POLICY IFC-50: Management of COVID-19/ Novel Respiratory Influenza Like Illness

Infection Control

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COVID-19 Signs and Symptoms

When assessing for the symptoms below the focus should be on evaluating if they are new, or worsening, or different from an individual's baseline health status.

- **Fever** (Temperature of 38 degrees Celsius/100.4 degrees Fahrenheit or greater) and /or **chills**
- **Cough or barking cough** (that is new or worsening (e.g. continuous, more than usual if chronic cough) including croup (barking cough, making a whistling noise when breathing)
    - Not related to asthma, post-infectious reactive airways, COPD or other known causes or conditions you already have
- **Shortness of breath** (dyspnea, out of breath, unable to breathe deeply, wheeze, that is worse than usual if chronically short of breath)
    - Not related to other known causes or conditions (e.g. CHF, asthma, COPD)
- **Decrease or loss of smell or taste.**
    - Not related to other known causes or conditions (e.g. nasal polyps, neurological disorder, seasonal allergies)
- **Fatigue, lethargy, or malaise** (general feeling of being unwell, lack of energy, extreme tiredness) that is unusual or unexplained.
    - Not related to other known causes or conditions (e.g. depression, insomnia, thyroid dysfunction, anemia, malignancy, receiving a COVID-19 vaccine in the past 48 hours)
- **Muscle aches and pain** (that are unexplained, unusual, or long-lasting)

    - Not related to other known causes or conditions (e.g. fibromyalgia, sudden injury or receiving a COVID-19 vaccine in the past 48 hours)
- **Sore Throat**
    - Painful or difficulty swallowing (not related to post-nasal drip, acid reflux, or other known causes or conditions you already have)
- **Runny or stuff/congested nose**
    - Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have
- **Headache**
    - New, unusual, long-lasting (not related to tension-type headaches, chronic migraines, or other known causes or conditions you already have. If you have received a COVID-19 and/or flu vaccination in the last 48 hours and are experiencing a headache that only began after vaccination, select "No"
- **Nausea, vomiting and/or diarrhea.**
    - Not related to other known causes or conditions (e.g. transient vomiting due to anxiety in children, chronic vestibular dysfunction, irritable bowel syndrome, inflammatory bowel disease, side effect of medication)

Case Management

COVID-19

- Confirmed or probable COVID-19 case should self-isolate on Droplet and Contact Precautions for at least 5 days from symptom onset and until symptoms have been improving for 24 hrs (or 48 hours if gastrointestinal symptoms) and no fever is present
- For a total of 10 days from symptom onset, cases should wear a well-fitted mask, if tolerated when receiving care and when outside of the room
    - If unable to mask, the case should remain on Droplet and Contact Precautions for 10 days from symptom onset.

Contact Management

Roommates who remain in the same room

- Self-isolate on Droplet and Contact Precautions for 5 days (including day zero) from the case's symptom onset
- For a total of 10 days, from the case's symptom onset, wear a well-fitted mask, if tolerated, when receiving care and when outside of their room

Non-roommate close contacts (i.e., Tablemate)

- Self-isolate on Droplet and Contact Precautions for 5 days (including day zero) from the case's symptom onset
- For a total of 10 days, from the case's symptom onset, wear a well-fitted mask, if tolerated, when receiving care and when outside of their room

Prevention and Control Measures

SCREENING PROCEDURES

Residents

New Admission/Re-Admission/Daily surveillance

- All new admissions to the Home will be assessed for indicators of an Acute Respiratory Infection on the Admission Assessment. If the Resident fails admission screening, they will be placed on droplet/contact precautions and isolated to their room.
- Residents returning from hospital or upon their return from a social absence, will be screened for any signs or symptoms of an ARI upon their return at the next screening interval.
- Registered staff complete Qshift symptom surveillance via the EMAR system to identify any new sign or symptom of respiratory, enteric or new infectious rash.
- Registered staff complete the hard copy daily surveillance sheet and submit to IPAC Q24hs which indicate any new Resident with respiratory/enteric symptoms, new infectious rash or any other health care associated infections which allows IPAC to monitor infectious trends in the Home daily.

