Government of
Northwest Territories

NWT Office of the Chief Public Health Officer

Interim Outbreak Management of Influenza and Coronavirus Disease (COVID-19) in Long Term Care Facilities

Interim Guidance for the Northwest Territories

9//2020

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The Office of the Chief Public Health Officer (OCPHO) will update this document as new information emerges. See Appendix A for list of revisions.

Introduction and Purpose

Influenza and COVID-19 outbreaks in Long Term Care Facilities (LTCFs) have presented at the same time that community transmission of infections are detected in some Canadian jurisdictions and elsewhere in the world. The Office of the Chief Public Health Officer (OCPHO) requires that all LTCFs in the territory implement enhanced outbreak prevention activities immediately.

The purpose of the "*Outbreak Management of Influenza and COVID-19 in Long Term Care Facilities: Interim Guidance for the Northwest Territories*" document is to provide direction to LTCFs in the Northwest Territories (NWT) on both influenza and coronavirus disease (COVID-19) outbreak management during the current pandemic. It is based on current evidence and will be updated as the situation evolves or new evidence emerges. Elsewhere in Canada, outbreaks of Influenza and COVID-19 have severely impacted LTCFs. Early recognition and swift action is critical for effective management of outbreaks in LTCFs due to the increased risk of severe symptoms and the increased risk of spread when individuals who are vulnerable live in congregate settings.

The goal of outbreak management is to identify new cases early, decrease transmission, and ultimately prevent morbidity and mortality from Influenza and/or COVID-19 in LTCFs and in the community. Older adults and people with underlying medical conditions are at highest risk of severe outcomes.

The signs and symptoms of both COVID-19 and Influenza are similar, emphasizing the importance of maintaining stringent measures for long term care facilities during COVID-19 Pandemic. Based on diagnosis health care providers must follow appropriate guidance to ensure that safety of residents in long term care facilities, both for COVID 19 and Influenza. Appropriate management and guidance for Influenza in a long term care facility can be found in Appendix B.

Staff and managers of the LTCF must notify the Chief Public Health Officer (CPHO) or designate immediately if influenza or Covid-19 activity is suspected, and be prepared to implement this protocol.

The OCPHO of the NWT adopts the Government of Canada's Infection Prevention and Control for COVID-19: Interim Guidance for Long Term Care Homes and uses the NWT Infection Prevention and Control Manual 2012: Policies and Guidelines, Standards and Manuals | HSS Professionals as the minimum standards for infection prevention and control (IPAC) for LTCFs.

In addition to the above documents users are expected to implement the direction contained within this document in conjunction with existing organizational/Health and Social Services Authority (HSSA), protocols, guidance/direction, NWT OCPHO standards and guidance documents, and Government of Canada guidelines on IPAC and public health management for Influenza and COVID-19 including:

- NWT Interim Coronavirus Disease (COVID-19) Assessment Algorithm
- NWT Interim COVID-19 Public Health Management of Cases & Contacts
- Northwest Territories Infection Prevention and Control Manual (2012)
- Government of Canada Interim Guidance: Death Care Services and Handling of Dead Bodies During the Coronavirus Disease (COVID-19) pandemic
- Canadian Immunization Guide Chapter on Influenza and Statement on Seasonal Influenza Vaccine for 2020-2021

Early detection and immediate implementation of control measures are two of the most important factors in reducing the impact of an outbreak.

Health care professionals (HCPs) must report all suspect outbreaks to OCPHO immediately by telephone at (867) 920-8646.

Note on terms:

- **"Health Care Worker" (HCW) -** HCWs include any person, paid or unpaid, who provides services, works, volunteers, or trains in a hospital, clinic, or other health care facility. *(NACI Statement on Seasonal Influenza Vaccine for 2020-2021)*
- **"Staff"** applies to all staff or persons paid or unpaid, who provide services, work, volunteer, or train in the LTCF. This includes but is not limited to: administration staff, health and allied care professionals, recreation staff, housekeeping, laundry, dietary, security, inspectors, building maintenance, contractors, delivery staff, etc.
- **"Resident"** includes all individuals residing or receiving respite care in a LTCF.
- **"Essential Visitor"** A person who is permitted to visit in accordance with organizational/HSSA direction/guidance (i.e. palliation or end-of-life, etc.). See page 14 for further explanation.
- **"Mask"** When using the term "mask" in this document, it refers to a surgical, medical grade 1 mask
- **"Resident Care Area"** applies to all areas where residents live, spend time in or have regular access to (i.e. residents rooms, common areas)
- **"Administration Area"** applies to all areas that residents do not access regularly (i.e. offices)

1.0 Identification and Definition of a COVID-19 Outbreak

COVID-19 Definition of an Outbreak

An outbreak is confirmed in the LTCF when a single staff, resident or essential visitor testing positive for COVID-19.

- **Institutional outbreaks must be reported immediately to the OCPHO.**
- **In addition to the OCPHO, outbreaks in LTCFs should be reported to Territorial IPAC for additional direction and guidance.**
- **All outbreak control measures take priority over routine operations until the outbreak is declared over.**
- **Restrictions will be in place until otherwise directed by the OCPHO.**
- **The OCPHO will determine if an outbreak is occurring and declare when the outbreak is over.**

Follow guidance in the NWT OCPHO Interim Coronavirus Disease (COVID-19) Public Health Management of Exposures/Cases/Contacts. Notify the local public health unit or community health centre staff to assist in facilitating the contact investigation including assessment and testing of contacts and providing guidance on mandatory self-isolation and self-monitoring requirements for staff and essential visitors.

