Saskatchewan Health Authority

COVID-19

Saskatchewan Health Authority COVID-19 Outbreak Guidance For Long Term Care Homes

2023

Infection Prevention and Control

Revised: April 12, 2023

Summary of Revisions:

Revision Date	Description of changes	Page
Mar-22	Added a new Section: Suspect Outbreak Investigation and Key Actions, revised Suspect outbreak definition	6
Mar-22	Removed requirements for visitor logs under Section 6.3 Identify Contacts/Contact Tracing	
Mar-22	Revised Section 6.3 Identify Contacts/Contact Tracing and removed the requirement to isolate close contacts	8
Mar-22	Revised Section 6.5 Resident Placement and Additional Precautions to include who requires isolation	9
Mar-22	Removed reference to PPE Guidelines when Caring for Patients Confirmed to have COVID-19 in Designated Units/Rooms in Section 6.5 (i.e., no extended use of gowns)	
Mar-22	Added links to Work Standards under Section 6.9 Move-Ins and Transfers to LTC	14
Mar-22	Revised frequency of audits in Section 6.10 Safety Walk/Risk Assessment	15
Mar-22	Revised Section 7.4 Enhanced Cleaning to include clarity on cleaning in shared spaces	16
Mar-22	Provided further guidance in Section 7.7 Group/Social Activities and Other Events	19
Mar-22	Revised Section 8 Declaration of End of Outbreak to align with Saskatchewan CD Manual	21
Jun-22	Updated Section 6.5 Resident Placement and Additional Precautions to remove reference to continuous eye protection	10
Jun-22	Updated order of resident bathing in Section 7.6 Resident Bathing	18
Sept-22	Updated Section 6.5 Resident Placement and Additional Precautions to return reference to continuous eye protection	10
Sept-22	Added reference to Family Presence letter templates in Section 7.8	20
March-23	Updated Section 6.5 Resident Placement and Additional Precautions to remove reference to continuous eye protection	10
March-23	Revised testing recommendations to align with current provincial testing protocols	throughout
March-23	Revised Section 6.8 Staff Cohorting and Return to Work to remove requirement for testing when moving between homes	12
April 23	Addition of box in Section 6 Outbreak Response to include statement that additional IPAC measures such as continuous masking and physical distancing may be temporarily implemented during the outbreak at the discretion of the MHO/designate	6
April 23	Updated Section 6.5 Resident Placement and Additional Precautions to remove reference to continuous masking	9

1 Table of Contents

Introduction 4

Key Sources of Provincial COVID-19 Guidance and Information 4

2 Outbreak Preparedness 5

2.1 Preparedness Assessment 5

2.2 COVID-19 Vaccination 5

3 Suspect Outbreak Investigation 5

3.1 Key Actions 5

4 Confirmed Outbreak Definition 6

5 Declaration of an Outbreak 6

6 Outbreak Response - First 24 Hours 6

6.1 Isolate Index Case(s)/Lab Confirmed 6

6.2 Identify Additional Symptomatic Residents & Staff 7

6.3 Identify Contacts/Contact Tracing 7

Close Contacts 7

Roommates 7

Review Recent Transfers 7

6.4 Line Lists 8

6.5 Resident Placement and Additional Precautions 8

Resident Movement 8

Cohort Residents 9

Personal Protective Equipment (PPE) 9

Outbreak Signage 9

Hand Hygiene 9

6.6 Laboratory Testing 10

6.7 Communication and Cancellations 10

Assemble C-ORT 10

Communication 11

6.8 Staff Cohorting and Return to Work 11
Return to Work 12
6.9 Move-ins and Transfers 12
Move-Ins and Transfers to LTC (from Acute Care or LTC/PCH) 12
Transfers to Acute Care or other Off-Site Location for Medical Appointments/Treatments 12
6.10 Safety Walk/Risk Assessment 13
Process for conducting a safety walk/risk assessment 13
7 Ongoing Outbreak Management 13
7.1 Monitoring of Symptoms 13
7.2 Risk Reduction Strategies 14
7.3 Equipment Cleaning 14
7.4 Enhanced Cleaning 14
7.5 Food Service Delivery 15
7.6 Resident Bathing 16
7.7 Group/Social Activities and Other Events 17
Cancellations 17
7.8 Family Presence and Visitor Restrictions 17
7.9 Discontinuation of Precautions 18
7.10 End of Life COVID-19 Related Care 18
7.11 Facility Animals/Pets 18
7.12 Accessing Provincial LTC COVID-19 Surge Plan 18
7.13 Portable Air Handling Units 18
8 Declaration of End of Outbreak 19
9 Outbreak Debrief 19
Appendix A – Resident Line List 21
Appendix B – Staff Member Line List 22

Introduction

The purpose of this document is to provide guidance for the investigation and management of COVID-19 outbreaks in long term care homes in an effort to control and prevent further spread to residents and staff within the home.

This guidance document is based on the latest available scientific evidence about this emerging disease, which is subject to change as new information becomes available.

