms should not return to work/placement for 5 days from the onset of symptoms of a respiratory illness or until symptoms have resolved whichever is shorter. If influenza is suspected or diagnosed, the person must remain off work/placement until the period of communicability (five days from the onset for influenza) has passed.³ This includes

staff on antiviral medication.

4.3.3 *Working at Other Facilities*

During **non-influenza outbreaks**, staff, students, and volunteers should be advised not to work/provide services at any other facility until one incubation period has passed.

During an **influenza outbreak**, assuming there is not a significant influenza vaccine drift, staff protected by either immunization or antiviral have no restrictions on their ability to work at other facilities. However, unimmunized 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 they are not incubating influenza. However, unimmunized staff on antiviral prophylactic therapy that wishes to work at another facility may do so, assuming the following considerations:

- They do not have a fever and/or other symptoms of ARI.
- This does not conflict with the policies of the receiving facility, as these would supersede the general direction provided here.
- This does not conflict with direction provided by the Medical Officer of Health or designate based on information available to them about the epidemiology of the outbreak or other local considerations.

Staff, students, and volunteers experiencing respiratory symptoms or fever should not work/provide services in any health care setting.³

If there is an identified “drift” or difference between vaccine strain components and circulating strains, in order for all staff to work between facilities, they would be required to start prophylactic antiviral treatment, regardless of immunization status.

4.3.4 *Cohort Staffing*

During non-influenza outbreaks, consider the possibility of one staff member looking after only ill residents and others looking after only well residents. Alternatively, consider the possibility of keeping staff members working on only one unit if possible. Attempts should be made to minimize movement of staff, students, or volunteers between floors/resident home areas, especially if some units are unaffected. These measures should not be required during influenza outbreaks where all staff are immunized or on an appropriate antiviral medication.²²

4.3.5 *Exclusion of Unimmunized Staff*

During a laboratory-confirmed influenza outbreak, only immunized staff who has been immunized at least two weeks prior to outbreak declaration should be working in the outbreak home. Unimmunized staff may resume work at the affected home as soon as they are taking antiviral prophylaxis. The home’s policy should require proof of taking the prescribed antiviral medication. If issues arise regarding compliance with work exclusions, options should be reviewed with the OMT.³

4.4 Control Measures for Visitors, Private Pay Caregivers, and Communal Activities

4.4.1 Notification of Visitors and Private Pay Caregivers

During a vaccine-preventable disease outbreak, such as influenza or pneumonia, all visitors/private pay caregivers should be encouraged to be immunized, as some residents may not be immunized, or may have waning protection from immunization.⁷ LTCHs shall post outbreak notification signs at all entrances to the home indicating the institution is in outbreak.

Visitors/private pay caregivers shall be advised of the potential risk of acquiring illness within the home, and the re-introduction of illness into the home, and of the visiting restrictions as indicated below. LTCHs may choose to notify families of the outbreak and the impact on visitation.

4.4.2 Visitor and Private Pay Caregiver Restrictions

Ill visitors/private pay caregivers shall not be permitted in the home, unless under extenuating circumstances. Under these circumstances, they should wear the appropriate PPE, perform HH upon arrival, as needed during their stay and when leaving both the room of the resident and the LTCH, and finally, they should restrict their visit to the resident.²²

Well visitors/private pay caregivers who choose to visit during an outbreak **and who are not going to be providing direct care** to an ill resident should be asked to:

- Perform hand hygiene when entering the LTCH, before entering and upon leaving the resident's room.
- Visit residents only in their rooms and avoid communal areas.
- If possible, visit only one resident and leave the LTCH immediately after the visit; if multiple residents are in the home but in different locations, it is recommended that the healthy resident(s) (non-outbreak case) be visited first.
- Not mingle with other residents.
- Wear personal protective equipment as needed, especially if providing direct care, such as toileting, to the resident.

In addition to these recommendations, well visitors who choose to visit during an outbreak **and are going to be providing direct care** to an ill resident should be asked to wear the appropriate PPE.

Moreover, the following recommendations apply regarding visitors restrictions:

- Notices shall be placed on the door of the rooms of ill residents or in other visible locations advising all visitors to check at the nursing station before entering the room. Visitors are to be advised of the above visitor restrictions.
- Ill residents should be visited in their room only.

Complete closure of a LTCH to visitation is not permitted unless there is an order issued by the Medical Officer of Health as it may cause residents and visitors emotional hardship. Under exceptional circumstances, the Medical Officer of Health may assess the risk to be significant such that it requires complete closure to visitors. In these circumstances, an order from the MOH to the licensee is required to ensure compliance. It is important to note however that even under these circumstances, that there are exceptional personal circumstances under which barring visitors is neither ethical nor permitted. In these situations, the LTCH must ensure full compliance with infection control requirements. Furthermore, decisions to restrict visitors with or without an order of the MOH may be challenged and therefore need to be carefully considered and implemented. Visitation restrictions should be discussed by the OMT.

4.4.3 Communal and Other Activities

The following should be implemented during an outbreak:

- Reschedule communal meetings on the affected unit/floor. However, other meetings or activities may proceed in non-affected areas;
- Discontinue group outings from the affected unit/floor;
- The OMT should discuss restricting meetings or activities in the entire LTCH if the outbreak spreads to two or more units/floors;
- Do not permit visits by outside groups, such as entertainers, volunteer organizations and community groups;
- Conduct on-site programs such as physiotherapy and foot care for residents in their rooms, if possible. Proper precautions should be taken for ill residents; and
- Ensure there is no interaction between the affected floor/unit and participants in on-site child-care or other day programs.

4.5 Cleaning

The principles of Routine Practices are based on the premise that all residents, their secretions, excretions and body fluids and their environment might potentially be contaminated with harmful microorganisms. By following simple preventive practices at all times regardless of whether or not an illness is 'known', staff will be protecting residents/visitors and themselves from an unknown, undiagnosed infectious risk.²³

During an outbreak there may be a requirement for additional or enhanced cleaning of a health care setting, in order to contain the spread of the microorganism causing the outbreak. Policies and procedures regarding staffing in Environmental Services (ES) departments should allow for surge capacity (e.g., additional staff, supervision, supplies, equipment) during outbreaks as determined by the outbreak management committee. The outbreak management committee should include, among other departments, representation from ES who will lead the coordination of the department's activities.²³

Health units and LTCHs should become familiar with PIDAC's [Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, May 2012](#).²³ This document will help health unit and LTCH staff assess the cleaning requirements:

- Frequency of cleaning is determined according to the Risk Stratification Matrix in Appendix B of PIDAC's [Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, May 2012](#).²³
- Recommended minimum cleaning and disinfection level and frequency for non-critical resident care equipment and environmental items, Appendix G of PIDAC's [Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, May 2012](#).²³

In addition, procedures for assigning responsibility and accountability of routine cleaning of all environmental surfaces and non-critical resident care items should be established.

4.6 Use of Influenza Antivirals

Vaccination is recognized as the cornerstone for preventing or attenuating the risk of influenza infection for those at high risk of serious illness or death from influenza and its complications.

Health care workers and their employers should actively promote, implement and comply with influenza immunization recommendations in order to decrease the risk of infection and complications among the vulnerable populations for whom they care. For immunization recommendations, please refer to the current season's [National Advisory Committee on Influenza \(NACI\)](#) statement of seasonal influenza vaccine.⁶

Antiviral prophylaxis should not replace annual influenza immunization.

Antiviral medication is recommended for the management of institutional outbreaks of influenza A and/or influenza B. Antivirals play a key role in outbreak management and control. Research has shown that antiviral drugs are effective for both the prevention (prophylaxis) and early treatment of influenza infection. The use of antiviral medication, in conjunction with other outbreak control measures, can quickly bring influenza outbreaks in health care facilities under control.²⁵ While influenza vaccination is adequate to protect healthy adults from illness due to influenza, vaccination provides incomplete protection to the elderly and the immunocompromised.⁶ Antiviral medications offer protection that is additive to that of annual influenza immunization in these populations. Antiviral medications are also effective in the prevention of influenza in unvaccinated healthy adults.²⁵

Three antiviral drugs are available in Canada for the treatment and prophylaxis of influenza in two classes: the M2 ion channel inhibitors (i.e. amantadine) and the neuraminidase inhibitors (i.e. oseltamivir and zanamivir).²⁵ Amantadine has not been recommended since 2006 for prophylaxis or treatment due to adverse side effects and the emergence of amantadine-resistant influenza A strains.²⁵

Decisions regarding influenza antiviral prophylaxis or treatment should be made based on current data of circulating influenza strains, including antiviral resistance. Testing of influenza isolates for antiviral resistance is performed as part of routine laboratory surveillance at the National Microbiology Laboratory (NML), and is reported by [PHO's Ontario Respiratory Virus Bulletin](#), the [Laboratory-Based Respiratory Pathogen Surveillance Report](#) and the national [FluWatch](#) report.^{1, 26, 27}

Health care providers are advised to refer to updates on influenza activity and antiviral resistance patterns in ongoing surveillance reports disseminated by Public Health Ontario reports mentioned above.

If antiviral drug resistance is detected or suspected in an institutional outbreak (e.g. if an outbreak appears poorly controlled despite proper antiviral use), or resistance has been reported in local community, local and provincial health authorities should be contacted for up-to-date advice on antiviral use.

4.6.1 Antiviral Medication Recommendations

Health units should be aware that clinical recommendations for the use of antiviral medications may change from season to season, as additional evidence becomes available. For example, oseltamivir dosing recommendations for influenza have changed for some groups (e.g., individuals with renal impairment) since the MOHLTC's release of dosing recommendations in 2010.