Older adults may present with mild symptoms that are disproportionate to the severity of their illness and may present with usual or atypical COVID-19 symptoms. Maintain a high degree of suspicion for COVID-19 especially with any change in status in elderly individuals. Initiate additional outbreak management precautions while waiting for laboratory confirmation when there is a high clinical suspicion of COVID-19.

Symptoms of COVID-19, not definitively attributable to another cause, include:

- Fever 38^{o} C*,
- New onset (or exacerbated chronic) cough,
- Dyspnea (difficulty breathing),
- Fatigue (really tired),
- Malaise (generally feeling unwell),
- Myalgia (muscle aches),
- Sore throat,
- Rhinorrhea (runny nose),
- Headache,
- Diarrhea/vomiting,
- Anosmia/Dysgeusia (loss of smell/taste),
- Anorexia (loss of appetite)

*Young children, older adults, immunocompromised, or those taking medication such as corticosteroids, Nonsteroidal anti-inflammatory (NSAIDs), acetaminophen may not develop an elevated body temperature during infection.

Atypical symptoms of COVID-19 in older adults include:

- Delirium,
- Loss of orientation to surroundings,
- Sleepiness,
- Increase in falls,
- Onset of incontinence,

- Increased agitation or sluggishness,
- Sleep disturbances,
- Dizziness,
- Chest pain,
- Hemoptysis,
- Abdominal pain,
- General change in behaviour or level of consciousness

Screening for COVID-19 in LTCFs during the Pandemic

Active screening of staff, residents and essential visitors, by inquiring about symptoms or exposures to COVID-19, enables early detection and rapid implementation of additional outbreak control measures. Any symptoms noted during the screening process will prompt immediate assessment for testing for COVID-19 and isolation of residents or mandatory self-isolation of staff and essential visitors. Note that other organization/HSSA guidance/direction (i.e. OHS, IPAC) are in effect and complement this guidance.

- LTCFs must place signs at all entrances to prompt staff and essential visitors to self-identify if they have symptoms of COVID-19 (i.e. "passive screening"). Signage must advise that the LTCF staff will actively screen everyone as they enter and exit the LTCF.

Active Screening of Staff and Essential Visitors

- Screeners must be present at the entrance of the LTCF to actively screen all individuals (staff, essential visitors,) before entering. If this is not feasible, there must be a method in place to ensure control and monitoring of entry/exiting of the LTCF and direct access to screening.
- Screeners should be behind a physical barrier (e.g. plexiglass). If this is not possible they must wear personal protective equipment (PPE) as per organization/HSSA IPAC direction/guidance.
- Emergency and first responders, who are wearing appropriate PPE, do not require screening in emergency situations only. At all other times they must be screened upon entry to the LTCF.
- Screening must be documented in a log upon entry and exit of the LTCF (i.e., at the beginning and end of the work shift or upon entering and leaving the LTCF).
- LTCF managers or delegate must maintain the log of all screening and provide it to the OCPHO upon request if an outbreak is suspected.
- The screen should include symptom inquiry, temperature check, and exposure history upon entry to the LTCF, and a symptom inquiry upon exit or at the end of shift:
    - Symptoms inquiry should include review of:
        - Fever,
        - New or worsening cough,
        - Dyspnea,
        - Fatigue,
        - Malaise,
        - Myalgia,
        - Sore throat,
        - Headache,
        - Rhinorrhea,
        - Diarrhea/vomiting,

        - Anosmia/dysgeusia,
        - Anorexia.

    - The use of non-contact infrared thermometers (NCIT) may be considered, however there is insufficient evidence to support the effective identification of those with elevated temperature at point of entry screening to discern active disease.
    - If NCITs are considered for use in screening, they should be used as part of a multi-faceted screening program and the factors that impact NCIT accuracy should be considered. At a minimum, staff using NCITs should receive appropriate training and follow manufacturer instructions for proper use.
    - Possible exposure to COVID-19 in the last 14 days include:
        - A contact of a confirmed or probable case; ***OR***
        - Returned to Canada from outside the country; ***OR***
        - Returned to the NWT from within Canada; ***OR***
        - Travelled to an affected area (i.e. community spread within the NWT)
        - Is a close contact of a person who had acute respiratory illness who returned from travel outside of the NWT in the previous 14 days before they become sick; ***OR***
        - Participated in a mass gathering identified as a source of exposure (i.e. a conference); ***OR***
        - Lived, worked, trained or volunteered in a closed facility experiencing a COVID-19 outbreak; ***OR***
        - Had laboratory exposure to biological material (e.g., primary clinical specimens, virus culture isolates) known to contain COVID-19
    - As a precautionary measure, if LTC staff or essential visitor is a household member of any person with a possible exposure to COVID-19, as listed above, they are considered as having an exposure as well. Staff should review and follow guidance of their employer and WSCC
    - Contact information (phone number or email for future contact if needed).