Key Sources of Provincial COVID-19 Guidance and Information

Provincial guidance and information specific to COVID-19 can be found at:

- Government of Saskatchewan: Ministry of Health (MoH) - Public Health Orders, Notices and Guidance: Control of Transmission of 2019 Novel Coronavirus: https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/treatment-procedures-and-guidelines/emerging-public-health-issues/2019-novel-coronavirus/public-health-measures/public-health-orders
- Saskatchewan Health Authority (SHA) – COVID-19 General Information for Health Care Providers
- Saskatchewan Health Authority (SHA) – COVID-19 PPE/Infection Prevention and Control
- Saskatchewan Communicable Disease Control Manual – COVID-19

2 Outbreak Preparedness

2.1 Preparedness Assessment

To prepare in advance and assess their readiness to respond to a COVID-19 outbreak, a safety assessment will be conducted by IPAC and Safety (if available) once per year, preferably before the respiratory virus season (late summer/early fall). This must be done for each neighbourhood/home using the following tools:

- IPAC Outbreak Preparedness Checklist
- Safety Review Guide for Preparedness
- Health Care Facility Outbreak Safety Walk – Risk Assessment

2.2 COVID-19 Vaccination

Vaccination is one of the most effective layers of protection against COVID-19. Evidence indicates that vaccines are very effective at preventing severe illness, hospitalization and death from COVID-19. It is strongly recommended that all eligible staff, residents, families and visitors be fully vaccinated.

3 Suspect Outbreak Investigation

Suspect COVID-19 Outbreak:

- One COVID-19 positive resident who may have acquired or transmitted COVID-19 in a setting (i.e., neighbourhood/home).
- Any case/cluster of cases involving HCWs only.

3.1 Key Actions

- Isolate COVID-19 positive case (refer to section 6.1).
- Identify additional symptomatic residents and staff (refer to section 6.2).
- Identify close contacts (refer to section 6.3)
- At a minimum, collect specimens of residents and staff who are symptomatic, or residents who are close contacts. **IMPORTANT:** Suspect outbreaks will no longer be assigned an outbreak number. Ensure the laboratory requisition is marked "stat" to expedite testing.
    - If testing/investigation reveals no additional resident cases (i.e., no evidence of transmission), then **no further action is required**.
    - If testing/investigation reveals additional resident cases (i.e., evidence of transmission), **a confirmed outbreak will be declared** (refer to section 5) and all outbreak measures within this document will be implemented).

REMEMBER: Early detection and immediate implementation of infection prevention and control measures are two important factors in reducing the impact of an outbreak.

4 Confirmed Outbreak Definition

- Two or more residents with confirmed or probable COVID-19 for whom the MHO has determined that transmission likely occurred[1] within the setting (i.e., unit/floor/facility). (Saskatchewan Communicable Disease Control Manual January 4, 2022).
- All outbreaks involving health care workers only will be considered "suspect." However, if there is evidence of transmission to/among residents, a "confirmed" outbreak will be declared and all outbreak prevention and control measures indicated in this document will apply.

IMPORTANT: In some instances, outbreak control measures beyond enhanced surveillance may not be required, even if the neighbourhood/home meets the outbreak definition above (e.g., The second case is a roommate of a known case and the second case has been appropriately placed on Droplet/Contact Plus precautions since identification of the first case. In this example, there should be no ongoing transmission risk from the second case).

5 Declaration of an Outbreak

- The Medical Health Officer (MHO)/designate[2] is responsible for declaring a COVID-19 outbreak and assigning an outbreak number.
- Public Health (PH) and/or Infection Prevention and Control (IPAC) will submit an Outbreak Notification Form and Summary Report. Refer to:
  - Instructions for Outbreak Notification and Summary Form
  - WS0052 COVID-19 Outbreak Notification and Reporting Process for Confirmed Outbreaks in Health Care Facilities

6 Outbreak Response - First 24 Hours

NOTE: Additional IPAC measures such as continuous masking and physical distancing MAY be temporarily implemented during a respiratory outbreak at the discretion of the MHO/designate.

6.1 Isolate Index Case(s)/Lab Confirmed

Staff Case

- COVID-19 positive staff member is excluded from work. Refer to section 6.8 Staff Cohorting and Return to Work.

[1] Reasonable evidence that transmission likely occurred within a common non-household setting include:
- Close contact is confirmed with COVID-19 from 2 to 14 days following exposure;
- Individual with exposure to a setting where confirmed case was present and onset of symptoms consistent with incubation period of COVID-19;
- The individual has been located within a closed setting (e.g., admitted to hospital, residing at a work camp, correctional facility) for ≥ 7 days before symptom onset or date of specimen collection if asymptomatic;
- No obvious source of exposure other than at the setting

[2] Designate may be Infection Control Officer (i.e., Medical Microbiologist, Infectious Disease Physician)

Resident Case

- Place COVID-19 positive resident on Droplet/Contact Plus precautions. Refer to section 7.9 Discontinuation of Precautions.

6.2 Identify Additional Symptomatic Residents & Staff

- Initially assess all residents and staff for signs and symptoms of COVID-19 using:
  - Inpatient and Continuing Care Screening Form
  - Healthcare Workforce Screening & Return to Work Questionnaire
- Immediately place all symptomatic residents on Droplet/Contact Plus precautions

QUICK TIP: Consider using Signs and Symptoms Monitoring – LTC daily for quick identification of symptomatic residents.

6.3 Identify Contacts/Contact Tracing

- IPAC will trace and advise all named contacts to the confirmed cases(s) during the outbreak investigation (refer to IPAC Contact Tracing Documents for more information).
- For staff inquiries regarding workplace exposures, refer to Exposure to COVID-19 Process for more information.

Close Contacts

- Residents who are deemed close contacts will be required to monitor for symptoms for 10 days after date of last exposure and be tested on day 0 and 5 (regardless of vaccination status). Refer to Continuing Care COVID-19 Close Contact Instructions for more information.
- If symptoms develop, immediately place resident on Droplet/Contact Plus precautions.