To ensure guidance related to the use of antivirals reflects the most up-to-date seasonal antiviral medication use recommendations, health units should be aware of the Association of Medical Microbiology and Infectious Disease (AMMI) Canada's current guidelines for the use of antiviral drugs for influenza.²⁵

- AMMI Canada is a national association that represents physicians, clinical microbiologists and researchers specializing in the fields of medical microbiology and infectious diseases and has published antiviral guidance for practitioners since the 2010/2011 influenza season.

In addition to AMMI, the current manufacturer's product monograph for antiviral medications makes recommendations for use in Canada for influenza. Currently, the manufacturer of Tamiflu™ (oseltamivir phosphate) is Roche Canada.²⁸

- The manufacturer publishes an updated product monograph when changes relating to recommended use of their products take effect.

The Tamiflu™ product monograph is located on the [Roche Canada website](#).²⁷

In addition, if information differs between AMMI and the product manufacturer, Public Health Ontario will provide advice to the field as to which recommendations to follow (i.e., the AMMI guidelines versus the product monograph) in relation to identified differences.

- Memoranda to health units about antiviral use for influenza will be issued

by the MOHLTC.

It is important to ensure that the most current guidelines/publications/product monographs are accessed as guidelines/publications/product monographs may be revised for each influenza season.

As always, clinical decisions regarding the use of medications for influenza treatment and chemoprophylaxis are at the discretion of the attending physician / health care provider.

4.6.2 Antivirals as Part of an Influenza Outbreak Preparedness Plan

- An outbreak plan should include measures that will expedite the administration of antiviral medication for staff and residents. Since treatment is most effective when started within 48 hours of symptom onset,²⁵ the following recommendations, excerpted from the Influenza Prevention and Surveillance Protocol for Long-Term Care Homes, September 2014, should be addressed in appropriate LTCH policies in preparation for an outbreak to ensure that there are no delays in providing influenza immunization and/or antiviral medication. For further direction, please see [Appendix 9 – Influenza Prevention and Surveillance Protocol for Long-Term Care Homes, September 2014](#).
- Consent for antiviral medication use should be obtained from residents or their substitute decision-makers in advance of each influenza season. For long-term care homes, this consent may be obtained at the same time that consent is obtained for influenza immunization.
- In long-term care homes, advance medical orders for influenza antiviral medication for residents should be obtained from medical staff at the beginning of each influenza season, or a plan should be in place to obtain physician's orders quickly in the event of an outbreak. Advance medical orders can substantially expedite administration of antiviral medications.
- Persons who are unimmunized against influenza for any reason should be informed that in the event of an outbreak, they may be given the option of taking anti-viral medication for the duration of the outbreak in order to continue their duties, or if unable or refuse to take anti-viral medication for the duration of the outbreak, they may be excluded from working in the LTCH depending on the policy of the LTCH.³
- To facilitate anti-viral treatment during outbreaks, persons who are unable to receive the influenza vaccine should be assessed for eligibility for anti-viral drugs such as oseltamivir or zanamivir prior to the influenza season. A record of this information should be kept on-hand at the LTCH to expedite timely implementation of anti-viral prophylaxis. In addition, persons who are not immunized, who conduct activities in the LTCH, and who are assessed as being able to take anti-viral medication, may wish to obtain and keep prescriptions on hand to assist with timely commencement of antivirals, in the event of an

influenza outbreak.³

- During the influenza season, LTCH administration must keep a current list of staff working in the LTCH who are not immunized, in order to promptly implement control measures such as antiviral prophylaxis and cohorting staff.³
- Staff that do not receive current seasonal influenza vaccine at the beginning of the influenza season (or when vaccine becomes available) should obtain a prescription for a neuraminidase inhibitor at the beginning of the influenza season. The LTCH should make staff aware of policies relating to health care worker influenza immunization status.
- The PIDAC document *Annex B: Prevention of Transmission of Acute Respiratory Infection in all Health Care Settings*, March 2013 recommends: “Annual influenza vaccination should be a condition of continued employment in, or reappointment to, health care organizations” (p. 29).⁷
- As soon as an outbreak of influenza is suspected, unimmunized residents and persons carrying on activities in the LTCH, who do not have contraindications to the vaccination, should be offered the vaccine. When an outbreak is declared, immunized persons carrying on activities in the LTCH may continue to work without disruption of their work pattern. Those who have not provided documentation of receipt of vaccine should be managed as unimmunized.³
- Unimmunized persons carrying on activities in the LTCH who refuse chemoprophylaxis during an outbreak should not provide resident care or conduct activities where they have a potential to acquire or transmit influenza.⁶ The LTCH may choose to exclude from work unimmunized persons carrying on activities in the LTCH, unless they take antivirals. Unimmunized persons carrying on activities in the LTCH who agree to be immunized during an outbreak but do not take antivirals may return to work 14 days following receipt of vaccine (the duration required to achieve vaccine-induced immunity). They may return earlier if they begin a course of anti-viral prophylaxis.³
- Newly immunized or unimmunized staff taking antiviral prophylaxis could continue their work without interruption.³
- Anti-viral drugs for persons carrying on activities in the LTCH require a prescription. All persons should try to use their own doctor for medical services. However in the event of an outbreak, to facilitate eligible staff with timely anti-viral medication (in situations where the medical assessment does not contraindicate such) the LTCH may wish to discuss with the LTCH physician(s)/nurse practitioners the opportunity for LTCH staff to access their medical services as applicable.³
- Unimmunized staff working in an outbreak LTCH can work in a non-outbreak or alternate healthcare setting if three or more days (one incubation period) have passed since their last day of activities in the outbreak LTCH.³

4.6.3 Antiviral Medication for Prevention (Prophylaxis)

During a public health-confirmed influenza outbreak, antiviral medication for prevention shall be offered to all residents/patients in the outbreak-affected area who are not already ill with influenza, whether previously vaccinated or not, **until the outbreak is declared over**.

- In addition, all unvaccinated asymptomatic staff who work in the area of the LTCH where the influenza outbreak is occurring should be advised to take prophylactic antiviral medication **until the outbreak is declared over**.

During a confirmed influenza outbreak, when the circulating strain is not well-matched by the vaccine, antiviral prophylaxis should be offered to all staff, regardless of vaccination status, until the outbreak is declared over. The local public health unit will notify the LTCH when this is necessary.

Antiviral prophylaxis should be initiated as soon as an influenza outbreak is declared. In almost all situations, it is prudent to wait for laboratory confirmation of influenza before initiating prophylaxis and treatment. Once the specimen reaches the appropriate laboratory, test results are usually available within one business day.

Institutions should consult with local public health unit representatives on the outbreak management team when starting antiviral prophylaxis and treatment.

Recommendations regarding influenza antiviral prophylaxis:⁶

- It is reasonable to allow unvaccinated staff to work with residents or patients as soon as they start antiviral prophylaxis. Unless there is a contraindication, consenting staff should also immediately be offered immunization against influenza with the current seasonal influenza vaccine.
- In healthy adults, it takes two weeks to develop antibodies to the influenza virus after receiving the influenza vaccine. Staff who have been vaccinated for less than two weeks at the time the influenza outbreak is declared should take antiviral prophylaxis for two weeks after vaccination or until the outbreak is declared over (whichever comes first). Note: Antiviral medications do not interfere with the immune response to vaccine.
- Staff should be alerted to the symptoms and signs of influenza, particularly within the first 4 days after starting antiviral prophylaxis. Staff illness should immediately be reported to the supervisor, ICP and/or occupational health. Staff reporting signs and symptoms of influenza should be excluded from working in any health care setting if symptoms develop. This information should be shared with the local public health representative.
- Prophylaxis may be discontinued once the outbreak is declared over.
- Prophylaxis may also be given during influenza season in non-outbreak institutional settings to unvaccinated individuals at high-risk of influenza-related complications, at the discretion of the treating physician.
- If a person taking a neuraminidase inhibitor (i.e. oseltamivir or zanamivir) for

prophylaxis of influenza develops symptoms of an influenza-like illness, the neuraminidase inhibitor can be continued, however, the neuraminidase inhibitor should be increased to the recommended treatment dose. Consideration should be given to obtaining a nasopharyngeal specimen if the individual has been on antiviral prophylaxis for more than four days (incubation period for influenza) to determine the presence of a resistant strain or another respiratory virus.

4.6.4 *Antiviral Medication for Treatment*

Treatment decisions for the residents/patients are the responsibility of the attending physicians. However, treatment decisions for health care staff that work in the LTCH rest with their health care provider and as such, obtaining prescriptions for antiviral treatment is the responsibility of the staff.³ See section 4.6.6 for payment information.

Treatment should be started within 48 hours (or less) of onset of symptoms for maximum effectiveness. This may also decrease complications of influenza infection.²⁵ Since treatment is most effective when started early, it is recommended that all long-term care homes have pre-authorized orders for antiviral medication for treatment and prophylaxis of residents, barring any contraindications, in the event of an outbreak, to ensure that there are no delays in providing medication. (Note: Refer to 4.6.2 above regarding consent.)

Recommendations regarding antiviral treatment:

- Antiviral treatment should be started for ill residents/patients (who meet the outbreak case definition), as soon as possible and preferably within 48 hours of symptom onset.²⁵ As much as possible symptomatic residents should be encouraged to remain in their rooms for the duration of antiviral treatment.
- Once an outbreak has been laboratory-confirmed as influenza, additional laboratory confirmation of each new case is not required in order to initiate antiviral treatment in individuals who meet the outbreak case definition.