- Any staff or essential visitor showing symptoms of COVID-19 must:
    - Be excluded from the LTCF and advised to go home and immediately self-isolate.
    - Contact their local public health unit or community health centre for investigation and follow-up of symptoms.
    - Staff must follow guidance from their employer and WSCC before returning to work.
- Once an individual has passed the screening and is able to enter the LTCF home, they should use hand sanitizer and the appropriate PPE, as required/recommended by the organization/HSSA.
- Anyone who has clearance to enter the LTCF should be advised to self-monitor and report any symptoms immediately.

Active Screening of Residents

Symptoms of COVID-19 in elderly residents may be subtle or atypical. Staff performing daily screening should be sensitive to detection of changes in the resident from baseline and have a low tolerance for assessment and testing for COVID-19.

Active screening of all residents must occur at least **twice daily** (at the beginning and end of the day).

- Screening must be documented in the chart and on the screening log.

- Screening must include temperature checks (with a thermometer and not self-reported), all of the above symptoms listed for staff, **and** other concerns for COVID-19, specific to older adults, not attributable to another cause, including but not limited to;
    - Delirium
    - Loss of orientation to surroundings
    - Sleepiness
    - Increase in falls
    - Onset of incontinence
    - Increased agitation or sluggishness
    - Sleep disturbances
    - Dizziness
    - Chest pain
    - Hemoptysis
    - Abdominal pain
    - General change in behaviour or level of consciousness.

- Include in the documentation of screening any exposure criteria including recent travel outside of the LTCF in the last 14 days for hospital care, appointments or visits with family.

If a resident exhibits any symptoms of COVID-19 or there is a concern for COVID-19 exposure:

- Immediately initiate contact and droplet precautions.
- Complete testing for COVID-19 as per testing section below.
- Notify the OCPHO at (867) 920-8646.

Follow guidance for COVID-19 testing and reporting found in the Interim COVID-19 Assessment Algorithm.

Testing for COVID-19

Testing is in accordance with the most recent guidance for testing and reporting in the Interim OCPHO Coronavirus Disease (COVID-19) Assessment Algorithm. OCPHO advises that HCPs in LTCFs must test for COVID-19 if any residents has symptoms of COVID-19 which are not definitively attributable to another cause HCPs in LTCFs should strongly consider testing if atypical symptoms are present, or they have any other clinical suspicion for COVID-19.

- Symptomatic individuals must be tested for COVID-19 and respiratory pathogen panel (RPP) as soon as possible.
- By completing a COVID-19 and RPP; identification of other causes of the respiratory outbreak including influenza can be identified.
    - **If test result positive for Influenza, please see Appendix B**
- Follow organization/HSSA guidance for swab collection. The following procedure is recommended by the OCPHO
    - Conduct a point-of-care risk assessment before the procedure.
    - When initiating COVID-19 testing, staff must immediately place resident on contact and droplet precautions.
    - Placing a mask over the resident's mouth during NP swab can reduce respiratory droplets from coughing or sneezing.

    - Persons in the room should ideally be limited to the patient and the person obtaining the specimen.
    - Specimens should be obtained by a health care provider experienced in their collection.
    - Residents should be provided with tissues to contain coughs and sneezes after the procedure.
    - Persons performing the testing should stand to the side of the resident, not directly in front of them, and should move away from the resident (to more than 2 meters distant) when the procedure is complete.

- If symptoms began (previously asymptomatic), continued or worsened after receiving negative test results, contact the most responsible practitioner (MRP) and OCPHO who may recommend repeat testing.
- Once an outbreak is declared, HCPs should have a low threshold to test if any additional residents, staff or essential visitors have any symptoms compatible with COVID-19.
- Anyone with symptoms should be managed as an epidemiologically linked confirmed case (symptoms and close contact with a confirmed case) while waiting for their test results.
- Continue screening and monitoring of all residents and staff in the LTCF for new symptoms.

Reporting to the OCPHO

HCP must:

- Notify OCPHO immediately by telephone at (867) 920-8646 for all confirmed or symptomatic (suspect) staff, residents or essential visitors that testing is being completed on.
- Complete the COVID-19 Report Form for Suspect Cases (Part A) must be and submit to OCPHO within 24 hours by fax (867) 873-0442 or secure file transfer (SFT)
- Complete and submit the COVID-19 Report Form for Confirmed Cases (Part B) to OCPHO within 24 hours of receiving the positive test result by fax (867) 873-0442 or SFT.
- Submit COVID-19 Report Form for Case Status Update (Part C) to OCPHO on all confirmed cases any time the disposition of the case changes, and/or at a minimum of weekly by fax (867) 873-0442 or SFT. This would be done by the healthcare provider at the hospital if a resident was transferred or by public health or community health if the positive case is a staff or essential visitor and is recovering at home.