Roommates

- If a COVID-19 positive resident is in a shared room, move the well, exposed resident(s) to a private room with a dedicated bathroom/commode.
- Exposed roommate(s) should not be transferred to any other shared room for 10 days from last exposure.
- If unable to move out the well, exposed resident(s) from room shared with COVID-19 case, follow IPAC Recommendations for Cohorting Patients on Additional Precautions in Acute Care during the COVID-19 Pandemic. Please note that this is the option of last resort.
  - Provide resident(s) with separate toileting (commode); remove toothbrushes and denture cups from washroom.

NOTE: The decision to place roommates (who are not fully vaccinated with a booster dose) on Droplet/Contact Plus precautions may be made at the discretion of the MHO/designate.

IMPORTANT: Residents who are deemed close contacts will no longer require isolation (regardless of vaccination status).

Review Recent Transfers

- Provide a list to IPAC/PH of all residents transferred **OUT** of the home (to other Long Term Care Homes, Personal Care Homes or acute care sites) going back to 10 days prior to onset of

symptoms in the first positive case. IPAC/PH will follow up and determine if any isolation, monitoring or testing is advised.

6.4 Line Lists

- Unit manager/charge nurse/designate will initiate Resident and Staff line lists (Appendix A and Appendix B) and provide this to IPAC/PH. Line lists will continue to be updated (e.g., date recovered, new symptoms, etc.) and new cases added to the original list as they are identified.
- All sick calls from staff should be screened for symptoms of COVID-19 and added to line list, if symptoms compatible.
- Retain line list forms on the unit for IPAC/PH to review daily or fax to a central location as per local process.

6.5 Resident Placement and Additional Precautions

- Place COVID-19 positive resident(s) and those with symptoms on Droplet/Contact Plus precautions. Refer to the Patient Placement and Precautions Table – LTC for duration of precautions.

Resident Movement

- Residents may leave their room (but must remain in the outbreak area) if the following criteria have been met:
  - not on Droplet/Contact Plus precautions
  - asymptomatic
- Residents who are able to leave their room are strongly encouraged to wear a mask (if tolerated). Residents who are unable to wear a mask may still leave their room but should be monitored closely for symptoms.
- Residents not meeting the above criteria must remain in their rooms for the duration of their precautions. If a need should arise where the resident requires ambulation before precautions have been discontinued, a risk assessment in consultation with the MHO/designate is recommended, and should include:
  - outbreak status (e.g., duration, evidence of reduced transmission, number and location of cases, date of last new case)
  - staff resources (e.g., direct care providers, environmental service staff)
  - resident population/health status
  - resident quality of life/care needs
  - identified areas for ambulation

Safe Ambulation for Residents on Additional Precautions

Residents must:

- Be accompanied by staff. Staff must wear PPE as per Additional Precautions or according to their Point of Care Risk Assessment.
- Wear a mask (if tolerated).
- Perform hand hygiene/assisted with hand hygiene prior to ambulation.
- Maintain safe physical distancing (>2 metres) from other residents.
- Limit interaction with other residents and staff. Staff should consider scheduling time/location for ambulating.

Cohort Residents

- Place COVID-19 positive residents in single rooms and when possible, cohort in a section of the neighbourhood to facilitate care and limit contact between COVID-19 residents and other residents.
    - If single rooms are not available, cohort confirmed COVID-19 residents in shared rooms ensuring 2 metres of separation between bed spaces with privacy curtains drawn. Attempts should be made to not cohort residents with other conditions warranting precautions (Influenza, MRSA, etc.).
- Refer to IPAC Recommendations for Cohorting Patients on Additional Precautions in Acute Care for details.

Personal Protective Equipment (PPE)

- PPE is required according to Point of Care Risk Assessment and/or Additional precautions signage.
- Re-emphasize donning and doffing sequences with staff. Refer to:
    - Putting on (Donning) PPE
    - Taking off (Doffing) PPE
- PPE donning posters may be placed outside the room near the PPE Cart
- PPE removal posters are placed inside the room, ideally above the garbage and/or linen hamper.
- Appropriately stocked PPE carts/tables have been placed outside room. Refer to the SHA IPAC Recommendations for the selection and Management of PPE carts.
    - Ensure there are sufficient quantities of supplies (e.g., N95 respirators, masks, goggles (non-vented or indirectly vented) or face shields, gowns and gloves) to last a minimum of 72 hours;
    - All PPE should be kept off the floor;
    - Refrain from folding gowns (i.e., keep in bag); refolding may result in potential contamination of clean linen.

PPE QUICK TIPS:

- If continuous masking is implemented, extend use of mask/respirator (i.e., wear for repeated interactions with multiple patients for a maximum of one shift).
    - Change mask/respirator and face shield when wet, soiled or damaged. Discard when taking a scheduled break and at end of shift.
- Always change gown, gloves and eye protection[3] between each resident encounter.

Outbreak Signage

- Close affected neighbourhood doors to discourage traffic through the affected areas and to separate from other unaffected areas
- Post outbreak signage at entrances to neighbourhood/home as appropriate (refer to Outbreak Notification Poster).

Hand Hygiene

Strict hand hygiene is the single most important measure in preventing the spread of infections for both staff and residents. Hand hygiene is everyone's responsibility.

[3] Eye protection refers to face shield or goggles (indirectly or non-vented)

- Staff are to review the SHA Hand Hygiene policy (specifically how to perform hand hygiene and the 4 Moments for Hand Hygiene).
- When possible, instruct residents how to perform hand hygiene and respiratory hygiene.
- Ensure alcohol-based hand rub (ABHR) is readily available and accessible to residents and HCWs at all home and neighbourhood entry and exit points, common areas and at point-of-care in the resident's room.
- Soap, paper towel and ABHR dispensers should be checked daily and replaced as needed.
- Glove use is not a substitute for hand hygiene. Hand hygiene is required after glove removal.