Diagrams 1 and 2, below, provide additional detail on actions to take in cases where antiviral treatment is not initiated within 48 hours (Diagram 1), or in cases where treatment has been completed but an outbreak is still ongoing (Diagram 2).

Diagram 1: Antiviral Treatment Use Recommendation in Influenza Outbreaks. If Treatment is not Initiated Within 48 Hours of Symptoms Onset

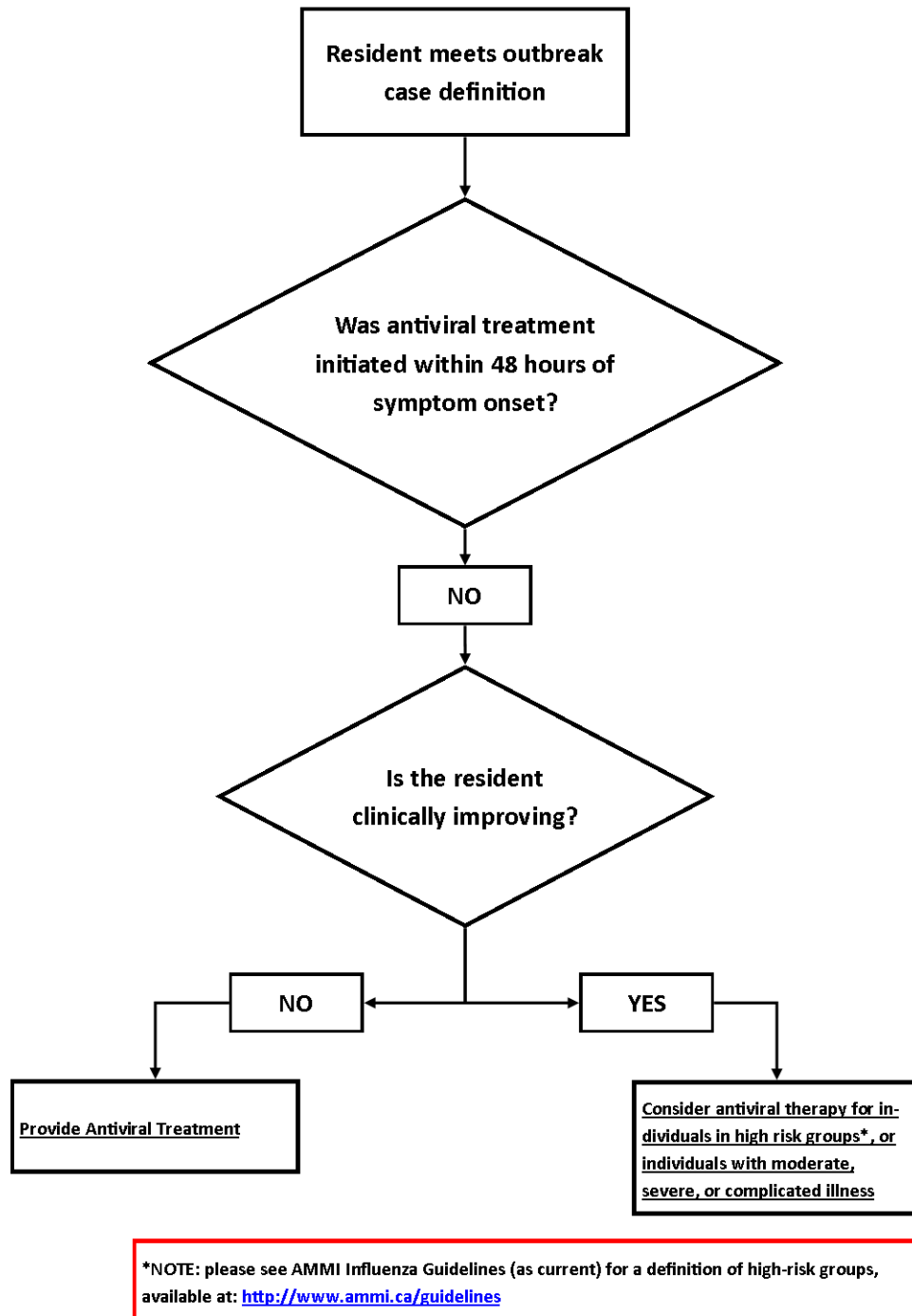
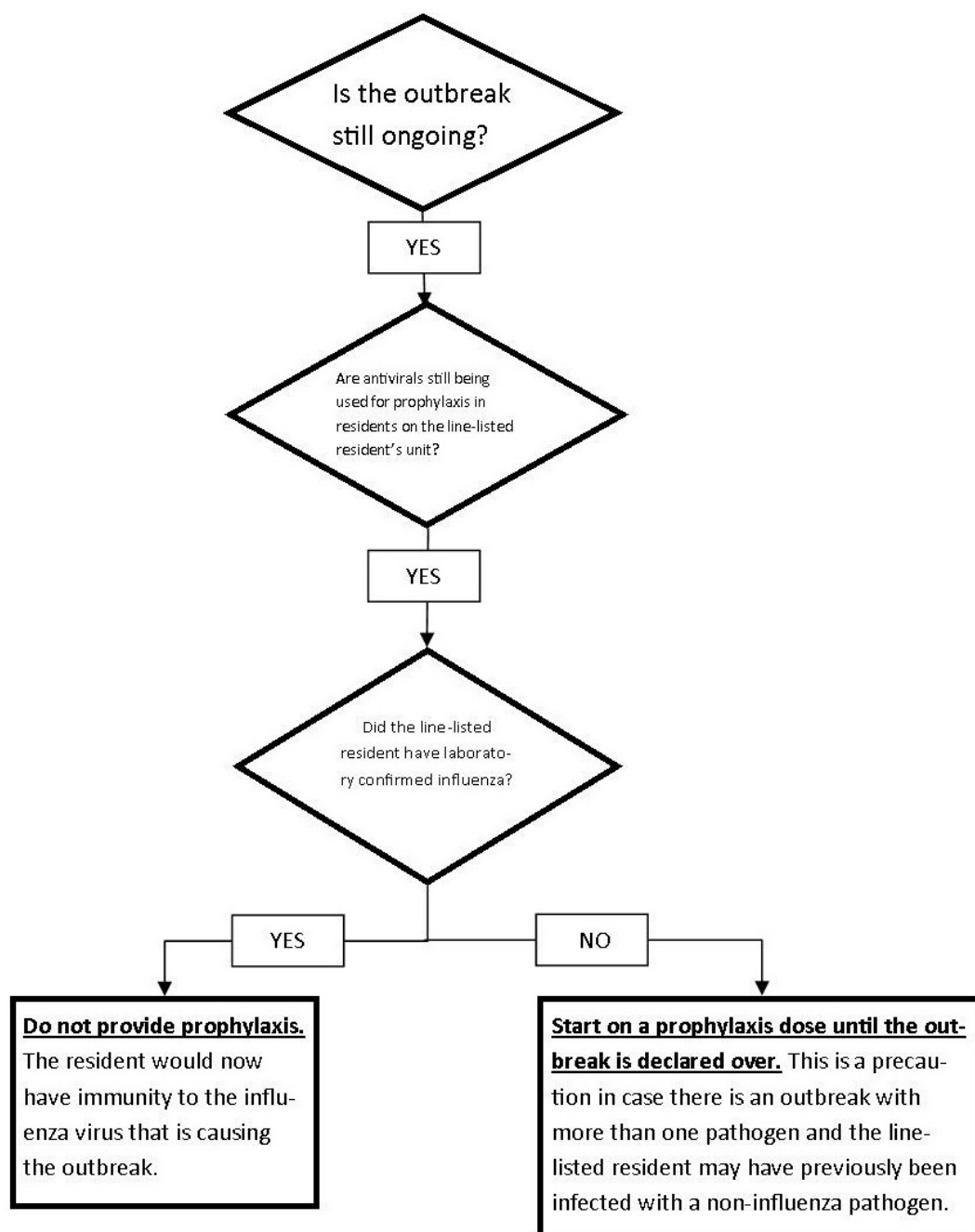


Diagram 2: Antiviral Prophylaxis Recommendations in Influenza Outbreaks for Line-listed Cases After Completion of Treatment with Antiviral Medication



4.6.5 When Antiviral Use Does Not Control the Outbreak

As discussed above, it is prudent to wait for laboratory confirmation of the causative agent of an outbreak before initiating antiviral prophylaxis or treatment. If new cases of influenza-like illness continue to occur 72-96 hours after the initiation of antiviral use, one or more of the following may be occurring:

- The new cases could be caused by an agent other than influenza (e.g. RSV);
- There may be compliance issues;
- Resistance to the antiviral medication may have developed in the circulating influenza strain (this is less likely with neuraminidase inhibitors oseltamivir and zanamivir)

In the event that the outbreak is not controlled with antiviral use, the following actions should be taken:

- Nasopharyngeal swabs should be obtained for virus detection from new cases, including staff cases.
- The health unit should consult with PHOL should the health unit wish to test additional samples using molecular testing
- The public health representative on the outbreak management team should be consulted regarding continued use of antivirals.
- Sensitivity testing may be done in consultation with the Public Health Ontario Laboratory if resistance is suspected and no other organism is identified in the outbreak. The results, however, may not be received within a time-frame to influence decision-making regarding the continued use of antivirals to control the outbreak. Health units should contact customer service at PHOL in the event that they want to perform sensitivity testing.