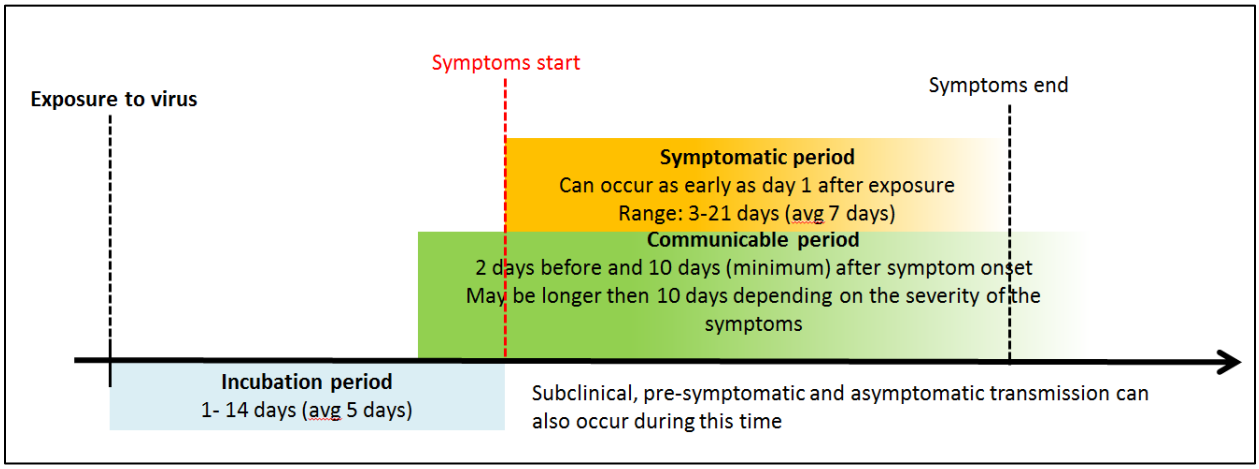
Case-finding during an Outbreak

Once a person is diagnosed with COVID-19 in a LTCF and OCPHO declares an outbreak, actively finding others with COVID-19 is critical. Staff must gather information and timelines regarding symptoms, possible exposures and communicable period, and contacts by using all available information including the screening logs.

HCP must:

- Determine the communicable period (see Figure 1):
    - Two days before until a minimum of 10 days a **symptomatic** confirmed case.
    - Two day before until a minimum of 10 days after the date the lab sample was collected from an **asymptomatic** confirmed case.

Figure 1.



- Identify, asses and test, for COVID-19 on every resident, staff and essential visitor that were present in the LTCF during the **period of communicability** whether they are symptomatic or not.
    - Repeat testing weekly for two weeks after a single exposure
    - Weekly testing of all residents, staff or essential visitors with ongoing exposures during the outbreak for a further three weeks after their initial test (i.e. testing at days 0, 7, 14 and 21)
    - After 21 days consult OCPHO for further recommendations for facility wide weekly testing
- Determine the **exposure period** which includes 14 days before symptoms onset or specimen collected (if case is asymptomatic).
    - Determine any potential sources of COVID-19 infection of any probable or confirmed case (e.g. travel to another facility in a high incidence area).
    - Collaborate with the local health centre or public health and OCPHO to consider investigations to identify the source of the outbreak and prevent any ongoing exposures from a presumed source.
    - Consider assessment and testing of every resident, staff and essential visitor that were present in the LTCF during the **period of exposure**. When initiating investigation into source consider the following:
        - Uncertainty regarding source of the first infection in the facility,
        - Presence or absence of known community transmission
- Increase frequency of active screening for COVID-19 symptoms and testing of residents, staff.
- Have a low threshold to test any residents, staff or essential visitors who develop symptoms of COVID-19.
- Daily screening should continue for the duration of the pandemic.

Case and Contact Investigation during an Outbreak

Completion of a case and contact investigation is critical to the identification and control of the COVID-19 outbreak. The OCPHO Public Health Communicable Disease Control (PHCDC) Unit will provide direction and guidance to the organization/HSSA, LTCF and community health/public health nursing staff on case and contact investigations, and will make recommendations for testing and monitoring of cases and contacts as per Interim COVID-19 Public Health Management of Exposures/Cases and Contacts.

The case reporting form, exposure investigation timeline and contact line listing must be initiated and sent to the OCPHO within 24 hours. Local public health/community health nursing staff as experts in case and contact investigations must be contacted to assist with this investigation.

HCPs must:

- Complete a case and exposure investigation to identify the case's source of exposure and period of communicability (see Figure 1).
- Initiate a contact investigation using the contact line list within 24 hours so that contacts can be, assessed, tested, isolated, and monitored for symptoms during their incubation period.
- In addition to known contacts of the case, include a list of a list of **ALL** staff, residents or essential visitors who entered the LTCF during the two days prior to onset of symptoms or date of swab collection (asymptomatic cases).
- Conduct an exposure risk assessment on each contact and determine their risk of exposure and follow up appropriately.
    - See Interim COVID-19 Public Health Management of Exposures/Cases and Contacts for management of contacts.
    - Determine if contact is at risk for severe illness (co-morbidly, immunocompromised, older) and if they may need additional follow–up from HCP.
    - Any staff or essential visitor who is required to self-isolate due to an exposure to COVID-19 are encouraged to notify their household members so that household members who are essential workers may notify their employer and follow WSCC guidance.
- Update the contact line list daily with any new information and send to the OCPHO every 24 hours and upon request.
- Provide screening logs from the 14 days prior to onset of symptoms and/or COVID0-19 test collection (asymptomatic cases) of the case to the community health/public health nursing staff and OCPHO PHCDC for review and to assist with identification of the exposure, contact investigation and case finding.
- Advise all individuals who are self-isolating and monitoring themselves for symptoms should be advised to immediately report any symptoms to public health or community health centre staff.