REMEMBER – 4 Moments for Hand Hygiene

1. BEFORE initial patient/patient environment contact
2. BEFORE aseptic procedure
3. AFTER body fluid exposure risk
4. AFTER patient/patient environment contact

6.6 Laboratory Testing

- Initial testing of any symptomatic residents and known close contacts to COVID-19 cases should be performed as soon as possible (within 24hr of the declaration of the outbreak).
    - Laboratory PCR (full respiratory panel) is recommended for up to 6 residents who are symptomatic.
    - Rapid antigen tests may be used for testing symptomatic residents and care providers or known close contacts to COVID-19 cases to inform clinical management and treatment decisions, or if a causative organism has not yet been identified (including while laboratory PCR tests are pending).
    - Residents that have tested positive within the last 90 days (except for those who are immunocompromised) are not to be re-tested as they are considered immune/non-infectious.
    - Residents who have been tested within 48 hours do not need to be re-tested unless they have developed symptoms compatible with COVID-19 since their last negative test.
- Additional testing of staff and residents and/or testing frequency may be increased or decreased depending on the circumstances of each outbreak. This will be at the discretion of the MHO/designate.
    - Rapid antigen tests are appropriate for testing symptomatic staff
- For more information on testing, specimen collection and lab requisitions, refer to COVID-19 Testing

6.7 Communication and Cancellations

Assemble C-ORT

- The local COVID Outbreak Response Team (C-ORT) will oversee control of the outbreak and should include (as applicable), but is not limited to:
    - Medical Health Officer (MHO) or designate
    - Infection Prevention and Control (IPAC)
    - Communicable Disease Coordinator
    - Occupational Health and Safety/Employee Health Nurse
    - Manager of Neighbourhood/Home
    - Environmental Services

- Lab Services
- Nutrition Food Services
- Additional membership based on the extent of the outbreak and anticipated support requirements (i.e., security, supply chain, etc.).

- Initially, the C-ORT should meet daily (should occur in the morning) to discuss and review the situation until the outbreak is declared over (refer to Sample Outbreak Response Daily Huddle Agenda). Ensure any issues/barriers that were identified during the daily huddle are escalated appropriately. The frequency of meetings may be reduced once the outbreak preventative measures are in place and no further transmission has been reported.

Communication

- Communication plan/notification strategy initiated for staff
  - Notify staff through usual process (i.e., phone calls, e-mail, text)
- Ensure all departments are notified of outbreak status, including laundry, nutrition and food services, therapies, environmental services etc.
- Notify non-facility staff, professionals, and service providers of the outbreak and assess their need to visit the LTC home. Visits should be postponed unless providing:
  - An essential therapeutic service that can adversely affect the health of the resident(s).
  - Essential services (e.g., maintenance, etc.) to maintain the safe operation of the home.
- Communicate with families of the residents concerning the outbreak.
- Consult with outbreak lead/IPAC/MHO and SHA communications regarding any media releases or requests.

REMINDER FOR STAFF:
- Be diligent with hand hygiene
- Change uniforms at work
- Leave shoes at work

6.8 Staff Cohorting and Return to Work

1. All staff on the outbreak neighbourhood/home should be cohorted to that neighbourhood/ home starting on the date the outbreak was declared.
   - If support services staff cannot be dedicated to the outbreak neighbourhood/home, then staff should organize workflow whereby tasks are performed on non-outbreak areas first and the outbreak area last.
   - Staff who have worked on the outbreak area cannot work on another area until 10 days after their last shift or until the outbreak is declared over (whichever is earlier), unless directed otherwise.
2. For integrated facilities (where one or both areas are in outbreak), there may be consideration for staff to work in both the acute care and long term care areas after consultation with the MHO and/or designate.
3. Staff should not move from an outbreak neighbourhood to another neighbourhood, long term care home, private care home or acute care facility. If for operational reasons it is not feasible for all staff in all settings and/or geographies to work at only one site, exceptions may be made by an MHO after other options have been exhausted, such as reassigning staff and reduction or redirection of services as appropriate. Staff should not have had any personal protective equipment (PPE) breaches and must screen negative on the daily Healthcare Workforce Screening & Return to Work Questionnaire.

4. Any health science students (e.g., Medicine, Nursing, Pharmacy & Nutrition, Rehabilitation Science, Dentistry, Lab, etc.) in preceptored or group clinical placements will be allowed to complete their placements on a neighbourhood/home where an outbreak has been declared, regardless if the placement has started. Students will follow the same cohorting principles for confirmed outbreaks that apply to their discipline provided health science programs commit to ongoing PPE training and time on outbreak units is minimized for those learners that cannot be cohorted.

Return to Work

- Staff/Physicians/Students who have tested positive or have symptoms of COVID-19 are to remain off work as per the Healthcare Workforce Screening & Return to Work Questionnaire. Staff should work with their manager or supervisor to determine when they can return to work.
- Staff with potential workplace exposures are to follow the Exposure to COVID-19 Process.

6.9 Move-ins and Transfers

Move-Ins and Transfers to LTC (from Acute Care or LTC/PCH)

- New resident move-in and transfers to LTC homes during outbreaks should not occur until the outbreak is declared over; however, this may not always be possible due to resident circumstances or operational needs (including bed pressures). In these situations, Population and Public Health (PPH) has provided recommendations to support transfers and new move-ins into LTC homes during a declared outbreak (refer to Transfer or Move-in to LTC-During a Confirmed COVID, other Respiratory or Gastrointestinal Outbreak and LTC Request for Transfer or Move-In During a Confirmed Gastrointestinal or Respiratory Outbreak)
- Note: If the entire home is not on outbreak, move-ins may still occur to the other unaffected neighbourhoods.