4.6.6 Procedures for Obtaining Reimbursement for Antiviral Medications from the Ontario Drug Benefit (ODB) Program

All LTCH residents are eligible for prescription drug coverage under the Ontario Drug Benefit (ODB) Program. Prescriptions for antiviral medications, as for all other medications, are the responsibility of the medical directors or attending physicians of the residents.

A searchable on-line ODB [eFormulary database](#) is available with information on the conditions for reimbursement of the neuraminidase inhibitors oseltamivir and zanamivir.

Health care workers are not eligible for prescription drug coverage under any circumstances from the ODB Program. Under very specific circumstances, immunized health care workers may be eligible for reimbursement through the High Intensity Needs Fund (HINF). In all other circumstances, health care workers are responsible for their own antiviral-related expenses.

Prescriptions for antiviral medications for staff, as for all other medications, are obtained from their health care provider or another source, as appropriate.

General information regarding the ODB Program is available at the [ODB Program](#).

Full details of the reimbursement criteria are below in Table 1. Reimbursement for residents/institutionalized individuals applies only during a public health-confirmed influenza outbreak for residents requiring treatment (up to five days of therapy) and for residents requiring prophylactic therapy (up to six weeks of therapy for prophylaxis).

Oseltamivir (Tamiflu®) Reimbursement²⁹

Oseltamivir is available as a Limited Use (LU) benefit and is the recommended drug of choice for both prophylaxis and treatment in an influenza outbreak. The MOHLTC reimburses LTCHs and other institutions for the use of oseltamivir for prophylaxis and treatment *only* during public health-confirmed influenza outbreaks. Refer to Table 1 for the clinical criteria to obtain reimbursement under the ODB Program.

Zanamivir (Relenza®) Reimbursement³⁰

Zanamivir is available as a LU benefit for both prophylaxis and treatment in an influenza outbreak when the predominant circulating strain is resistant to oseltamivir. Zanamivir is reimbursed in a similar manner when the predominant circulating strain is resistant to oseltamivir. Refer to Table 1 for the clinical criteria to obtain reimbursement under the ODB Program.

Amantadine reimbursement³¹

Amantadine is NOT currently recommended for prophylaxis or treatment due to its adverse side effects and the emergence of amantadine-resistant influenza A strains. Amantadine, however, is available as a General Benefit in the ODB Formulary.

Table 1: Limited Use (LU) Criteria for Oseltamivir (Tamiflu™) and Zanamivir (Relenza™)^{29,30}

LU Code	Drug	Clinical Criteria
371	Oseltamivir (Tamiflu®) 30mg, 45mg, 75 mg capsule	For the prophylaxis (max: 75 mg daily) of institutionalized individuals during confirmed outbreaks of influenza A or influenza B. Supply is limited to a maximum of 6 weeks. The outbreak must be confirmed by Public Health.
372	Oseltamivir (Tamiflu®) 30mg, 45mg, 75 mg capsule	For the treatment (max: 75 mg twice daily) of institutionalized individuals during confirmed outbreaks due to influenza A or influenza B. Supply is limited to 5 days. The outbreak must be confirmed by Public Health.
414	Zanamivir (Relenza) 5 mg inhalation	For treatment: 2 inhalations of 5 mg (10 mg) twice daily for 5 days. For the treatment of institutionalized individuals during confirmed outbreaks due to influenza A or influenza B when the predominant circulating strain is resistant to oseltamivir The outbreak must be confirmed by Public Health.
415	Zanamivir (Relenza) 5 mg inhalation	For prophylaxis: 2 inhalations of 5 mg (10 mg) once daily for 10 days For the prophylaxis of institutionalized individuals during confirmed outbreaks due to influenza A or influenza B when the predominant circulating strain is resistant to oseltamivir. The outbreak must be confirmed by Public Health.

Antiviral Limited Use process: individual prescription

Under the general LU process, an individual LU prescription must be completed for each patient and kept on file at the dispensing pharmacy. Note that the LU form has been discontinued; LU codes are now written directly onto the prescription.

Oseltamivir Only Limited Use process: institutional prescriptions

Recognizing that this could result in a delay in therapy in institutions with large numbers of residents, the MOHLTC has created an exception to this requirement for oseltamivir ONLY. The MOHLTC will accept a single LU prescription to be completed for multiple patients who require treatment or prophylaxis and meet one of the approved criteria. All institutions are eligible for the exemption provided the outbreak was confirmed by the MOH or the PHU.

Once confirmation of an outbreak is received and an attending physician decides to prescribe oseltamivir or zanamivir, the prescribing physician must complete a LU prescription by filling in the appropriate LU code, date, CPSO number and signing the form. The name of the home should be written in under "Patient's name". The completed LU prescription must then be attached to a list of affected patients and forwarded to the dispensing pharmacy. One LU prescription should be used for patients/residents requiring treatment and a separate LU prescription must be completed for patients/residents requiring prophylactic therapy during the influenza outbreak. The standard LU process (i.e. one completed LU prescription for each patient) is also acceptable.

APPENDICES

- [A- 1 Incubation Periods of Acute Respiratory Viral Infections](#)
- [A- 2 How to Take a Nasopharyngeal Swab](#)
- [A- 3 Sample respiratory Outbreak Sample Line Listing Form](#)
- [A- 4 Respiratory Outbreak Investigation Checklist](#)
- [A- 5 Sample Consent form – Pneumococcal Vaccination](#)
- [A- 6 Sample Consent form – Influenza Vaccination](#)
- [A- 7 Sample Staff Letter to Physicians Regarding Antiviral Prophylaxis for Staff in LTCHs](#)
- [A- 8 Sample Home Exclusion Policy Content](#)
- [A- 9 Influenza Prevention and Surveillance Protocol for Long-Term Care Homes, Sept. 2014](#)
- [A- 10 Outbreak Transfer Notification](#)
- [A- 11 Sample Transfer and Return Algorithm during Outbreaks](#)
- [A- 12 Sample Language for Returning to a Long-Term Care Home during an Outbreak](#)
- [A- 13 Resources and Useful Links](#)

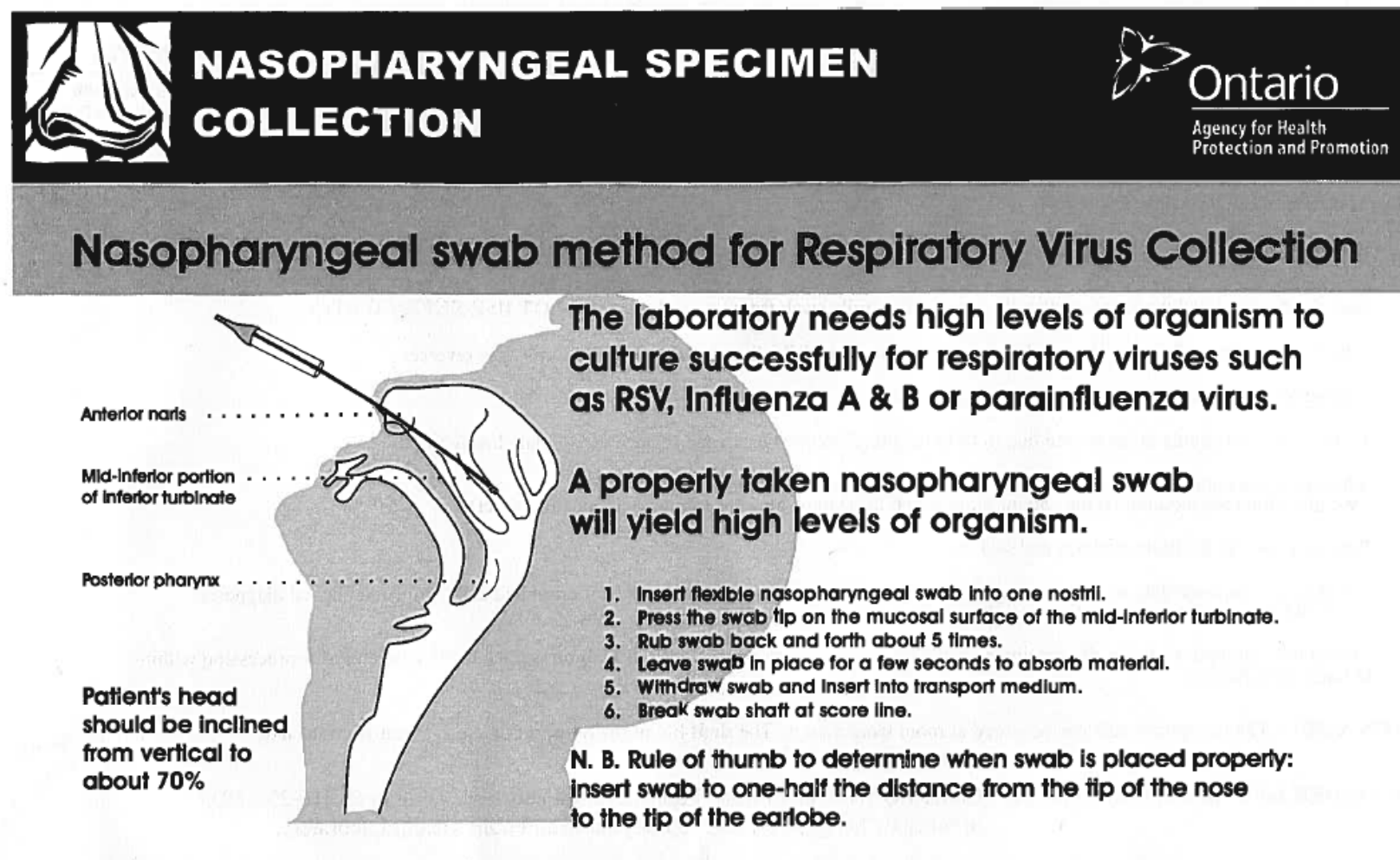
Appendix 1 - Incubation Periods of Acute Respiratory Viral Infections