Masking for Source Control

Continuous masking aims to prevent asymptomatic/pre-symptomatic transmission of Covid-19 between staff and essential visitors within the LTCF. Continuous masking applies whether the LTCF is in an outbreak or not, and the practice of masking for source control must be in accordance with organizational/HSSA direction/guidance.

To facilitate judicious and effective use of masks the following are recommended as best practices. LTCF staff should:

- Follow organizational/HSSA direction/guidance regarding mask usage and allocation.
- Don the mask when entering the LTCF and remove or exchange it during breaks, when it becomes damp or soiled or when leaving the LTCF at the end of the shift or visit.
- Perform hand hygiene before putting on and after removing or otherwise handling masks.
- Remain two meters away from others during breaks whether they remove their mask or not to prevent transmission.

If tolerated, masks are recommended for use by residents when travelling outside of the LTCF to attend appointments and when in the same room as an essential visitor or staff.

Aerosol-generating Medical Procedures (AGMPs)

An AGMP is any procedure conducted on a resident that can induce production of aerosols of various sizes, including droplet nuclei. AGMPs are rarely performed in LTCFs , though potential examples in this setting may include; performing cardiopulmonary resuscitation (CPR), use of cough assist machines, open suctioning in residents with a tracheostomy, or use of continuous positive pressure airway pressure (CPAP) machines. HCP should follow organizational/HSSAs procedures and guidelines when it is necessary to perform an AGMP and ensure necessary environmental controls, PPE and staff training are in place.

AGMPs on a resident suspected or confirmed to have COVID-19 should be minimized and only be performed if:

- The AGMP is medically necessary and performed by the most experienced person.
- The minimum number of persons required to safely perform the procedure are present.
- All persons in the room are wearing a fit-tested, seal-checked N95 respirator, gloves, gown and face or eye protection.
- The door of the room is closed.

2.0 Outbreak Control Measures

In consultation with the OCPHO, the organization/HSSA may consider initiating outbreak control measures while waiting for results of COVID-19 testing. In addition to organization/HSSA enhanced prevention measures the subsequent outbreak control measures must be followed once a case of COVID-19 has been confirmed in a staff, resident or essential visitor. Due to the similarity of symptoms in both COVID-19 and Influenza, all control measures need to implemented and maintained if a confirmed case of either COVID-19 or Influenza is identified.

- The HCP must notify organization/HSSA Territorial Manager of Continuing Care, IPAC and OHS immediately for guidance and additional measures.
- When a LTCF outbreak occurs, outbreak signage should be posted at all LTCF entrances, floor or unit advising about the outbreak.

Resident Movement

Pre LTCF Outbreak

- For residents who wish to visit family during the pandemic follow organizational/HSSA's directives and guidelines in consultation with the Territorial Manager of Continuing Care.
- For residents that leave the LTCF for an essential out-patient medical visit, staff must follow organizational/HSSA direction/guidance for providing an appropriate mask to the resident and PPE to staff.
    - If tolerated, the mask must be worn by the resident while out of the LTFC.
- Consultation with NTHSSA Territorial Manager of Continuing Care should occur for the following:
    - Transfers within and between facilities (this should be avoided unless medically indicated).
    - If an admission or re-admission is required.
    - Any resident who is due to be discharged from the LTCF into community during an outbreak will not be discharged until a risk assessment is completed.
    - In situations when the resident is removed from the LTCF by the family to determine re-admission.
- New admissions, re-admissions and transfers to a LTCF will not be permitted if the resident is currently in a facility or residing in a region that is experiencing an outbreak of COVID-19.
- At any time a resident is permitted to return to the LTCF they would need to be screened for symptoms prior to entry, and placed on droplet and contact precautions for the 14-day incubation period.
- HCPs, after consultation with the NTHSSA Territorial Manager of Continuing Care, may consider testing residents for COVID-19 prior to their admission to the LTCF.

- A negative result does not rule out COVID-19 and the resident must remain on droplet and contact precautions for a 14-day incubation period following the transfer/admission.

During a LTCF Outbreak

The following must be implemented for residents who are symptomatic, lab confirmed or who are high risk contacts of a confirmed case:

- Isolate resident in a private room (if not already residing in one) and place on droplet and contact precautions.
- Notify HSSA IPAC immediately and follow organizational/HSSA IPAC directives and guidance.
- Provide in-room meal service.
- Complete a point of care risk assessment (PCRA) and use additional IPAC precautions as determined.
- When possible/tolerated, the resident should wear a mask when another individual is in their room.

All Residents:

- Ensure the local public health unit, community health centre, Territorial Manager of Continuing Care, HSSA IPAC, EMS and hospital are informed about the LTCF outbreak, especially if residents are to be transferred.
- Admissions (permanent, respite, palliative), re-admissions and transfers are not permitted into a LTCFs once COVID-19 is detected in the community or region.
- If admissions, re-admissions or transfers are required the NTHSSA Territorial Manager of Continuing Care must be consulted.
- Minimize contact between residents on affected floors/units/houses/pods with unaffected areas.
- Movement must be restricted within the LTCF and communal activities discontinued.
- Remind residents to practice good hand hygiene, healthy respiratory practices, and physical distancing.
- Cancel or reschedule any appointments that do not risk the health or well-being of residents until the outbreak is declared over.
- If an appointment is deemed essential to the health and wellbeing of the resident a risk assessment should be conducted by the NTHSSA Territorial Manager of Continuing Care.
- Any resident who is transferred out of the LTCF during an outbreak to receive medical care in another facility (e.g. hospital) would only be considered for transfer back to the LTCF based on their medical condition and the outbreak status in the sending and receiving facility.
    - The decision on transfer will be made in consultation with NTHSSA Territorial Manager of Continuing Care.
- A resident who transfers out of the LTCF, for non-medical reasons must not be transferred back during an outbreak.
- Active daily monitoring of a resident transferred to another facility from a LTCF with an outbreak must also be implemented.