Transfers to Acute Care or other Off-Site Location for Medical Appointments/Treatments

- All non-essential off-site medical appointments are on hold. The Most Responsible Practitioner (MRP) may be consulted to determine if a specific appointment is medically necessary.
- If residents must be transferred for medically necessary tests or treatments:
  - MUST advise EMS and receiving unit that the resident is coming from a COVID-19 outbreak area (if being admitted, advise if resident is COVID-19 positive (case), symptomatic and undiagnosed or a close contact).
  - Maintain Droplet/Contact Plus precautions during transport.
  - If the resident will tolerate a medical mask, have them wear one.
  - As a precautionary measure, residents not currently on precautions must be placed on Droplet/Contact Plus precautions for 10 days post transfer from the outbreak area or until the outbreak is declared over, whichever is sooner. **Note:** Residents who are considered COVID-19 recovered[4] do not need to be placed on precautions.
  - For residents currently on precautions follow the Placement and Precautions Table - Long Term Care Homes for duration of precautions.

[4] Considered COVID-19 recovered if confirmed infection has been within 90 days of symptom onset or date of specimen collection, if asymptomatic AND criteria for discontinuation of precautions has been met

6.10 Safety Walk/Risk Assessment

A safety walk/risk assessment will be conducted after and in response to a COVID-19 outbreak having been declared in a neighbourhood/home. It must be completed by IPAC, Safety* (*if available) and the manager/designate using the following tools:

- IPAC Outbreak Response Checklist
- Health Care Facility Outbreak Safety Walk – Risk Assessment

Process for conducting a safety walk/risk assessment

A safety walk/risk assessment is to be conducted by IPAC and Safety within 72 hours of the declaration of an outbreak. Arrangements for the initial assessment must be made in advance with the manager/ designate. Important: Subsequent/follow-up visits may not always be announced or planned and may occur without prior arrangements made. Long term care directors are responsible for ensuring that deficiencies and recommendations from the visits are addressed.

1. Confirmed outbreak:
   - Must conduct a safety walk/risk assessment on-site.
2. Recurring outbreak less than 6 months:
   - IPAC will review the previous health care facility outbreak safety walk risk assessment tool and work with the manager to determine if there are any outstanding deficiencies. At the discretion of the ICP and IPAC manager, another safety walk/risk assessment may be conducted (consider factors such as staff capacity and resources, outstanding risk assessment deficiencies and the level of support requested by the neighbourhood/home manager).
   - If a risk assessment is needed, consider conducted virtually (e.g., phone, WebEx, FaceTime).
3. Recurring outbreak greater than 6 months:
   - Must conduct an additional safety walk/risk assessment on-site, if capacity and resources allow.
4. Additional site visits/audits (e.g., hand hygiene audits, tub room audits, etc.) may be done more frequently and on additional neighbourhoods/areas (e.g., clean and dirty service rooms) as part of routine IPAC work at the discretion of local ICPs and the IPAC manager.

7 Ongoing Outbreak Management

NOTE: The neighbourhood/home manager/charge nurse/designate is responsible for ensuring the implementation of the following control measures.

Depending on the layout of the home, the location of cases and the degree of unavoidable movement of HCWs between neighbourhoods, outbreak measures may be applied to specific neighbourhoods, or to the entire LTC home, at the discretion of the MHO.

7.1 Monitoring of Symptoms

- Perform ongoing monitoring and assessment of all residents in the outbreak area for signs and symptoms according to local practice. Any resident who develops symptoms consistent with COVID-19 during the incubation period must be added to the Line List and placed on Droplet/Contact Plus precautions.
- Continue to actively monitor all residents and staff for symptoms for the duration of the outbreak.

QUICK TIP: Consider using Signs and Symptoms Monitoring Form – LTC for quick identification of symptomatic residents.

7.2 Risk Reduction Strategies

Risk reduction strategies may be implemented for residents on Droplet/Contact Plus precautions who can't/unable to remain in their room.

- Review Promoting Physical Distancing During Outbreaks – Behaviour Support

THINK MR. CLEAN when caring for a resident who "wanders":
Mask (as tolerated),
Redirect back to their room, provide meaningful activities,
Clean hands often; assist as needed,
Lead others away (keep residents who are unwell from those well),
Environmental cleaning,
All staff can help,
No go (visual barriers to encourage resident to remain in/keep out).

7.3 Equipment Cleaning

- Use disposable equipment when possible.
- All reusable equipment and supplies, along with toys, electronic games, personal belongings, etc., should be dedicated to the resident until the outbreak has been declared over.
- If reusable equipment cannot be dedicated to a single resident, clean and disinfect thoroughly before use on another resident. Remember to clean the entire piece of equipment and not just the area that comes into contact with the resident.
- All items that cannot be appropriately cleaned and disinfected should be discarded or dedicated to one resident.
- Process is in place to clearly identify clean and dirty resident equipment (e.g., tags marked "I am clean"). A clear separation between clean and dirty carts and equipment should exist.
- Review and identify which surfaces/items unit staff is responsible for cleaning.
- Increased cleaning of high touch surfaces, at minimum twice per day
  - Resident wheel chairs – hand contact areas
  - Telephone/keyboard/desk and chair arms/backs at nursing stations
  - Medication carts – hand contact areas