Table 2: Incubation Periods of Acute Respiratory Viral Infections

Virus	Incubation (range) ³²	Shedding/potential infectious period	Comments
Influenza	1-4 days	Usually 5 to 10 days, peak at 24 to 48hrs	The immunocompromised may shed virus for months.
RSV	3-7 days	Usually 3 to 8 days; up to 3-4 weeks in children and immunocompromised	Acute phase of illness 3 to 10 days.
Human Metapneumovirus	Not known (4-9 days?)	Shed for 1 to 2 weeks	Similar to RSV; the immunocompromised may shed virus for months
Rhinovirus	2-4 days	1 to 3 weeks; peak days 2 to 3 of illness	Immunocompromised may shed for months.
Adenovirus	4-8 days	Days to weeks	Immunocompromised may shed for months.
Parainfluenza virus	2-6 days	Up to 10 days in children	Shorter duration of shedding in elderly
Bocavirus	Not established	Duration of shedding variable: 50% <1 week, 25% over one month (1 record of 402 days).	Not firmly established as a respiratory pathogen. Role in respiratory infection remains under investigation
Human Coronaviruses (229E, OC43, HKU1, NL63)	2-5 days	Peak shedding occurs during days 2 to 3 of illness	
SARS Coronavirus	2-10 days	Peak shedding and transmission occurs during week 2 of illness. Maximum communicability is less than 21 days.	May be detectable week 3 to months after illness onset

Appendix 2 - How to Take a Nasopharyngeal Swab³³

Figure 1: How to Take a Nasopharyngeal Swab



Appendix 4 - Respiratory Outbreak Investigation Checklist

Table 3: Respiratory Outbreak Investigation Checklist

Outbreak Investigation Action	Date Completed
Is there a suspected outbreak and has an assessment been conducted?	
Have general infection prevention and control measures been implemented?	
Has the local Medical Officer of Health or designate been notified?	
Has an outbreak investigation laboratory number been obtained from the health unit?	
Have appropriate individuals associated with the LTCH been notified of the suspected/confirmed outbreak?	
Has an initial OMT meeting been set which will address the establishment of a working case definition for the outbreak, review of control measures and confirming communication issues and systems?	
Has the communication of laboratory results been reviewed?	
Have organism specific control measures for influenza A or B been reviewed and implemented (if appropriate to do so)?	
Has the responsibility for ongoing monitoring of the outbreak been established?	
Have the criteria to declare the outbreak over been confirmed?	
Have the individuals who were notified of the onset of the outbreak been notified that the outbreak has been declared over?	
Once the outbreak has been declared over, has the outbreak summary report been completed?	
Has a post outbreak review meeting been set to review the management of the outbreak?	

Appendix 5 - Sample Consent Form – Pneumococcal Vaccination

To be used in conjunction with fact sheets on pneumococcal vaccines.

Consent for Pneumococcal Vaccination

I _____ (Resident/Substitute decision-maker) have been informed of the treatment, benefits, contraindications and side effects to the administration of a dose of pneumococcal vaccine and understand the procedure. I give consent to the administration of a dose of the pneumococcal vaccine to _____ (Resident) by a registered nurse or attending physician

Signature of resident/substitute decision-maker giving consent

Date

Appendix 6 - Sample Consent Form – Influenza Vaccination

To be used in conjunction with fact sheets on the influenza vaccine.

Consent for Annual Influenza Vaccination

I _____ (Resident/Substitute decision-maker) have been informed of the treatments, benefits, contraindications to the administration of the influenza vaccine every autumn and understand the procedure and its side effects. I give consent to the administration of the influenza vaccine to _____ (Resident) by a registered nurse or attending physician. I understand that the vaccine will not be given if the resident has a contraindication to receipt at the scheduled time of administration of the vaccine.

Signature of resident/substitute decision-maker giving consent

Date

Please return this form promptly by mail or in person. Telephone consent may be given.

Appendix 7 - Sample Letter to Physicians Regarding Antiviral Prophylaxis for Staff in LTCHs

Dear Doctor,

- (staff member's name) is a LTCH employee who has chosen not to be immunized against influenza this year. In the event of influenza outbreak in the LTCH this employee, in accordance with the home's exclusion policy will not be allowed to return to work until the outbreak is declared over by the Medical Officer of Health or designate or unless he/she is taking antiviral prophylaxis for influenza.

Please provide a prescription for the recommended medication for influenza

prophylaxis. Oseltamivir (Tamiflu™)-

Zanamivir (Relenza™)-

If you have any questions, please contact the local Public Health office.

Appendix 8 - Sample Home Exclusion Policy Content

Points to consider in the development of an exclusion policy:

- How and when the exclusion policy comes into effect
- Who falls under the definition of staff
- Consequences of failure to comply
- Managing shared staff working in a home with a declared outbreak
- Length of exclusion time clearly defined when staff are not on an antiviral drug
- How to verify staff are taking the antiviral
- How staff will be educated and updated regarding the policy requirements
- Obtaining antiviral prescription pre-season from staff member's health care provider (as per [Appendix 7](#))
- Define Human Resource issues, e.g. time off designation, cost of antivirals.

Appendix 9 - Influenza Prevention and Surveillance Protocol for Long- Term Care Homes, September 2014

1) Disclaimer

This document is a surveillance protocol under s. 229 (7) of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007 and does not constitute legal advice. This document 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 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.

2) Introduction

This is a surveillance protocol under s. 229(7) of O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007* (LTCHA). All LTCH licensees are required to implement this protocol.

This protocol was developed to ensure that those at greatest risk of complications and death from influenza, including individuals with fragile health in Long-Term Care Homes (LTCHs), are optimally protected through the appropriate use of influenza vaccine.

This protocol requires LTCH licensees to develop an influenza policy for the surveillance, prevention and control of influenza and the reporting of immunization coverage to the Local Medical Officer of Health. (*Refer to A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes section 2.1.3 Policy and Procedure Preparation*)

This protocol does not address other preventive measures such as anti-viral drugs or infection prevention and control measures, for this and other information the reader is referred to existing Ministry documents and other guidelines^{1,2}.

3) Definitions

In this protocol,

“**staff**” has the same meaning as under the LTCHA. Subsection 2 (1) of the LTCHA defines staff as follows:

“staff, in relation to a long-term care home, means persons who work at the home,

- a) as employees of the licensee,
- b) pursuant to a contract or agreement with the licensee, or
- c) pursuant to a contract or agreement between the licensee and an employment agency or other third party;

“licensee” has the same meaning as under the LTCHA. Subsection 2 (1) of the LTCHA defines licensee as follows:

“licensee” means the holder of a licence issued under this Act [LTCHA], and includes the municipality or municipalities or board of management that maintains a municipal home, joint home or First Nations home approved under Part VIII”.

“long-term care home” (LTCH) has the same meaning as under the LTCHA. Subsection 2 (1) of the LTCHA defines long-term care home as follows:

“long-term care home” means a place that is licensed under this Act [LTCHA], and includes a municipal home, joint home or First Nations home approved under Part VIII.

“private pay caregiver” means a person who is hired directly or indirectly by a resident, or a person acting on behalf of a resident as the case may be, to provide care or companionship to the resident.

“resident” has the same meaning as under the LTCHA. Subsection 2(1) of the LTCHA defines resident as follows:

“resident” means a person admitted to and living in a LTCH

“visitor” means a person who attends at a LTCH but is not staff, a volunteer or a private pay caregiver.

“volunteer” has the same meaning as under the LTCHA. Subsection 2(1) of the LTCHA defines volunteer as follows:

“volunteer” means a person who is part of the organized volunteer program of the long-term care home under section 16 [of the LTCHA] and who does not receive a wage or salary for the services or work provided for that program.

4) Influenza

Influenza is an acute viral disease of the respiratory tract characterized by fever, headache, myalgia, prostration, sore throat and cough. Measures for influenza prevention are important due to the rapidity with which epidemics evolve, widespread morbidity, and the seriousness of complications, notably viral and bacterial pneumonia. During epidemics, severe illness and deaths occur, primarily among the elderly, children, and those with medical conditions. Attack rates during epidemics vary from 10% to 20% in the general population (National Advisory Committee on Immunization (NACI)). In closed populations such as LTCHs, they can be higher than 50%, as LTCH residents are at high risk of developing serious, sometimes fatal, complications related to influenza.³

Vaccination of persons each year, before the influenza season, is currently the most effective measure for reducing the impact of influenza, especially for persons at high risk of complications, and for people who are potentially capable of transmitting influenza.⁴ LTCH licensees shall ensure that the use of appropriate anti-viral drugs

such as oseltamivir or zanamivir are taken into consideration as a supplementary measure in specific circumstances, such as where vaccination is not medically possible.