Enhanced Monitoring of asymptomatic Residents

- New admissions/re-admissions and transfers from a hospital to the Home, will require the Resident to be placed on enhanced monitoring for 10 days with twice daily temps for ongoing surveillance.
- Residents who are on Enhanced Monitoring do not require isolation.

Symptomatic Resident Symptom Monitoring

- Symptomatic Residents will be monitored twice daily (including vital signs – temp and O2) to monitor for new or worsening symptoms of COVID-19

Visitors

Visitors to the Home will enter and exit via the main entrance and passively screen using the signage in the vestibule and perform hand hygiene.

Signage is posted at all entrances instructing visitors how to wash hands with ABHR, how to apply a mask and how to conduct proper respiratory etiquette.

All caregivers, students, volunteers, and visitors must complete passive screening upon entry to the Home using the COVID-19 Screening Form.

The Home will have one entrance for all Visitors. (The front entrance)

All persons are encouraged to self-monitor for COVID-19 symptoms prior to coming to Home and not come to the Home if they are ill.

All persons entering the Home must sign into the visitor logbook located at the front entrance. The visitor log can be used for contact tracing and is retained for 30 days.

Visitors who fail passive screening should not enter the Home when ill and should leave the Home immediately and self isolate at their own Home and follow Public Health guidance.

Exceptions where individuals who fail screening may be permitted entry into the Home:

1. Visitors for imminently palliative Residents must self screen prior to entry. If they fail screening, they must be permitted entry, but the Home ensures that they wear a medical (surgical or procedural) mask and maintain physical distance from other Residents and staff. It is recommended for this visit that the Resident also wear a mask.
2. General visitors who test positive for COVID-19 and where visits cannot be avoided (e.g. Essential caregiver visits), visitors should wear a medical mask, maintain physical distancing, and should notify the Home of their recent illness/positive test. It is recommended during this visit; the Resident also wear a mask.

Staff

All staff must passively screen for symptoms prior to their shift. Screening questions are posted in the service hallway, in each Home Area and throughout the Home.

All persons are encouraged to self-monitor for COVID-19 symptoms prior to coming to Home and not come to the Home if they are ill.

All staff and any persons entering the Home shall passively-screen for symptoms of COVID-19, exposure history and must not come to work ill.

Anyone showing symptoms or signs of COVID-19 shall not be allowed to enter the Home and should go Home to self-isolate immediately.

Emergency First Responders who, should in emergency situations be permitted in without screening.

Handwashing

All staff, visitors and Residents are to perform hand hygiene as per the Just Clean Your Hands Program (4 moments).

To use:
-ABHR-70-90%
-Soap and water when hands and visibly soiled

Respiratory Hygiene/Cough Etiquette

The following measures to contain respiratory secretions are recommended for all individuals

- Avoid touching eyes, nose, and mouth.
- Cover your mouth and nose with a tissue when coughing or sneezing.
- Use in the nearest waste receptacle to dispose of tissue after use.
- If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands.
- Perform hand hygiene (i.e., hand washing with non-antimicrobial soap and water, alcohol-base hand rub, or antiseptic hand wash) after contact with respiratory secretions and contaminated objects/materials.

Required PPE Precautions

- Where it is not possible to use other control measures to sufficiently reduce a worker's risk of exposure, personal protective equipment (PPE) will be needed. As much as possible, PPE should be used in combination with other controls.

- It is important that any PPE that workers use is appropriate for the purpose. While caring for a suspected or confirmed patient with COVID-19 appropriate PPE consists of a N95 mask or well fitted surgical mask, eye protection (e.g. face shield, goggles), gloves and a gown.

Activity	**Precautions**
Before every Resident interaction	Staff must conduct a point-of-care assessment to determine the health and safety measures required.
All interactions with and within 2 metres of Residents who screen negative	• Staff must conduct a point of care risk assessment when within 2 meters of a Resident. • Perform hand hygiene before and after contact with the Resident and the Resident's environment and after the removal of PPE.
All interactions with and within 2 metres of Residents who screen positive, symptomatic, identified as a high-risk contact of a known COVID-19 case, or have a confirmed COVID-19 infection	Droplet and Contact Precautions: • N95 mask and/or surgical mask • Isolation gown • Gloves • Eye protection (e.g. goggles, face shield) • Perform hand hygiene before and after contact with the Resident and the Resident's environment and after the removal of PPE

Mask Etiquette

- Clean hands before putting on your mask.
- Avoid touching your face and the outside of your mask.
- Clean hands before touching your face and if you touch the outside of your mask.
- Avoid hanging your mask under your chin.
- Double masking is not advised-use one mask that fits well.