    - The nurse-in charge (or appropriate delegate) of the LTCF must contact the facility every day and in addition, advise the facility to proactively report back to the LTCF any changes in status of the admitted resident which may signal COVID-19 infection and of any facility outbreaks.
    - If there is a change in status noted for a resident transferred to another facility, the nurse-in-charge (or appropriate delegate) must contact the OCPHO.
- If there is an outbreak in either facilities at the time of a permitted transfer consult the NTHSSA Territorial Manager of Continuing Care prior to transfer.

Staff Movement and Cohorting

Pre LTCF Outbreak

Staff who work in more than one setting (LTCF, health care, other employment setting) increase the risk of transmission of influenza or COVID-19 within a LTCF due to their potential exposure to the virus in multiple settings.

The management of the LTCF must determine an appropriate mitigation strategy to prevent introduction of viruses to the susceptible population. This includes development of a plan to restrict movement of staff between work settings.

- Staff should be assigned to work in the LTCF, health center, acute care or administrative area but not move back and forth between these areas.
    - This includes instances where services (housekeeping, dietary) share staff that move between facilities or within a facility (acute care area to an extended care or LTC area).
- Risk of locum staff introducing COVID-19 or other viruses must be assessed and mitigated for any risks with travel in and out of the territory and potential exposures in shared housing/accommodations.
- The organization/HSSA must have guidance/direction that addresses the following:
    - Staff movement between facilities and/or other employment sites;
    - The use of locum staff in LTCFs, which considers their shared housing/accommodations;
- Once a case of COVID-19 is confirmed in a region or community, only staff working in facilities that use continuous masking will be permitted to work in LTCF.
- Cohort staff as strictly as possible e.g. staff working with symptomatic residents or those residents who are on IPAC precautions must avoid working with residents who are well.
- Perform a PCRA and use routine and additional precautions when caring for residents or going into and cleaning resident rooms.
- Practice strict hand hygiene, health respiratory practices and physical distancing

During a LTCF Outbreak

During an outbreak, in addition to the above recommendation, staff from that LTCF:

- Must only work in the LTCF and not work in outside employment or in other health care facilities.

- Must not work in non-outbreak facilities.
    - In the event of critical staff shortages, the organization/HSSA must develop a plan to ensure safe care and limit exposures. In consultation with the OCPHO, staff from non-outbreak facilities may work in outbreak facilities with strict IPAC and OHS guidelines.

Managing Visitors

During the pandemic allowing visitors into a LTCF puts residents and staff at risk. All LTCFs must develop and implement direction/guidance related to admission of visitors that protects residents and staff from COVID-19 and other virus exposures. Limiting visitors may be one method to decrease this risk.

- Signage directing whether visitors are permitted into the facility or not must be placed at all entrances to the LTCF.

Pre LTCF Outbreak

Essential Visitors: Under certain circumstances (e.g. palliation, end-of-life, etc.), LTCFs may seek permission to permit a visitor (essential visitor) in accordance with organizational/HSSA direction/guidance.

Recommendations to prevent outbreaks in LTCF from essential visitors:

- It is recommended that all routine visitations in LTCFs cease and guidance/directives be drafted by organizations/HSSA to identify essential visitors and possible exceptions.
- Visitors should be limited to one person at a time for each resident and their movement should be limited to visiting the resident only and exiting the LTCF directly after their visit.
- At every visit, the essential visitor must be screened for symptoms and exposures (follow guidance in the screening section of this document) and must sign-in to and out of the LTCF.
- Staff must support, train and monitor essential visitors for compliance in hand hygiene, healthy respiratory practices, physical distancing and appropriate use of PPE for the duration of their visit.
- Symptomatic persons or persons that meet the exposure criteria in the last 14 days must not enter the LTCF.
    - The symptomatic or previously exposed visitor should be advised to wash their hands, be given a mask and instructed to return home. They should be advised to contact their public health unit or community health centre for further investigation and assessment.

During a LTCF Outbreak

Admission of essential visitors must be immediately suspended when COVID-19 is detected in the LTCF, or the community/region where the LTCF is located.