In a season when the circulating influenza viruses and the vaccine are well matched, influenza vaccination will prevent illness in 60 to 80% of healthy young adults. In elderly populations, the inactivated vaccine can reduce disease severity and incidence of complications by 50 to 60% and death by up to 80%.⁵ The efficacy of the vaccine in preventing illness is only 30 to 40% among elderly residents of LTCHs. However, among these persons, the vaccine will prevent 50 to 60% of hospitalizations and pneumonia, and up to 85% of deaths.⁴

A 44% reduction in influenza mortality among residents of geriatric medical long-term care sites has been noted following an intensive campaign to immunize health care workers (HCWs).⁶ More recently, HCW vaccination has also demonstrated a shielding effect against hospital-acquired influenza in acute-care hospital patients.⁷ The vaccine has also been shown to be effective in reducing absenteeism and febrile respiratory illness among HCWs and other working adults.^{8, 9}

Annual immunization is necessary because the vaccine is updated each year in response to changes in the influenza virus. Secondly, antibody titres that an individual might have achieved from the previous year's vaccination will have waned requiring a booster dose of the current year's vaccine. Protection from the vaccine generally begins about 2 weeks after immunization and may last 6 months or longer in healthy, young individuals. Among the elderly, antibody levels decline below protective levels in 4 months or less.¹⁰ The recommended time for influenza immunization is from October to mid-November, before the influenza season begins.

5) Purpose of the Protocol

The purpose of this protocol is to:

- Provide direction to LTCH licensees for preventing influenza virus infections among residents, staff, and other persons carrying on activities in the LTCH;
- Prevent the transmission of influenza virus among residents and persons carrying on activities in the LTCH; and
- Reduce morbidity and mortality among residents who contract influenza.

6) Applicability of the Protocol

This protocol applies to all LTCH licensees as well as the residents, staff, private pay caregivers and volunteers of LTCHs.

7) Immunization

Residents

Prior to admission, Community Care Access Centres (CCACs) are required, as part of the eligibility determination process, to complete a health assessment for each

applicant that includes information about immunizations. In the situation where a LTCH does not have this information, LTCH licensees shall ensure that each resident is assessed upon admission regarding immunization and medical status. Based on the assessments, LTCH licensees shall ensure that residents are offered immunization against influenza at the appropriate time each year. In addition, LTCH licensees must offer residents immunizations against pneumococcus, tetanus, and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.¹ (*Refer to paragraphs 3 and 4 of s. 229(10) of O. Reg. 79/10 under the LTCHA*)

Consent

Obtaining consent for LTCH residents is governed by the *Health Care Consent Act, 1996* (HCCA). The HCCA is the legislation that governs health practitioners proposing treatment for a person, including a "course of treatment" and a "plan of treatment." The HCCA defines "treatment," "course of treatment," and "plan of treatment."

Administration of an influenza vaccine falls within the definition of "treatment" and may also be a "course of treatment" or fall within a "plan of treatment." Under the HCCA, it is the responsibility of the health practitioner to obtain informed consent from a person before administering the annual influenza vaccination or antiviral medication (where needed) or, if the health professional is of the opinion that the person is incapable, informed consent from the person's Substitute Decision Maker (SDM). The content of consent can vary and a health practitioner cannot rely on a consent that does not comply with the definition of informed consent in the HCCA. A resident/SDM may also withdraw consent at any time pursuant to the HCCA. For further information related to informed consent, LTCH licensees may wish to consult with their respective legal counsel relating to this issue, including the development of a process to obtain consent for the influenza vaccine and/or antiviral treatments.

It is necessary that health care professionals check for changes to the resident's health status that might represent contraindication to the influenza vaccine or antiviral medication before any dose is administered, as they would with any other medication or vaccine.

In cases where consent for the resident to be immunized is not obtained, the resident must be assessed by the health care professionals for eligibility for antiviral drugs such as oseltamivir or zanamivir, or alternative influenza prophylaxis treatment prior to the influenza season, in the event of an influenza outbreak.

LTCH licensees shall ensure that at the appropriate time each year each resident is offered influenza vaccine and, with informed consent, the current season's influenza vaccine is administered to the resident prior to or during the influenza season, unless a medical contraindication exists/develops or consent is withdrawn.

If a resident is admitted during influenza season (approximately November through April) and has no record of receipt of the current season's influenza vaccine, LTCH

licensees shall ensure that the resident is offered influenza vaccine and, with informed consent, the vaccine is administered to the resident upon admission.

LTCH licensees shall ensure that the immunization records of residents are retained in a readily accessible part of their health record.

Staff

LTCH licensees must ensure that there is a staff immunization program in place in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. *(Refer to paragraph 5 of s.229(10) of O. Reg. 79/10 under the LTCHA)*

Based on current evidence^{12,13} LTCH staff who consent are required to have an annual influenza vaccination, subject to medical contraindication. LTCH licensees shall ensure that the required surveillance, prevention and control of influenza policy outlines how to manage staff who have a medical contraindication to, or refuse the influenza vaccination, in the event of an influenza outbreak. LTCH licensees shall ensure that information about the requirement to have an annual influenza vaccination is provided to all staff at the time of hiring and thereafter at the appropriate time each year.

In addition, if the time of hiring or placement occurs during the influenza season, the LTCH licensee shall ensure that the person responsible for coordinating the infection prevention and control program in the LTCH asks any new staff for evidence of immunization with the current year's influenza vaccine.

LTCH licensees shall ensure that only the following are accepted as proof of influenza immunization:

- A personal immunization record (e.g., Ontario Yellow Card) documenting receipt of the current season's influenza vaccine
- A record of immunization from a health care provider (e.g., pharmacist, physician or public health unit immunization clinic) documenting receipt of the current season's influenza vaccine.

If this documentation is not available, LTCH staff who consent are required to have an influenza vaccination, subject to medical contraindication.

Staff who are unable to receive influenza vaccination due to medical contraindications *(Refer to section 2.1.1 Immunization of 'A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes')* shall provide medical documentation of their contraindication.¹ LTCH licensees shall ensure that a written record is kept of this information on file in the LTCH for future reference. LTCH licensees must ensure that vaccines are offered in subsequent years to persons who decline influenza vaccination but have no medical contraindications and that a written record of the staff influenza vaccination refusal, without medical contraindications, is kept on file in the LTCH for future reference.

LTCH licensees shall ensure that staff who are unimmunized against influenza for any reason are informed of the options available to them in the event of an outbreak, as outlined in the LTCH's influenza policy or the staff member's collective agreement (e.g. taking anti-viral medication, or being excluded from working in the LTCH for the duration of the influenza outbreak).

During the influenza season, LTCH licensees shall ensure that a current list of staff in the LTCH who are not immunized is kept, in order to promptly implement control measures such as antiviral prophylaxis and cohorting staff. In addition, staff who are not immunized and who are assessed as being able to take anti-viral medication may wish to obtain and keep prescriptions on hand to assist with timely commencement of antivirals, in the event of an influenza outbreak.

Private Pay Caregivers

LTCH licensees must ensure that the immunization program in place addresses how to manage private pay caregiver immunization, including how to manage private pay caregivers who have a medical contraindication to, or refuse the influenza vaccination, in the event of an influenza outbreak.

Upon notification of the commencement of a private pay caregiver in the LTCH, the person responsible for coordinating the infection prevention and control (IPAC) program in the LTCH shall provide the private pay caregivers information about the importance of annual influenza vaccination at the appropriate time each year, and ask the caregiver for his/her immunization status with the current year's influenza vaccine. In accordance with the influenza policy of the LTCH, the private pay caregiver will be given information related to how the private pay caregiver will be managed in the event of an outbreak. Private pay caregivers who are unimmunized against influenza for any reason shall be informed of the options available to them in the event of an outbreak, as outlined in the LTCH's influenza policy (e.g. taking anti-viral medication, or being excluded from working in the LTCH for the duration of the influenza outbreak). Based on the immunization status of the private pay caregiver, the person responsible for coordinating the IPAC program shall advise the private pay caregiver to inform the resident/SDM of any potential negative effect, e.g. disruption of service that may occur in the event of an influenza outbreak.

Similar to staff, the LTCH licensee shall ensure that only the following are accepted as proof of influenza immunization:

- A personal immunization record (e.g., Ontario Yellow Card) documenting receipt of the current season's influenza vaccine
- A record of immunization from a health care provider (e.g., pharmacist, physician or public health unit immunization clinic) documenting receipt of the current season's influenza vaccine

The person in charge of the IPAC program shall ensure that a current list of private

pay caregivers in the LTCH who are not immunized is kept, in order to implement measures as outlined in the LTCH's influenza policy related to private pay caregivers.

Volunteers and Visitors

LTCH licensees shall ensure that volunteers and visitors are encouraged to be immunized against influenza prior to the start of Influenza season each autumn and advised to defer their visit if they are ill with influenza-like illness, especially during a declared outbreak. However, it is not the responsibility of LTCH licensees to verify the immunization status of these persons beyond providing information on the importance and role of vaccination and where they may get vaccinated. For further information please see *A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes*, 2014 (or as current).¹

Annual Vaccination Scheduling

Residents

Residents must be offered immunizations against influenza at the appropriate time each year. (*O. Reg. 79/10 s.229 (10)2.*)

Staff, Private Pay Caregivers, Volunteers and Visitors

Availability of on-site vaccination clinics for all staff, private pay caregivers, volunteers and visitors is recommended to provide optimal access to immunization services. LTCH licensees shall ensure that a record of immunized residents and staff is completed annually by mid- November (and updated as applicable) and is reported to the local Medical Officer of Health by December 15th. If the information is available, it is recommended that the record of immunized individuals also include private pay caregivers, volunteers and visitors. In seasons when influenza activity starts earlier, such as in late September, the Medical Officer of Health may recommend completing influenza immunization, as much as possible, earlier than mid- November, dependent on vaccine availability.