Masking for Staff, Students, Volunteers

- All staff will perform a point-of-care risk assessment prior to any ill Resident interaction to determine their use of masking (surgical or N95 mask if COVID-19 is Suspected or Confirmed) and will include assessing the exposure risk specific to the care intervention being performed and the duration of the activity.
- For respiratory illnesses, if the Resident chooses not to wear a mask, or is unable to safely wear a mask, Staff should review their PCRA and adjust PPE accordingly.
- Masking is based on the return-to-work protocols following a COVID-19 infection.
- A PCRA must be completed by every health care worker before every Resident interaction and task to determine whether there is a risk to the health care worker or other individuals of being exposed to an infectious agent, including COVID-19, and determine the appropriate IPAC measures to be taken.
- Staff, students and volunteers may consider wearing a mask during prolonged direct Resident care defined as one-on-one within two meters of an individual for fifteen minutes or longer.
- Masking must still continue in Home Areas when in outbreak and when providing care to a symptomatic Resident on droplet/contact precautions.
- Communication will be provided when the Outbreak Management Team decision is made to implement situational masking, targeted masking or continuous masking during times of higher positivity rates of respiratory illness in the community, Residents and staff.

Masking for caregivers and visitors

- In outbreak situations, or if a Resident is on Additional Precautions, all individuals are required to comply with masking and other personal protective equipment requirements as directed by the outbreak management team and the local public health unit.
- Signage will be posted when the Outbreak Management Team decision is made to implement situational masking, targeted masking or continuous masking during times of higher positivity rates of respiratory illness in the community, Residents and staff.
- Adult and Pediatric masks will be available in the vestibule/sign in desk for all visitors with instructional signage on how to apply and remove a mask.

In outbreak situations and/or for Residents who are on additional precautions the exceptions to the masking requirements are as follows:

1. Children who are younger than 2 years of age
2. Any individual who is being accommodated in accordance with the Accessibility for Ontarians with Disabilities Act, 2005 or the Ontario Human Rights Code

Addressing the above noted exceptions:

Visitors to the Home:

- The individual will wear a face shield into the Home. The face shield must cover their mouth. (See Visitor's Policy)

Staff:

- Assessed on a case-by-case situation in line with Policy OHS-05 Accommodation Program and Plan.

Signage for the appropriate application and removal of a mask and/or PPE is posted for all visitors and staff

When Should Masks be Changed?

Masks can be used continuously for repeated close contact encounters with Residents who are not in isolation, without being removed between Resident interactions.

Masks used as PPE: for providing direct care where this is a risk of contamination- should be changed as part of routine doffing process. However, when co-horting measures have been implemented, the same mask can be used across several Resident interaction within the co-hort (same room).

A mask MUST be disposed of if:

- It becomes visibly soiled.
- It makes contact with the Resident or their droplet/secretions.
- It becomes very moist such that the integrity becomes compromised.
- It is being changed as part of the doffing of PPE after a Resident interaction or care is completed to a cohorts group ex: those in Droplet/Contact precautions.

Extended use of N95 Masks (ex. N95 masks)

Staff must remove their masks by the ties or elastics taking care not to touch the front of the mask and perform hand hygiene before and after mask removal and before putting it on again.

- Remove and discard if wet, contaminated, damaged, hard to breathe through, at break times or following an AGMP.
- During extended use for N95 respirators, always change gloves and gown between

Eye Protection

Appropriate eye protection (goggles or face shield) is required for all staff, caregivers and essential visitors when providing care or visiting a Resident with suspected or confirmed COVID-19 and in the provision of direct care within two meters of Residents in an outbreak area.

In all other circumstances, the use of eye protection by staff is based on the point-of-care risk assessment when within two meters of a Resident. This is a requirement regardless of whether the Home is in an outbreak or not.

Eye Protection includes face shields, some safety glasses, goggles. Goggles/safety glasses must be close fitting around the head and/or with integrated side shields to provide a barrier from the front, the sides and the top.

