Outbreaks

Outbreaks in Long Term Care and Integrated Facilities
Generic Protocol – Introduction

Preamble

Outbreaks are common in long term care (LTC) facilities.[1] The following generic protocol provides general information regarding outbreaks in LTC and integrated facilities. These defined principles can be applied to a variety of settings. Regional and local infection control manuals contain supplementary information that should be referred to.

Protocols for the management of non-influenza respiratory and enteric outbreaks are included in Sections 9-40 and 9-50. Please refer to these sections for specific guidelines.

General Measures

An emphasis on health promotion and outbreak prevention from the traditional outbreak control is an important shift that needs to take place. Staff education and communication are essential to the success of infection control measures and outbreak management. Institutions should:

- Develop active, formal orientation and ongoing education programs for all staff.
- Ensure that all staff receive education in infection prevention and control (IPC) practices.
- Measure the effectiveness of their education program.
- Educate residents/clients, health care workers, and the public about their personal responsibility for disease prevention.

Long term care (LTC) facilities should also establish links with their regional and local IPC personnel[2] and Public Health to ensure the communication of roles and responsibilities prior to, and during outbreaks, are clear. To assist with this, key players should understand their roles and the roles of others.

[1] For the purpose of this document long term care facilities is inclusive of special care homes and similar care facilities.

[2] IPC Personnel can include onsite staff that specialize in IPC, regional IPC Practitioners, and in rare cases Public Health provides IPC services. Each facility should maintain the name and contact information of the appropriate IPC personnel to contact for prevention and control protocols.

Pre-Season Planning and Prevention

Outbreaks can occur at any time throughout the year but they occur more frequently throughout the winter months. Annually, ideally before outbreak season, all facilities should:

- Review laboratory procedures and ensure appropriate laboratory supplies are available in sufficient quantities. For additional information, refer to Section 9-43 Generic Respiratory – Investigation and Section 9-53 Generic Enteric Protocol – Investigation.
- Assemble other material and supplies (e.g., personal protective equipment, cleaning and hand hygiene supplies) required for outbreak management and ensure procedures are in place for rapidly obtaining additional supplies in sufficient quantities when an outbreak occurs.
- Create or update a list of key people and their contact information for notification purposes in the event of an outbreak in a facility. This may include members of the outbreak team, as well as a list of individuals or agencies that may be contacted for supplies or services.

Additionally, the Ontario Ministry of Health and Long-Term Care (2006) indicates the best practice in surveillance and IPC for infectious illness consists of the following:

1. Immunization – where available/applicable.
2. Case Finding/Surveillance.
3. Preventive Practices.
4. Reporting.
5. Evaluation.

Case Finding/Surveillance

The goals of ongoing surveillance include: identify early signs of infectious illnesses (in the community and within facilities), monitor for possible clusters of infections so outbreak measures can be implemented; prevent outbreaks of infectious diseases; protect resident/patient and staff health; and identify a potential outbreak in its early stages.

Early identification of cases can assist in abating an outbreak. All health care settings should ensure that they have the ability to identify cases of infectious illness and to detect clusters or outbreaks of infectious illness. A key component of case identification is also ensuring that case status is communicated to nursing staff, physicians, and infection control. *Public health must be notified when the etiology of the illness is a reportable disease or when there is an outbreak or cluster in any health care facility.*

Preventive Practices

IPC practices are designed to protect clients, health care workers and the public from exposures to infectious diseases, and reduce the risk of transmission in health care settings. Regional infection control committees provide expertise for determining IPC guidelines for LTC facilities. There is no such thing as "zero risk" for clients, staff or visitors; however, there are steps that should be taken to significantly reduce the risk. Details of the specific measures are included under Section 9-32 Generic Protocol – Prevention and Control Measures.

Reporting

Communication is essential during all phases of surveillance activities and throughout an outbreak. Reporting outbreaks early and in a consistent manner ensures that health care facilities and public health authorities have the information they need to prevent and control the spread of infectious respiratory and enteric illnesses. There are requirements for communication and reporting for both internal and external agencies. For additional information see Outbreak Management Team for Facility-Based Outbreaks - Membership Roles and Expectations on page 6 below.

Reports of circulating enteric or infectious respiratory illness in the community should be communicated by Public Health to facilities so they may heighten surveillance within the facility.

Evaluation

Evaluation is an important aspect of communicable disease and IPC programs. The management of outbreaks should be regularly evaluated to determine what went well, what were the challenges, and are there alternatives to managing the outbreak that may have been more successful. A lot of useful information is gained through evaluation and should be used as a learning opportunity during outbreak debriefing and be incorporated into the work process to enhance outbreak prevention and control measures.