7.4 Enhanced Cleaning

- A minimum of twice daily cleaning should be completed by staff in Droplet/Contact Plus rooms and all common areas of the affected unit.
  - If staff cannot be cohorted and must move between areas, they are to limit contact with the ill residents and visit the outbreak area last.
- Cleaning is always performed from clean areas to dirty areas. Clean additional precautions rooms last.
- Consider paying particular attention to high touch surfaces including:
  - Staff and public washrooms (sinks/taps/toilets)
  - Hand rails/stair rails
  - Call lights/bed rails/overbed tables
  - Light switches/elevator buttons
  - Door knobs, push plates

- Common area TV remotes/public phones
- Discharge clean of the room should be completed when additional precautions are discontinued.
- Rooms and surfaces are free of clutter to enable easy cleaning and disinfection of surfaces (e.g., hallways, nursing stations, resident rooms etc.).
- Clean linen is to be covered and kept away from contaminated items (e.g., dirty linen hampers, garbage bins).
- Indoor garbage cans should be hands-free (e.g., have foot release or the lid removed).
- When staff and environmental services staff both participate in the cleaning; ensure documentation exists of cleaning responsibilities.

IMPORTANT:
- In a shared room, only the bed space for which precautions were discontinued requires a discharge clean.
- However, if an AGMP has occurred in a shared room, then all bed spaces require a discharge clean.

7.5 Food Service Delivery

Dining room guidelines are as follows:

- For those residents that are able to leave their room (see Section 6.5), communal dining may continue if located within the outbreak area. In-room meal service should occur for those residents that are unable to leave their room.
- If communal dining occurs, as much as possible, residents should dine in small cohorts (i.e., small grouping of residents who normally participate in activities and dine together). The number of residents in a cohort may vary depending on the size of the dining area. **Rationale:** This is to minimize the potential number of contacts and to reduce the risk of transmission across the home.
  - If a home is unable to cohort residents, the number of residents dining should be reduced to allow for physical distancing.
  - If multiple neighbourhoods must share dining areas, schedule the sittings so that different neighbourhoods do not mix. Do not mix outbreak and non-outbreak areas.
  - Consider cohorting residents from the same outbreak neighbourhood during meals based on health status (i.e., separate sittings for recovered and negative residents).
  - COVID-19 positive residents who have not yet been cleared should not use dining areas which are used by non-COVID-19 residents.
  - Enhanced cleaning to be undertaken between and after meal sittings and during dining and as needed (specifically high touch points of arms of chairs, tabletops and edges of tables).
- Food services staff should not enter outbreak area or at minimum Droplet/Contact Plus precautions rooms.
  - Whenever feasible, it is advised that food carts be dropped off and then picked up by food services staff at the entry onto the outbreak neighbourhood, and the staff in the outbreak area deliver the trays to the residents.
  - If staff are unable to be appropriately cohorted, well residents are served first followed by the ill residents.
- Cart handles should be cleaned and disinfected before entering and after leaving the outbreak area.
- Staff must perform hand hygiene:
  - Prior to delivering food trays

- Between assisting residents during meals as per the 4 Moments for Hand Hygiene
- After leaving residents rooms and neighbourhoods when delivering and picking up food trays

- Staff should ensure hand hygiene is performed or assist (when necessary) all residents with hand hygiene prior to eating.
- Regular dishes and cutlery should be used (i.e., disposable not required). No special precautions are required for handling of dishes (i.e., bagging of dishes is not required) or cleaning of dishes. Follow your regular dishwashing process as per the Public Eating Establishment Standards[5] to clean dishware.
- Automatic ice dispensing machines should be used by staff only (i.e., bulk ice machines with a scoop are not allowed).
- Holding carts and dish trolleys (including the wheels) are cleaned and sanitized as per local processes.

7.6 Resident Bathing

- When private bathrooms are available, staff may continue bathing residents as per normal bathing schedule.
- If communal shower or tub rooms are used, asymptomatic residents who are not on Droplet/Contact Plus precautions can be bathed as staffing allows. Residents who are on Droplet/Contact Plus precautions should be bed bathed until additional precautions are discontinued, at which time they may resume use of the communal tub/shower.
- If a resident on additional precautions requires a tub bath due to skin breakdown, heavy soiling or personal need, a tub bath can be provided and should be given in the following order:
    1. Residents not on Droplet/Contact Plus precautions
    2. Asymptomatic exposed (i.e., close contacts not on Droplet/Contact Plus Precautions)
    3. Asymptomatic exposed roommates on Droplet/Contact Plus Precautions (if applicable as per MHO direction)
    4. Symptomatic residents with negative COVID-19 lab results
    5. Lab confirmed COVID-19 positive
- If assisting residents with bathing, HCWs will wear appropriate PPE as indicated by the point of care risk assessment (PCRA) or as per precautions signage for that particular resident.
- Residents should wear a mask (if tolerated) to the tub room. Once in the tub, the mask may be removed and discarded. A new mask should be donned prior to leaving the tub room.
- Clean and disinfect communal shower/tub rooms as per local process after each resident use, including high-touch surfaces within 2 metres of the tub.
- All bathing supplies should be kept closed and stored at least two metres away from the tub.
    - All residents must have their own personal care items (e.g., razors, combs etc.) brought into the tub room as needed. If unable to store in resident room, these items should be labeled with the resident's name and kept in a closed, cleanable container/basket at minimum two metres away from the tub.