Routine practices

IPAC best practices used by staff and essential visitors can reduce the risk of transmitting COVID-19 and other infections to and from residents, staff and essential visitors in the LTCF setting. Follow organizations/HSSAs directives and guidance regarding IPAC. Additional recommendations include but are not limited to:

- Signage and guidance on the following should be placed in strategic locations throughout the LTCF:
    - Reminders for hand hygiene, healthy respiratory practices, physical distancing, proper mask use,
    - Steps to be taken if COVID-19 is suspected or confirmed,
    - Locations of alcohol-based hand sanitizers, no touch waste receptacles, cleaning/disinfection supplies,
    - Essential visitor procedures.
- Staff must be trained in organizational/HSSAs IPAC measures including; performing PCRA in advance of any interactions with residents, proper hand hygiene, use of PPE and the importance of maintaining a 2 metre distance between themselves and residents.
- It is recommended that organizations/HSSAs ensure staff are monitored for compliance with appropriate IPAC measures on a regular basis
- Essential visitors should be instructed on proper hand hygiene and use of PPE, and provided health teaching on the importance of physical distancing and healthy respiratory practices.
- Access to alcohol-based hand sanitizer, no touch waste receptacles and PPE must be provided in resident care areas and other strategic locations within the LTCF.
- All non-essential activities and communal gatherings should be discontinued and volunteers be excluded from the LTCF.

Environmental Cleaning, Waste Management and Food Services during an Outbreak

Notify housekeeping, food services and laundry that the LTCF has an outbreak of COVID-19 so their department-specific outbreak management protocols are initiated.

The virus has the potential to survive in the environment for up to several days depending on the surface. A person who has contact with a contaminated surface or object is at risk of infection. Cleaning and disinfecting, particularly of frequently touched surfaces, can kill the virus, making it no longer able to infect people. It is recommended that in addition to Organizational/HSSAs IPAC procedures and guidelines, LTCFs:

- Increase frequency of cleaning and disinfection of high-touch surfaces to a minimum of two times per day.
    - This includes resident rooms, equipment, and any central areas (e.g., doorknobs, light switches, call bells, handrails, phones, elevator buttons, TV remote, etc.).
- Room cleaning and disinfection should be performed at least once per day on all low touch surfaces.
- Staff responsible for cleaning, food services, waste management, etc. should limit their need to be in resident care areas as much as possible thereby limiting their need to wear PPE.
- Staff who must be in resident care areas must wear appropriate PPE when providing services within 2 metres of a resident.
- Reusable equipment should be dedicated to the use of the resident.

    - If this is not feasible, equipment must be cleaned and disinfected with a hospital grade disinfectant before and after each use.
- All staff equipment (e.g. computer carts and/or screens, medication carts, charting desks or tables, telephones, touch screens, chair arms, etc.) must be cleaned and disinfected at minimum 2 times per day.

3.0 Declaring the LTCF Outbreak Over

Outbreak control measures are to be continued until determined by the CPHO or designate. They may continue for the duration of the pandemic depending on community and regional spread of the disease.

- The CPHO or delegate declares when the LTCF outbreak is over.
    - The COVID-19 outbreak may be declared over when there are no new cases in residents, staff or essential visitors for 2 full incubation periods (28 days) since the last confirmed case's symptoms have resolved and has had a negative test for COVID-19.
    - For information specific to declaring an Influenza outbreak over, please see Appendix B

4.0 Debriefing

Following the outbreak, organizations/HSSAs must review and evaluate the outbreak management that occurred and revise any protocols for improvement where necessary.

Key subjects for discussion may include but are not limited to:

- Whether screening and surveillance for COVID-19 was occurring so that the initial cases were identified early and prior to extensive spread of the disease.
- Identify any problem areas that allowed spread of disease in an effort to reduce the impact of future outbreaks:
    - Screening
    - Testing and Case Finding
    - Reporting
    - Case and contact investigation
    - Resident and Staff movement, and cohorting
    - Visitor guidance/direction
    - Routine practices
    - Masking for source control
    - AGMPs
    - Environmental cleaning, waste management and food services

- Was the outbreak protocol activated in a timely manner
- What was the status of community spread of COVID-19 at the time of the outbreak in the LTCF including:
    - Was there increased COVID-19 activity in the community prior to the LTCF outbreak, and
    - Was the LTCF adequately informed of the activity

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Appendix A: Version Table

Version Date	Summary of Updates
June 18, 2020	Version 1
September 16, 2020	Additional information regarding inferred thermometers and a version table.
September 25, 2020	Addition of Influenza Outbreak Management Guidance for Long Term Care Facilities

Appendix B: Influenza Specific Information

Influenza-Like Illness (ILI) Case Definition (FluWatch Canada: Influenza definitions)

ILI is described in the general population as the sudden onset (over 2 days or less) of flu symptoms with fever and cough and with one or more of the following:

- Sore throat
- Joint pain (arthralgia)
- Muscle aches (myalgia)
- Severe exhaustion (prostration)

In children under five years of age, gastrointestinal symptoms may also be present. In patients under five years or 65 years and older, fever may not be prominent.

Definition of Outbreak in a LTCF as per FluWatch Canada

Two or more cases of ILI, within a seven-day period, including at least one laboratory confirmed case of flu in the same setting (on the same floor, or in the same unity or ward). These cases can be in either a resident or staff person.

> **Institutional outbreaks must be reported immediately to the CPHO or designate. The CPHO will determine if an outbreak is occurring and declare when an outbreak is over.**

Surveillance and Reporting

"For control of an outbreak of influenza among residents of a LTCF, surveillance for ILI is critical for early identification and response" (AMMI Canada). It is important that all confirmed and suspect cases of ILI are reported to the CPHO or designate as soon as possible using the Influenza Reporting Form found here: Communicable Disease | HSS Professionals

Suspect cases should be tested for influenza viral infection as per the Alberta Provincial Laboratory Guide to Services

All LTCFs must have a process in place to keep track of resident and staff influenza vaccine uptake. This list must be available immediately upon request of the CPHO or designate.