In addition, outbreak management teams are recognized to play a major role in outbreak response.

Outbreak Management Team for Facility-Based Outbreaks

An outbreak management team should be established within the facility and health region. This team ensures coordination and communication to assist in containing an existing outbreak and to reduce the risk of further transmission of the infection to clients, residents, staff and the community.

Role of the Team

- To ensure communication to family, staff and community is timely and accurate.
- To ensure that Standard/Additional Precautions are in place, are understood and adhered to.
- To develop strategies to handle specific facility situational issues or concerns that may arise during an outbreak.
- To evaluate the effectiveness of the actions taken.
- To identify needs and communicate this to the regional corporate office.
- To submit a final report to the Regional Infection Control Committee once the outbreak is deemed over.
- To ensure that the Ministry of Health has received the required reports (initial and final) of the outbreak.

Suggested Membership of the Team

Facility:

- Facility Director of Care/Manager or designate
- Nursing staff of the facility

Regional:

- Medical Health Officer (MHO)
- Employee Health
- IPC personnel
- Communicable Disease Coordinator
- Public Health staff, such as the Senior Public Health Inspector (PHI), Public Health Nurse (PHN), or a representative of Environmental Health Team
- Director of Acute/Long Term Care
- Director of Environmental Services or designate
- Director of Food and Nutrition Services or designate
- Director of Building Services and Grounds or designate
- Manager of Administrative Services
- Corporate Communications Officer
- Staff Scheduling Coordinator
- Client Placement Coordinator

Other key players:

- Laboratory
- Occupational Health
- Human Resources
- Other – Pharmacy, Security, Laundry, Materials Management, Housekeeping, Dietary, Medical staff, Client Representative, Scheduling

Membership Roles and Expectations

Facility Director of Care/Manager or designate:

- Inform the MHO and the appropriate IPC personnel of the cluster of symptoms.
- Reinforce standard precautions and implement additional precautions as dictated by the situation.
- Once the outbreak is declared, post appropriate signage throughout the building as dictated by type of outbreak.
- Communicate to Directors that there is an outbreak and request names of those who will represent the departments on the Outbreak Management Committee.
- Maintain the daily line listing and ensure the updated list is sent to public health services.
- Ensure communication process is in place for nursing staff, families, physicians and referring-in sites.
- Notify Human Resources of required exclusion period staff members are required to wait before working in other health-care facilities/settings.
- Notify staff of outbreak and the period of exclusion recommended before working in other health-care facilities/settings.
- Ensure adequate supplies are on hand and are replenished as required (e.g. hand hygiene supplies, personal protective equipment, cleaning supplies, etc).
- Manage applicable visitor restrictions over the duration of the outbreak.

MHO/Designate:

- Declare that there is an outbreak.

- Create Outbreak Case Definition in collaboration with IPC and designated facility staff.[3]
- Follow regional policy on notifying regional administration staff of outbreak.
- Participate in the outbreak team meetings as per regional policy.
- Collaboration with regional Communications department to create a communication plan for media if necessary (radio/newspapers, public announcements, format, frequency etc.).
- Make the necessary recommendations for specific interventions required to mitigate the outbreak.
- Make staff-specific recommendations for chemoprophylaxis or immunization and cohorting.
- Institute standing orders for resident testing/chemoprophylaxis or immunization as necessary.
- Order facility closure if necessary.
- Declare the outbreak over.

Infection Prevention and Control and Employee Health:

- To ensure preventative, routine and appropriate additional precautions are in place and understood. The policy that is in place should have been reviewed prior to outbreak season.
- Ensure staff are aware of staff restrictions advised by the MHO.
- Advise staff of facility closure and exclusion period requirements advised by the MHO.
- To be a resource for outbreak team on outbreak control processes.

[3] The MHO and IPC personnel will develop a specific case definition for each outbreak. Case definitions usually include these four components:

1. Clinical information about the disease,
2. Characteristics about the people who are affected,
3. Information about the location or place, and
4. Time period for the outbreak.

Case definitions and the procedures to respond may be revised during an outbreak as laboratory information and clinical information becomes available.

Senior Management:

- Ensure that the staff understand and adhere to the routine and additional precautions that are put into place.
- Communicate to staff the strategies developed to ensure containment and evaluate effectiveness of these strategies.

Communications Officer:

- In collaboration with the MHO and the Ministry of Health, develop a communication plan for outbreak if necessary (radio/newspapers, public announcements, format, frequency etc.).
- Participate in the outbreak team meetings as required or as per regional policy.