[5] Reference: https://pubsaskdev.blob.core.windows.net/pubsask-prod/107009/Public-Eating-Establishment-Standards-June-2019.pdf

7.7 Group/Social Activities and Other Events

- All group activities should be suspended for the duration of the outbreak. However, if the home wishes to resume activities* before the outbreak has been declared over, they may do so only after consultation with the MHO/designate and a risk assessment has been performed.
- All previously scheduled resident special events/activities (e.g., special holiday meal celebrations, birthday parties, entertainers, school groups, community presentations) must be cancelled/postponed for the duration of the outbreak.
- All non-resident events previously booked for areas in the outbreak area (e.g., meetings) must be cancelled/postponed for the duration of the outbreak.
- In the event the decision has been made to resume activities, residents may participate provided they are able to leave their room (refer to section 6.5 Resident Movement) and are placed in small, consistent cohorts.
- In addition, the group activity must take place on the outbreak unit. Consider physical distancing between cohorts:
    - Review Promoting Physical Distancing During Outbreaks – Behaviour Support and Creating Meaningful Moments – Making the Most of Everyday Activities

*Note: High-risk group activities should be restricted for the duration of the outbreak (e.g., singing, bus outings, large gatherings without physical distancing etc.).

For Residents on Precautions:

- Residents should not participate in group activities.
- Staff may implement 1:1 visits and hallway/doorway* programming to support residents confined to their room in order to support the biopsychosocial health of residents during outbreak restrictions.
  **Hallway and doorway programming refers to staff placement, not resident placement.*
- If creating "activity bags" for individual resident use while in their room, any materials unable to be cleaned must be disposed of once the resident is finished using them.

Cancellations

- Cancel/reschedule outside contractors scheduled to perform work on the outbreak unit unless the job is urgent or related to resolving the outbreak (i.e., oxygen, respiratory equipment).
- Cancel non-essential services including hair salon, pet therapy, VON foot care and chapel (Note: For 1:1 spiritual care, refer to WS – COVID-19 Spiritual Care Provision and WS – Infection Prevention Orientation for COVID-19 Spiritual Care Provision).

7.8 Family Presence and Visitor Restrictions

- Family presence levels will be at the discretion of the local MHO/designate. The determination of family presence level will be based on outbreak transmission risk assessments and will be reviewed on a regular basis for the duration of the outbreak.
- Staff can communicate with families using LTC – Template Letter to Families Yellow Precautions or LTC – Template Letter to Families Red Precautions as applicable.
- Information on the level of family presence and visitor restrictions can be found at Family Presence and Visitor Restrictions at Health Care Facilities.
- Those permitted to enter the facility must screen using existing screening tools at entrance and prior to arrival.

7.9 Discontinuation of Precautions

- Refer to Resident Placement and Precautions Table - LTC Homes

Note: A dry cough may persist for several weeks, so a dry cough alone as a symptom does not indicate transmissibility or warrant continuation of isolation.

7.10 End of Life COVID-19 Related Care

- It is recommended that all deaths that occur during the outbreak regardless of symptoms are swabbed and tested for COVID-19.
- Refer to Death, Care of the Body During COVID-19 Pandemic document for information concerning handling of the deceased body, resident belongings and swabbing.

7.11 Facility Animals/Pets

- There is limited information on animals and COVID-19. Infection with COVID-19 has been seen in both cats and dogs but it is unknown if they can spread COVID-19 to people. During a COVID-19 outbreak, the following precautions should be implemented:
  - Ill residents and close contacts should avoid contact with animals/pets.
  - All staff and residents should practice hand hygiene before and after touching animals, their food or supplies.
  - Individuals at higher risk for severe COVID-19 illness should avoid contact with animals that have been exposed to an ill person.
- Review the Home's Pet Policy for resident pets and consider removing all pets offsite until the outbreak has been declared over

7.12 Accessing Provincial LTC COVID-19 Surge Plan

- During an outbreak, demands on the facility to provide care to residents may supersede the LTC's resources and ability to provide safe and appropriate care. In particular, staffing may be an issue due to exclusion of COVID-19 positive staff from the home.
- If the LTC has commenced its outbreak response plan but demands for resources (HR or otherwise) have escalated beyond the site's capacity, consider suggesting to Operational and Medical Directors of the impacted LTC facility to activate STAGE 1 of the Provincial LTC COVID-19 Response Plan, to request support for the home. The Provincial LTC COVID-19 Response Plan can mobilize different strategies including local staff redeployment, agency staffing, financial incentives, and volunteers, in support of contracted, as well as SHA owned and operated, sites.
- SHA's surge plan includes many actions to help care teams manage staff absences. As essential family/support persons are already our partners in care, one action is to explore enhancing the ways they safely support as a part of the caregiving team. Refer to Family Presence: Families as Caregivers Toolkit.

7.13 Portable Air Handling Units

- For more information, refer to IPAC Recommendations for Deployment of Air Handling Units in LTC Homes

8 Declaration of End of Outbreak

- All outbreak measures must remain in place until the MHO/designate declares the outbreak over. Generally, outbreaks will be declared over when no new confirmed cases linked to the setting are detected following two incubation periods[6] following the date of last known exposure in this setting. If the date of the last known exposure cannot be defined or is unknown, the period should be counted from the most recent case's date of onset of symptoms or date of specimen collection if asymptomatic.

Once the outbreak is declared over:

- An outbreak report is to be completed and submitted by PH and/or IPAC. Refer to:
  - Outbreak Notification Form and Summary Report
  - WS0052 COVID-19 Outbreak Notification and Reporting Process for Suspect/Confirmed Outbreaks in Health Care Facilities
- Provide notification of the end of the outbreak to all staff and families of residents who were notified of the start of the outbreak.
- Remove all outbreak signage.
- Re-stock any supplies depleted during the outbreak, including swabs for viral testing.
- Additional discharge cleaning should occur in common areas of the affected neighbourhood/home.
- Consider debriefing with C-ORT and LTC home staff to evaluate the management of the outbreak.
- Remain alert for possible new cases in staff and residents.
  - Continue to actively monitor residents as per local process for compatible symptoms/ presentations despite the outbreak being declared over in order to recognize if illness is reintroduced into the home.
- Report any newly identified cases in a timely fashion.