**Eye protection may be used between co-horted Residents, gloves must be removed and disposed of, followed by proper hand hygiene practices and new gloves that must be applied between each Resident.

Personal Protective Equipment (PPE) Stewardship

Supplies are available in each clean utility room, PPE towers in each Resident Home area, and a sufficient stockpile of PPE is stored in the Team Meeting room.

Doffing of PPE:

Staff must be greater than 2 metres of distance from the Resident and/or other staff and visitors before they remove their PPE. PPE will be removed in a manner that does not contaminate themselves or the environment.

Hand Hygiene is performed at every stage during the removal of PPE before preceding to next stage of PPE removal.

Waste receptacles are placed inside of the Residents room to support easy disposal of PPE and laundry carts when reusable gowns are used.

PPE for Residents on Droplet/Contact Precautions

1. **Gloves**
- Follow Routine Practices
2. **Gowns**
- Follow Routine Practices
3. **Eyewear:**
   In addition to Routine Practices**,** wear goggles/face shield when working within two (2) meters of the Resident.

Environmental Cleaning

When not in an outbreak, cleaning of care areas/ public areas/ high touch surfaces shall be cleaned/disinfected with a hospital grade disinfectant once daily and when visibly soiled.

In outbreak situations or when a Resident is on additional precautions related to a suspect and/or confirmed COVID-19 infection additional (twice per day) environmental cleaning is completed for high touch surfaces

High touch surfaces:

- Door handles
- Light switches
- Elevator buttons
- Handrails
- Trolleys
- Lifts (mechanical for Resident transfers)

All shared equipment and items should be cleaned and disinfected between each resident use. Dedicated equipment is preferred.

Co-horting

Staff - Non-outbreak:

- Full time staff to work on one Resident Home area as much as possible.
- Part time staff to work in one or two RHA as much as possible.

Staff – During an Outbreak:

- Full time staff to be work on one Resident Home area.
- Part time staff to work in one Resident Home area wherever possible as staffing allows.
- Staff should remain in a single cohort per shift.
- If staff must work with more than one cohort during a single shift, staff are to work with well Residents first.

Residents - Non-Outbreak:

There are no COVID-specific requirements or restrictions related to physical distancing or co-horting when not in outbreak.

Ventilation and Filtration

- The risk of COVID-19 transmission is higher in indoor settings. Where appropriate and possible, staff may encourage outdoor activities
- Indoor spaces are well ventilated centrally by a heading, ventilation and air conditioning (HVAC) system
- Directional currents can move air from one Resident to another. Portable units (e.g. Fans) should be placed in a manner that avoids person-to-person air currents.

Health and Safety in the Workplace/Education and Training

In case of an outbreak of COVID-19 Staff will be educated on:

- The characteristics of the disease.
- Symptoms of the disease.
- The level of risk in the community and within the Home.
- The Homes plan to respond to the COVID-19.
- Information about appropriate protective practices; hand hygiene, routine practices, additional precautions, and appropriate personal protective equipment.

Staff will be updated regularly when practices change and/or when new information becomes known.

Education

Training of staff/volunteers/student placements on the use of PPE and IPAC protocols. This policy will be reviewed by Resident Council, Family Council and Public Health as required.

Communications:

- LTCHs must keep staff, Residents and families informed about COVID-19, including frequent and ongoing communication during outbreaks.
- Issuing a media release to the public is the responsibility of the Administrator as required and will be done in collaboration with the public health unit.
- A copy of this policy is posted on the Norview Lodge Website and hard copies will be made available upon request.

Everyone visiting Norview Lodge, including staff, students, volunteers, caregivers, support workers, general visitors or Residents has the responsibility to ensure the ongoing health and safety of all by practicing these measures at all times.

References

Ministry of Long-Term Care COVID-19 Guidance Document for Long-Term Care Homes in Ontario, Nov 7, 2023

Ministry of Health. Infectious Disease Protocol. Appendix 1: Case Definitions and Disease-Specific Information. September 2023

Ontario. Ministry of Health. Recommendations for outbreak prevention and control in institutions and congregate living settings. Toronto, ON: King’s Printer for Ontario; 2024.