Director of Acute/Long Term Care:

- Participate in daily committee meetings.
- Liaise with other directors in institutional and emergency care.
- Assist if additional resources are required.
- Provide updates to the Chief Executive Officer (CEO) as per regional protocol.

Outbreaks in Long Term Care and Integrated Facilities
Generic Protocol – Prevention and Control

The fundamentals of Prevention and Control involve taking appropriate precautions. There are two levels of precautions: "Routine Practices/Standard Precautions" and "Additional Precautions".

A key to the success of these precautions in infection prevention and control is staff training. All staff must receive training in the principles of infection prevention and control (IPC) and in their role of ensuring residents/clients, themselves, and other staff are not placed at risk because of improper use of precautions. This knowledge is vital in understanding when additional precautions are necessary and the consequences of not adhering to the principles of IPC.

All housekeeping staff must be trained appropriately and made aware of the important role they play in the prevention of healthcare associated infections. New staff should be given a suitable amount of time to review regional policies and procedures for cleaning. Special training in IPC policies and protocols as well as Occupational Health and Safety standards, such as Workplace Hazardous Materials Information System (WHMIS) is vital. Training for new staff should involve hands-on training by initially shadowing staff members and then performing the cleaning duties under strict supervision.

Supervisors must play an active role in staff training and compliance as well as in the periodic review of policies. Equally important is the periodic evaluation and monitoring of staff in adhering to IPC protocols.

Routine Practices

Routine practices are the IPC protocols for use in the routine/daily care of all residents/clients at all times. Principles of routine practices include:

- Protecting residents/clients and health care workers (HCWs) and everyone in the long term care (LTC) facility;
- Considering all blood, body fluids, secretions, excretions, drainage, and tissues of all residents/clients potentially infective;
- Conducting a Point of Care Risk Assessment to determine the precautions required when providing care.

Routine practices include:

1. Hand hygiene
2. Point of Care Risk Assessment (PCRA)
3. Use of personal protective equipment (PPE) - (gloves, mask/respiratory/eye protection, face shields and gowns) when splashes or sprays of blood, body fluids, secretions, or excretions are possible
4. Respiratory hygiene (cough etiquette)
5. Environmental Controls - cleaning of resident/client care equipment, physical environment and soiled linen and patient placement/accommodation

Hand Hygiene

Hand hygiene is the most important measure in preventing the transmission of infections. Hand hygiene is the responsibility of <u>all</u> individuals involved in health care.

- Facilities must provide education, and reinforce strict adherence to hand washing by staff, residents/clients and visitors.
- Hand hygiene must be part of every HCW's orientation upon hiring.

Hand hygiene includes washing hands with warm water and approved non-antimicrobial soap from a dispenser for 15 seconds, and drying with a disposable towel. If hands are not visibly soiled, an alcohol-based hand rub can be used.

- Hand washing with soap and water <u>must</u> be performed when hands are visibly soiled and when gloves are removed.
- Alcohol-based hand rub/gel (with 60-90% alcohol content) can be used for decontaminating hands when hands are not visibly soiled.

Ideal locations for hand wash stations (alcohol-based hand rub/gel) include the entrance to a facility and on each unit/wing/ward with posted instructions on when and how to use the product. When using the resident's/client's sink, care must be taken to avoid contaminating hands from the environment after hand washing.

Hand Hygiene Technique

Refer to the facility/regional Infection Prevention and Control Manual for hand hygiene procedures.

When to perform hand hygiene:
Staff

- When entering and leaving the facility;
- Before and after any direct contact with a patient or their immediate environment and before contact with the next resident/client;
- Between procedures on the same resident/client where soiling of hands is likely;
- After a glove tear or suspected glove leak;
- After removing gloves;
- Before performing invasive procedures;
- Before preparing, handling, serving or eating food;
- Before feeding resident/client;
- Before preparing and administering medications;
- When hands are visibly soiled;
- After touching equipment and articles known or considered likely to be contaminated with blood, body fluids, secretions or excretions;
- After providing environmental services;
- After personal use of toilet, wiping nose, eating, make up application, smoking, coughing or sneezing, etc.

Resident/Client

- Before and after eating;
- After toileting;
- When hands are visibly soiled;
- Before going to another area within or outside the facility.

When resident/client hygiene is poor, staff should assist them with this task.

Visitors

- When entering and leaving the facility;
- When entering and leaving the unit/wing/ward;
- Before and after visiting a resident/client.

Proper instruction on hand washing should be provided to residents/clients, family members, and visitors.

Point of Care Risk Assessment

Prior to any resident/client interaction, all staff have a responsibility to always assess the infectious risk posed to themselves and others (including residents/clients, staff and visitors). A PCRA[1] is based on professional judgement about the clinical situation, along with the hierarchy of controls (engineering, administrative and PPE).