Valid medical exemptions to influenza immunization

Influenza vaccine should not be given to persons who had an anaphylactic reaction to a previous dose or any component of the influenza vaccine with the exception of egg. With careful review of the literature, the NACI, an expert group on immunization, concluded that egg-allergic individuals may safely receive the influenza vaccine under the following conditions:

- Those with mild reactions such as hives, or those who tolerate eggs in baked goods may be vaccinated in a regular immunization clinic;
- Those who have suffered from anaphylaxis with respiratory or cardiovascular symptoms should be vaccinated in a medical clinic, allergy office or hospital where appropriate expertise and equipment to manage respiratory or cardiovascular compromise is present.¹¹

8) Requirement for LTCH Influenza Policy Relating to the Surveillance, Prevention, and Control of Influenza and for Reporting of Immunization Coverage to the Local Medical Officer of Health

LTCH licensees shall ensure that there is a written influenza policy that includes the following and that the policy is complied with:

- Surveillance - early recognition of infectious conditions and potential for transmission
- Prevention
- Educational requirements for residents and staff, and education for private pay caregivers, volunteers and visitors, as appropriate
 - include the identification of staff with competencies related to correct technique for the collection of nasopharyngeal specimens
- Outbreak management including:
 - investigation and control
 - the composition and mandate of the outbreak management team
 - how to manage staff, private pay caregivers and volunteers who have a medical contraindication to, or refuse the influenza vaccination, in the event of an influenza outbreak, and
 - visitation
- Immunization requirements, including offering the vaccine to unimmunized persons when an outbreak is declared
- Antiviral use for unimmunized persons during an influenza outbreak, e.g. appropriate use, obtaining informed consent from residents/SDMs, obtaining medical directive signed by Medical Director for antiviral prophylaxis, payment and reimbursement processes (if applicable), as well as indications for oseltamivir (Tamiflu™) and zanamivir (Relenza™)
- Reporting requirements, including:
 - early reporting of suspected influenza;
 - reporting of individuals immunized to local PHU, etc.
- Communication requirements including:
 - processes between the LTCH, the local Medical Officer of Health and the laboratory used by the LTCH; and
 - effective communication with residents/substitute decision makers (SDMs), families of residents, staff and the media in the event of an outbreak
- Exclusions Including:
 - LTCH's direction to be taken during an outbreak as it relates to

unimmunized staff persons (e.g. if unable/unwilling to take antiviral medication) *[Note: For further guidance on developing exclusion policies, please refer to A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes, Appendix 8]*

- Staffing plans:
 - A staffing plan to address adequate staff to resident ratios as workload increases during an outbreak
 - A staffing contingency plan addressing varying levels of available staff during outbreaks due to illness, failure to immunize, unwillingness or contraindication to antiviral agents
 - The staffing plans need to address continued provision of care and full implementation of infection control measures

The influenza policy must be based on evidence based practice and, if there are none, in accordance with prevailing practices. *[Note: The recommendations contained in this document are based on current evidence and best practice as of August 2014. The local public health department and laboratories will have or be able to access current information.]*

The LTCH licensee shall ensure that the designated LTCH staff member who co-ordinates the Infection Prevention and Control (IPAC) program:

- Provides or co-ordinates education annually on the influenza policy to staff, residents, and appropriate educational materials to private pay caregivers, volunteers and visitors, as applicable
- Maintains resident, staff and private pay caregivers influenza immunization records
- Co-ordinates specimen collection and laboratory testing to rapidly access specimen kits, testing facilities, and results of laboratory tests in the event of a suspected outbreak
- Reports outbreaks of reportable or communicable disease as defined in the HPPA to the Director under the LTCHA (O. Reg. 79/10, s.107(1)5)

9) Exposure to Influenza during an Outbreak

Immunized Staff, Private Pay Caregivers and Volunteers

When an outbreak is declared, immunized staff, private pay caregivers and volunteers may continue to work/provide service without disruption of their work/service pattern. Those who have not provided documentation of receipt of vaccine should be managed as unimmunized.

Unimmunized Residents and Staff

As soon as an outbreak of influenza is suspected, LTCH licensees shall ensure that unimmunized residents and staff, who do not have contraindications to the vaccination, are offered the influenza vaccine.

Unimmunized Staff, Private Pay Caregivers and Volunteers

LTCH licensees shall ensure that unimmunized staff, private pay caregivers or volunteers who refuse chemoprophylaxis during an outbreak do not provide resident care or conduct activities where they have a potential to acquire or transmit influenza.¹² Dependent on the LTCH's influenza policy, the LTCH licensee may choose to exercise the option to exclude from the LTCH unimmunized staff, private pay caregivers and volunteers unless they take antivirals.

Unimmunized staff, and dependent on the LTCH's influenza policy private pay caregivers and volunteers, who agree to be immunized during an outbreak but do not take antivirals may return to work/placement 14 days following receipt of vaccine (the duration required to achieve vaccine-induced immunity). Safe return to work/placement will occur earlier if the particular staff, private pay caregiver, volunteer begins a course of anti-viral prophylaxis.

Newly immunized or unimmunized staff and dependent on the LTCH's influenza policy, private pay caregivers and volunteers, taking antiviral prophylaxis could continue their work/placement without interruption.

Anti-viral drugs require a prescription. Staff, private pay caregivers, volunteers and visitors should try to use their own doctor for medical services. However in the event of an outbreak, and to facilitate eligible staff with timely anti-viral medication, in situations where the medical assessment does not contraindicate such, LTCH licensees may wish to discuss with the LTCH physician(s)/nurse practitioner(s) the opportunity for LTCH staff to access their medical services, as applicable.

Unimmunized staff, private pay caregivers and volunteers working/providing service in an outbreak LTCH, can work/provide service in a non-outbreak or alternate health care setting if three or more days (one incubation period) have passed since their last day in the outbreak LTCH.

10) *Respiratory Illness or Influenza-like Illness*

Staff and Private Pay Caregivers

Based on the LTCH's policy, LTCH licensees shall ensure that all staff and private pay caregivers are reminded that if they experience symptoms of influenza-like-illness, they are required to self-report this as soon as possible to the designated staff person who co-ordinates the LTCH's Infection Prevention and Control program or their delegate. If these symptoms occur in the context of a suspect or confirmed influenza outbreak in the LTCH, LTCH licensees shall ensure that ill staff and private pay caregivers are off work for 5 days after the onset of symptoms or until symptoms have resolved, whichever is shorter. If these symptoms occur during the influenza season without an outbreak in the LTCH, LTCH licensees shall ensure that the staff and private pay caregivers obtain approval from the LTCH's person responsible for the IPAC program/delegate prior to coming to work in the LTCH.

Volunteers

LTCH licensees shall remind volunteers that if they experience symptoms of influenza-like-illness, they should avoid coming to the LTCH. If these symptoms occur in the context of a suspected or confirmed influenza outbreak in the LTCH, the volunteer should not provide service/visit for 5 days after the onset of symptoms or until symptom-free, if symptoms persist longer.

11) Visitors

For further guidance related to visitors refer to 4.4. Control Measures for Visitors and Communal Activities of '*A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes*'.¹

12) References

- (1) Ontario. Ministry of Health and Long-Term Care, Public Health Division. A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes. Toronto, ON: Queen's Printer for Ontario; 2014.
- (2) Ontario. Ministry of Health and Long-Term Care, Emergency Management Unit. A guide to influenza pandemic preparedness and response in long-term care homes. Toronto, ON: Queen's Printer for Ontario; 2005.
- (3) National Advisory Committee on Immunization (NACI). Statement of seasonal influenza vaccine for 2013-2014. An Advisory Committee Statement (ACS). Can Commun Dis Rep. 2013;39(ACS-4). Available from: <https://www.canada.ca/en/public-health/services/reports-publications/canada-communicable-disease-report-ccdr/monthly-issue/2013-39/statement-on-seasonal-influenza-vaccine-2013-2014.html>
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- (5) Bridges CB, Fry A, Fukuda K, Shindo N. Seasonal influenza. In: Heymann DL, editor. Control of communicable diseases manual. 19th ed. Washington, DC: American Public Health Association; 2008. p. 315-19.
- (6) Potter J, Stott DJ, Robert MA, Elder AG, O'Donnell B, Knight PV, et al. Influenza vaccination of health care workers in long-term care hospitals reduces the mortality of elderly patients. J Infect Dis. 1997;175(1):1-6. Available from: <http://jid.oxfordjournals.org/content/175/1/1.long>
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- (9) Nichol KL, Lind A, Margolis KL, Murdoch M, McFadden R, Hauge M, et al. The effectiveness of vaccination against influenza in healthy, working adults. N Engl J Med. 1995;333(14):889-93. Available from: http://www.nejm.org/doi/full/10.1056/NEJM199510053331401#article_citing_articles
- (10) National Advisory Committee on Immunization (NACI). Statement on influenza vaccination for the 2006-2007 season. An Advisory Committee Statement (ACS). Can Commun Dis Rep. 2006;32(ACS-7):1-27. Available from: <http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/06vol32/acs-07/index-eng.php>.
- (11) *Occupational Health and Safety Act*, R.S.O.1990, c. O.1. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90o01_e.htm
- (12) National Advisory Committee on Immunization (NACI). Statement on seasonal influenza vaccine for 2011-2012. An Advisory Committee Statement (ACS). Can Commun Dis Rep. 2011;37(ACS-5). Available from: <http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/11vol37/acs-dcc-5/index-eng.php>
- (13) Ontario Agency of Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. Routine practices and additional precautions in all health care settings. 3rd ed., 2012 revision. Toronto, ON: Queen’s Printer for Ontario; 2012. Available from: http://www.publichealthontario.ca/en/BrowseByTopic/InfectiousDiseases/PIDAC/Pages/Routine_Practices_Additional_Precautions.aspx

Appendix 10 - Outbreak Transfer Notification

Sample only

Please be advised that _____ (name of resident) is being transferred from a facility where there is a **potential** OR **confirmed** influenza outbreak.