9 Outbreak Debrief

It is strongly recommended that the C-ORT and staff from the outbreak schedule a debriefing session as soon as feasible following the end of an outbreak. The purpose of the debriefing session is to evaluate the management of the outbreak, identify interventions that worked well and discuss processes that can be improved (i.e., lessons learned), for instance:

- Communication
- Timeliness in recognizing and reporting outbreak
- Timeliness in implementing control measures
- Effectiveness of control measures in limiting the outbreak

[6] Refer to Saskatchewan CD Manual: https://www.ehealthsask.ca/services/Manuals/Documents/cdc-section2.pdf#page=12

References:

Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. Best practices for prevention, surveillance and infection control management of novel respiratory infections in all health care settings [Internet]. 1st ed. Toronto, ON: Queen's Printer for Ontario; 2020 [cited 2020 June]. Available from: https://www.publichealthontario.ca/-/media/documents/b/2020/bp-novel-respiratory-infections.pdf?la=en

Saskatchewan Health Authority (SHA). COVID-19 response guidance for long term care facilities [Internet]. 1st ed. 2020 [cited June 2020]. Available from: https://www.ehealthsask.ca/services/Manuals/Documents/Sec_9-20_LTC_COVID-19_Response_Guidance.pdf

Alberta Health Services. Guidelines for outbreak prevention, control and management in acute care and facility living sites, including influenza and gastrointestinal illness [Internet]. 2019 [cited 2020 June]. Available from: https://www.albertahealthservices.ca/assets/healthinfo/hi-dis-flu-prov-hlsl.pdf

Public Health Agency of Canada. Overview of influenza monitoring in Canada [Internet]. Ottawa, ON: Government of Canada; 2019 [cited 2020 June]. Available from: https://www.canada.ca/en/public-health/services/diseases/flu-influenza/influenza-surveillance/about-fluwatch.html

Provincial Infection Control Network of British Columbia (PICNet). Respiratory infection outbreak guidelines for healthcare facilities, reference document for use by health care organizations for internal policy/protocol development [Internet]. BC: British Columbia Provincial Infection Control Network; 2011 [cited 2020 June]. Available from: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%203%20-%20IC/RI_Outbreak_Guidelines_March17_Final.pdf

Alberta Health Services. Acute Care Guidelines for Patient Admission/Discharge/Transfer in Unit/Facility with a Confirmed COVID-19 Outbreak or on Watch [Internet]. 2020 [cited 2021 January]. Available from: https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-acute-care-admission-discharge-transfer-outbreak-watch.pdf

De-escalation of COVID-19 Outbreak Control Measures in Long-term Care and Retirement Homes Available from: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjupfu5tYPvAhVlFVkFHXZ3C9MQFjABegQIAhAD&url=https%3A%2F%2Fwww.publichealthontario.ca%2F-%2Fmedia%2Fdocuments%2Fncov%2Fltcrh%2F2020%2F06%2Fcovid-19-outbreak-de-escalation-ltch.pdf%3Fla%3Den&usg=AOvVaw0bztbw_veTNhCFI0Tq-Pwc

Appendix A – Resident Line List

Outbreak #: **Date Declared:**

Neighbourhood/Home:

Contact Name: **Phone Number:**

Case ID	Daily Update (past 24 hours)												Complications		Specimens			Vaccination Status			Precautions	
Case # Room #	Baseline Temp & SpO2	Date	Date of illness (Day 0 is onset of symptoms)	Fever	Cough (dry (D)/wet (W)	Runny nose (R) Nasal congestion (C)	Sore throat (S) Hoarse voice(H)	Headache	Myalgia (muscle pain)	Chest congestion	Malaise (M) Chills (C)	Others	Hospitalization (d/m/y)	Death (d/m/y)	NP Swab Taken Date (d/m/y)	Results/VOC	Other	1st Dose (d/m/y)	2nd Dose (d/m/y)	Booster (d/m/y)	Start Date	Removal Date
			Day 0																			
			Day 1																			
			Day 2																			
			Day 3																			
			Day 4																			
			Day 5																			
			Day 6																			
			Day 7																			
			Day 8																			
			Day 9																			
			Day 10																			
			Day 11																			
			Day 12																			
			Day 13																			
			Day 14																			
			Day 15																			

Comments/Diagnosis/Pertinent Respiratory History: ☐ Wanderer/non-compliant with precautions

Appendix B – Staff Member Line List

Outbreak #: **Date Declared:**

Neighbourhood/Home:

Contact Name: **Phone Number:**

Case ID		Daily Update (past 24 hours)									Complications		Specimens			Investigation		
Name & HSN	Role	Onset date	Temperature	Cough (dry (D)/wet (W)	Runny nose	Hoarse voice	Sore throat	Headache	Myalgia	Others i.e., malaise	Bronchitis/ Pneumonia	Hospitalization (d/m/y)	NP Swab Taken Date (d/m/y)	Results/VOC	Other	Dates & floors/areas worked while infectious	Return to work date	Fully vaccinated (y/n)
Case #:																		
Name:																		
HSN:																		
Comments:																		
Case #:																		
Name:																		
HSN:																		
Comments:																		

Saskatchewan Health Authority

saskatchewan.ca/COVID19

CV-19 G0110

Infectioncontrol@saskhealthauthority.ca