The PCRA is an activity performed by the HCW **before every patient interaction**, to:

- Evaluate the likelihood of exposure to the causative organism (suspected or known):

    1. From a specific interaction (e.g., performing clinical procedures, non-clinical interaction, direct face-to-face interaction, etc.).
    2. With a specific resident/client (e.g., patients not capable of self care/ hand hygiene, have poor-compliance with respiratory hygiene, etc.).
    3. In a specific environment (e.g., single room, bathtub, etc.).
    4. Under available conditions (e.g., minimal air exchanges area, etc.).

The final step of the PCRA is to choose the appropriate actions and/or PPE needed to minimize the risk of exposure.

[1] For more information on PCRA visit the Public Health Agency of Canada website

Personal Protective Equipment

Gloves

- Gloves provide an additional protective barrier between the hands and blood, body fluids, secretions, excretions and mucous membranes.
- Wear clean non-sterile gloves for contact with blood, body fluids, non-intact skin, mucous membranes and contaminated equipment.
- Must be changed after each resident/client contact, procedure or when moving from dirty to a clean area.
- Wear gloves when HCWs' skin is not intact and lesion can not be completely protected.
- Gloves should be used as an additional measure, not as a substitute for hand hygiene. Perform hand hygiene before and after glove use.
- Single use disposable gloves must never be reused or washed.

Gowns

- Long sleeved fluid resistant gowns are worn to protect skin and clothing of HCWs when there is potential exposure to blood or body fluids.
- If gowns are worn, they should be removed immediately after the indication for their use and placed into an appropriate receptacle.
- Perform hand hygiene after removing gowns.

Masks/Eye/Face Protection (safety glasses, goggles, face shields)

- Protect mucous membranes (e.g., eyes, nose, and mouth). In addition, respirators provide protection from inhalation transmission of airborne organisms.
- The need for a mask and eye protection during resident/client care depends on the task performed. Wear when there is the potential for splattering or spraying of blood, body fluids, secretions or excretions when providing direct care.
- Select the appropriate mask and eye protection: wear when within two meters of resident/client with respiratory illness and when performing cough-inducing and aerosolizing procedures.

Refer to Region/Facility Infection Control Manual for further information and procedures for donning and doffing PPE.

Respiratory Hygiene/Cough Etiquette

Respiratory illnesses are transmitted by:

- Coughing or sneezing (direct contact with droplet or airborne organisms by spray into mucous membranes or inhalation);
- Touching one's own eyes/nose/mouth with their hands after physical contact with someone who is sick or a contaminated environment.

Respiratory hygiene is a combination of measures designed to minimize the transmission of respiratory pathogens. Residents/clients, visitors, and staff should be instructed in proper respiratory hygiene including:

- Covering the mouth and nose with a tissue during coughing or sneezing with prompt disposal of the tissue into the garbage;
- Covering the mouth and nose with the upper sleeve if tissue not available;
- Performing appropriate hand hygiene;
- If staff, resident/client, and visitors are personally ill, wearing a surgical mask (if tolerated) when coughing or sneezing to contain droplets and decrease contamination of the surrounding environment;
- Maintaining spatial separation of two meters between others when coughing or sneezing.

Respiratory Education

- Post signage/alerts discouraging ill visitors from visiting the facility.
- Instruct residents/clients and visitors to inform facility staff if they are coughing or sneezing. Refer to Section 9-33 Generic Protocol – Limiting the Spread for details on restrictions.
- Provide masks or tissues to resident/clients who are coughing or sneezing.

- Provide masks or tissues to visitors who are coughing or sneezing who cannot be excluded from the facility (palliative/compassionate care visiting).
- Provide tissues and alcohol-based hand rub/gel in common areas (e.g., dining room, lounge), entrance to facility/unit/wing/ward.
- Place symptomatic residents/clients on Contact/Droplet Precautions. Refer to specific precautions in Attachment – Reference Table of Agents Commonly Responsible for Outbreaks of Respiratory Infections in LTC Facilities.

HCWs with symptoms of an acute viral respiratory infection should:

- Report to their immediate supervisor and, if directed, notify the appropriate facility/region employee health/IPC contacts and be assessed for fitness to work; if they are cleared to work, they should have minimal contact with individuals at high risk for complications of infectious respiratory infections.
- HCWs may also be required to wear a mask if they are coughing and/or sneezing.