Please ensure that appropriate isolation precautions are taken upon receipt of this resident.

At the time of transfer, this resident was confirmed OR suspected OR appears free of influenza.

Resident is on antiviral medication _____ starting on _____
_____. Dose of the medication _____

Resident's vaccination status:

Pneumococcal yes ____ no ____

Influenza yes ____ no ____

For further information, contact _____ (Name of ICP), Infection Control _____

Professional at _____ (Name of Home) at _____

____ - _____ (Phone Number)

Appendix 11 - Sample Transfer & Return Algorithm for Use During Outbreaks

Transfers and Returns between Long-Term Care Homes and Hospitals during Outbreaks

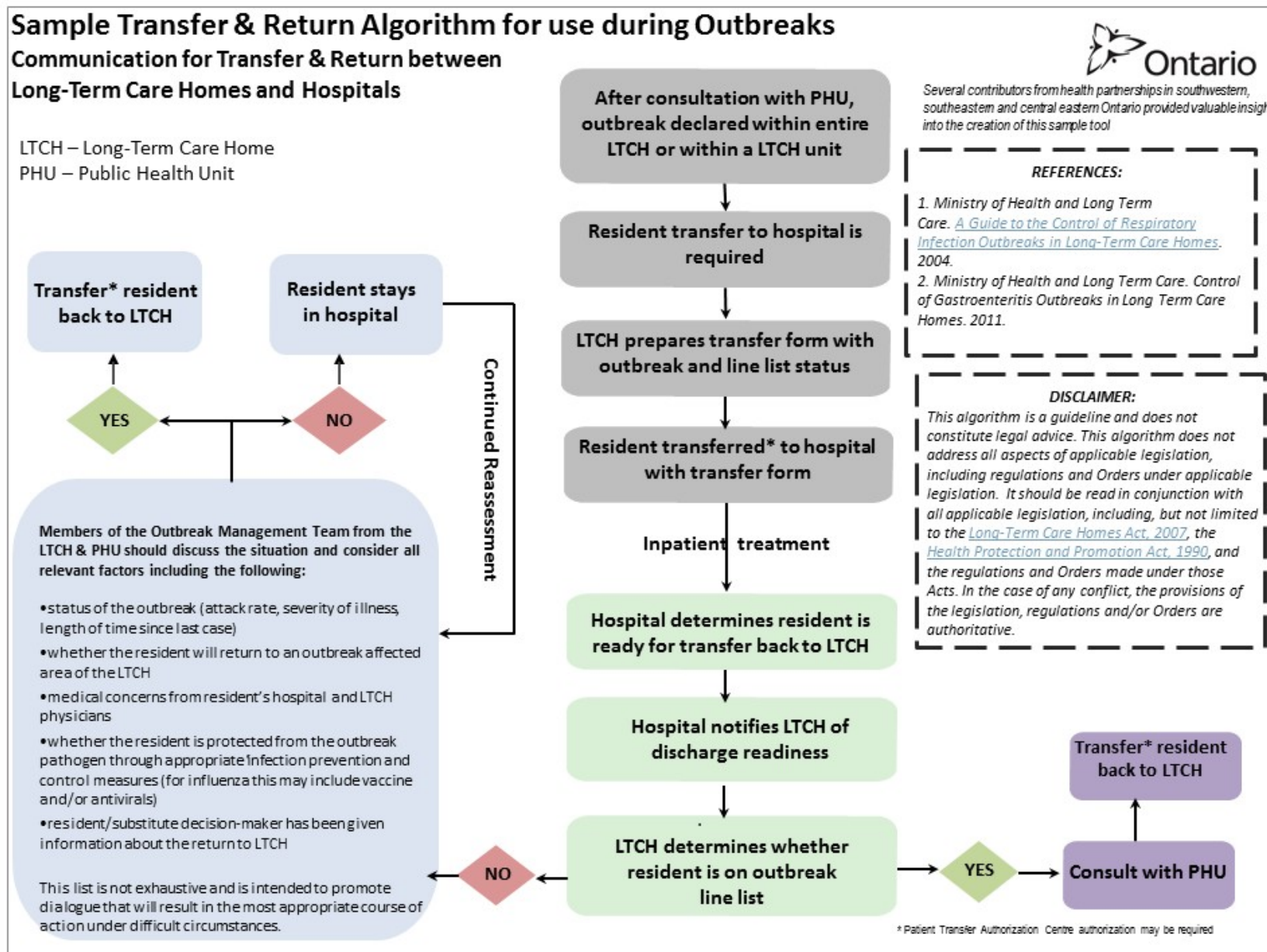
The return of residents to a long-term care home (LTCH) during outbreaks is generally restricted in an effort to protect susceptible individuals from being exposed to respiratory infections such as influenza, and gastrointestinal infections such as norovirus. Returns to LTCHs are not automatically prohibited. They must be considered carefully with respect to resident safety and quality of life, as well as system capacity.

The sample algorithm provided here is a compilation of work done in southwestern, southeastern, and central eastern Ontario involving all relevant partner organizations. The tool is an outline of the process and factors to consider when making decisions about returning residents to their long term care homes after a hospital stay. It outlines opportunities for dialogue among the system partners who are involved in the care of residents: long-term care homes, hospitals, public health units, physicians, and of course, the residents themselves.

The sample algorithm provided here, may be used or adapted by stakeholders across Ontario who may not have documented their processes and considerations for transfers and returns between LTCHs and hospitals during an outbreak. It is intended to promote dialogue of key considerations. Users of this sample may modify it as appropriate to reflect their local practices, and should do so in consultation with relevant partners.

For more information, LTCHs can follow up with their Regional Infection Control Network and public health unit, or see [Recommendations for the Control of Respiratory Infection Outbreaks in Long-Term Care Homes](#).

Image 1: Sample Transfer & Return Algorithm for use during Outbreaks



Appendix 12 - Sample Language for Returning to a Long-Term Care Home During an Outbreak

Initially published on January 18, 2013 as a Fact Sheet

Returning to a Long-Term Care Home during an Outbreak

Return of residents from hospitals to long term care homes (LTCHs) during outbreaks is generally restricted in order to protect unexposed individuals. Returns to LTCHs are not automatically prohibited however, and must be considered carefully with respect to patient safety and system capacity.

The following key messages for LTCH residents and their families may be useful to explain how these returns can happen. These messages should be adapted to reflect local processes.

LTCHs often restrict the return of residents to affected areas during outbreaks. Despite an outbreak, it may still be possible to return to the LTCH.

LTCHs, in partnership with public health units, carefully consider many factors to assess each return, such as:

- the status of the outbreak at the LTCH or a specific unit has been carefully reviewed
- the resident will not be exposed to the outbreak as the outbreak is in another unit
- the returning resident was already exposed to the outbreak before leaving the LTCH and therefore has now developed immunity
- the resident is protected from the outbreak through appropriate measures (for influenza this may include immunization and antiviral medications)

It is critical that you understand what is being done for you or your family member's wellbeing. If you have questions about being in a LTCH during an outbreak, you can ask questions before leaving the hospital or upon your return to the LTCH.

Appendix 13 - Resources and Useful Links

Ministry of Health website - <http://www.health.gov.on.ca/>

Health Protection and Promotion Act, 1990 - http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm

Long-Term Care Homes Act, 2007 - http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_07l08_e.htm

O. Reg. 79/10 - http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_100079_e.htm

Coroner's Act, 1990 - http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c37_e.htm

Occupational Health and Safety Act- <http://www.e-laws.gov.on.ca/index.html>

Ontario Drug Benefit Program - http://www.health.gov.on.ca/english/public/program/drugs/drugs_mn.html

Ontario Drug Benefit Formulary - http://www.health.gov.on.ca/english/providers/program/drugs/odbf_mn.html

PIDAC - http://www.publichealthontario.ca/en/BrowseByTopic/InfectiousDiseases/PIDAC/Pages/PIDAC_Documents.aspx

- i. Cleaning, Disinfection and Sterilization
- ii. Environmental Cleaning for Prevention and Control of Infections
- iii. Infection Prevention and Control Programs in Ontario
- iv. Hand Hygiene
- v. Routine Practices and Additional Precautions In All Health Care Settings
 - a. (Annex A) Screening, Testing and Surveillance for Antibiotic-Resistant Organisms in all health care settings
 - b. (Annex B) Prevention of Transmission of Acute Respiratory Infection
 - c. (Annex C) Testing, Surveillance and Management of Clostridium Difficile
- vi. Sexually Transmitted Infections Case Management and Contact Tracing
- vii. Surveillance of Health Care-Associated Infections

Labstracts - Public Health Ontario - <https://www.publichealthontario.ca/en/ServicesAndTools/LaboratoryServices/Pages/Labstracts.aspx>

National Advisory Committee on Immunization - <http://www.phac-aspc.gc.ca/naci-ccni/>

Association of Medical Microbiology and Infectious Disease Canada - <http://www.ammi.ca/>

PTAC - <https://www.hospitaltransfers.com/transfer/>

Health Canada websites - <http://www.hc-sc.gc.ca/pphb-dgspsp/sars-sras/index.html>

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