Infection Prevention and Control (IPC) Practices during Influenza Outbreaks in LTCF

Follow recommendations as per the Covid-19 outbreak measures and the NWT Infection Prevention and Control Manual 2012: Policies and Guidelines, Standards and Manuals | HSS Professionals

Immunization of HCP and Residents

On average, the flu and its complications send about 12,200 Canadians to hospital every year, and cause about 3,500 deaths (Canada.ca Flu (influenza)).

Immunization of residents, healthcare workers, volunteers and visitors with influenza vaccine each year is the cornerstone in prevention of influenza outbreaks in Long-Term Care Facilities (LTCF).

Each health care facility/health and social services region should have a policy and procedure referring to immunization of HCWs and HCWs coming to work when sick.

In order to protect vulnerable patients during an outbreak, the CPHO or designate may exclude HCWs who develop confirmed or presumed influenza as well as unvaccinated health care workers who are not taking antiviral prophylaxis from providing direct patient care. Every facility should have policies in place to deal with this issue.

"Given the potential for HCWs and other care providers to transmit influenza to individuals at high risk and knowing that vaccination is the most effective way to prevent influenza, NACI recommends that, in the absence of contraindications, HCWs and other care providers in facilities and community settings should be vaccinated against influenza annually. NACI considers the receipt of influenza vaccination to be an essential component of the standard of care for all HCWs and other care providers for their own protection and that of their patients. This group should consider annual influenza vaccination as part of their responsibilities to provide the highest standard of care." *(NACI Statement on Seasonal Influenza Vaccine for 2020-2021)*

Recommendations for Use of Antivirals during an Influenza Outbreak

The following principles will be followed during an outbreak of influenza in a LTCF:

- The recommendation to implement antiviral prophylaxis for outbreak management is made by the CPHO or designate.
- The prescribing of antivirals for the **treatment** of influenza of both residents and staff of the LTCF is the responsibility of the attending physician.
- It is recommended that AMMI Canada guidelines are followed: AMMI Canada.
- Seasonal vaccination is the primary preventative control measure.
- Antiviral prophylaxis should not replace seasonal influenza vaccination.
- Oseltamivir (Tamiflu®) is used for the treatment of both Influenza A and B and the prevention of clinical complications.
- Oseltamivir (Tamiflu®) is a neuraminidase inhibitor that can prevent the release of influenza virus from infected cells thereby minimizing the risk of severe illness.
- Oseltamivir (Tamiflu®) is available in 75 mg capsules as well as a powder that can be reconstituted into an oral suspension.
- Oseltamivir (Tamiflu®) is now a **MUST STOCK** item for health centers as per the April 2018 NWT Formulary.

- Antiviral therapy works best when initiated within the first 48 hours after symptom onset and/or upon identification of an influenza outbreak.
- Oseltamivir is not effective for prophylaxis of respiratory infections other than influenza.

Antiviral Prophylaxis and Treatment

During a facility outbreak where the confirmed cause is influenza virus, the CPHO or designate may recommend antiviral prophylaxis for all exposed, asymptomatic patients/residents (regardless of their influenza immunization status), and unimmunized HCW unless a contraindication is present.

Oral Antiviral (Oseltamivir) Prophylaxis Dosage*: 18 years and older

Creatinine Clearance	**Prophylaxis: consult OCPHO (within 48 hours of 1st exposure and to be continued for 10-14 days or until the outbreak has been declared over)**	**Treatment (within 2 days of onset) for 5 days**
Over 60ml/min	75 mg once daily	75 mg twice daily for five days
31-60 ml/min	30 mg once daily or 75 mg every other day (if supply of 30 mg not available)	30 mg twice daily for five days **OR** 75 mg once daily for five days (if supply of 30 mg not available)
10-30 ml/min	30 mg every other day	30 mg once daily for five days
Client on routine hemodialysis	Initial 30 mg prior to dialysis, with 30 mg after alternate hemodialysis sessions for duration of outbreak	Initial 30 mg prior to dialysis with 30 mg after every dialysis session over five days
Client on peritoneal dialysis	Initial 30 mg prior to the start of dialysis followed by further 30 mg dose administered every 7 days for a period of 10-14 days or for the duration of the outbreak	A single dose of 30 mg is administered

*As per TAMIFLU® product monograph and AMMI Guidelines and Alberta Health Services Outbreak Management 2019

Post-Outbreak Considerations

1. **Declaring the Outbreak Over**

The end of a LTCF outbreak is considered when no new cases of ILI have appeared for at least seven days or roughly two incubation periods. Only the CPHO or designate can declare the outbreak over.

2. **Debriefing**

Following an outbreak, a debriefing within the long-term care facility should take place. Issues to be considered include:

- Whether immunization protocols were followed and their effectiveness
- Whether surveillance for ILI was occurring so that initial cases were identified early prior to extensive spread of the disease
- Identify problem areas that allowed spread of disease in an effort to reduce the impact of future outbreaks e.g. early testing, early reporting
- Was the outbreak protocol activated in a timely manner
- What was the status of community ILI activity at the time of outbreak in LTCF
- Was there increased ILI activity in the community prior to LTCF outbreak, and if so, was the LTCF adequately informed