Environmental Control

The transfer of microorganisms from environmental surfaces to residents/clients and health care staff is largely via hand contact with contaminated environmental surfaces and equipment. While hand hygiene is important to minimize the impact of transmission, cleaning and disinfecting equipment and environmental surfaces plays a key role in reducing the potential contribution to the spread of infection. Items that are involved in environmental control include resident personal care items, reprocessing of resident/client care equipment, environmental cleaning, laundry and dishes. [2]

Resident/Client Personal Care Items

- Personal care items (i.e. lotions, creams, soaps, razors, toothbrushes, nail files/clippers) must not be shared between residents/clients.

[2] For more information refer to Health Canada's Infection Control Guidelines: Appendix II – Cleaning Procedures for Common Items

Reprocessing of Resident/Client Care Equipment

- Client care items include health care equipment such as intravenous poles, thermometers, patient lifts, etc.
- Whenever possible, resident/client care equipment should be dedicated to the resident/client. Health care equipment that has been in contact with a resident/client is cleaned, disinfected and sterilized (as indicated).
- Equipment soiled with blood, body fluids, secretions or excretions should be handled in a manner that prevents contamination of skin, mucous membrane exposure, contamination of clothing and transfer of microorganisms to other residents/clients and the environment.
- Ensure facility staff are trained and follow recommendations for cleaning, disinfection and sterilization of resident/client care equipment as per Health Canada Infection Control Guidelines: Hand Washing, Cleaning, Disinfection and Sterilization in Health Care.[3]
- Health care facilities should have policies and procedures in place for:
    - routine cleaning, disinfecting and monitoring of equipment;
    - sterilization of equipment and maintenance of sterility.

Environment Cleaning

Components of an effective cleaning/disinfecting process are:

- Correct quantity of cleanser/disinfectant;
- Correct concentration;
- Clean cloths;
- Correct contact time (follow manufacturer's directions);
- Correct technique.

Refer to your facility housekeeping policies and procedures for routine cleaning and disinfecting surfaces and objects with the facility approved detergent-low level disinfectant.

[3] http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/98pdf/cdr24s8e.pdf

- Cleaning proceeds from clean areas to dirty areas - isolation rooms are cleaned last (after other rooms are cleaned). Refer to your institutional policies and procedures for cleaning isolation rooms.
- Particular attention is paid to the cleaning of frequently touched areas such as call bells, side rails, telephones, over bed tables, light switches, door handles, etc and should include areas frequently touched by staff.
- Contaminated hard surfaces and fixtures in bathrooms are washed with detergent and water using a single-use cloth, and then disinfected.
- Mop heads and cleaning cloths are bagged and laundered after cleaning the room.

Once the resident/client is no longer on additional precautions, his/her room will require a terminal clean.

Terminal Cleaning

- Terminal cleaning should be done after other rooms are cleaned. Follow facility-based policies and procedures for terminal clean.
- Proper removal and disposition of personal protective equipment is important following terminal cleaning.

Cleaning Procedures for Other Materials

The following applies to isolation rooms or contaminated items in common areas:

- Vinyl covered furniture or mattresses must be maintained in good repair and will need to be thoroughly cleaned with detergent and hot water then disinfected with an appropriate solution.
- Soft furnishings or cloth-covered mattresses are thoroughly cleaned with detergent and hot water. For disinfection they should be thoroughly steam cleaned.
- Contaminated carpets are cleaned with detergent and hot water and disinfected with an appropriate solution or steam cleaned using water at a minimum of 60° Celsius.

Laundry

- Laundry protocol is the same as usual. Laundry processes are to always have IPC practices in place for handling contaminated laundry.

Food Services

- Dishes – regular dishes are recommended, but must be returned from ill resident/clients' rooms directly into the dishwashing area of the kitchen for immediate cleaning and disinfection. Disposable dishes are not required.

Proper hand hygiene must follow cleaning.

Refer to Region/Facility Infection Control Manual for specific procedures.

Additional Precautions

In addition to Routine Practices, Additional Precautions might be necessary during times of expected illness and during an outbreak.

Additional Precautions (formerly referred to as Transmission-Based Precautions) are used in addition to routine practices for residents/clients documented or suspected to be colonized or infected with a specific organism for which additional measures, beyond Routine Practices/Standard Precautions, are recommended to interrupt transmission. The type of required additional precautions is determined by the mode of transmission of the organism/disease.

The three modes of transmission on which these precautions are based are:

- Contact;
- Droplet;
- Airborne.

Droplet/Contact/Airborne Precautions are required to prevent illness from entering the facility and to control the transmission within the facility.

Refer to Region/Facility Infection Control Manual or:

- Public Health Agency of Canada: "Routine Practices and Additional (Transmission Based) Precautions for Preventing the Transmission of Infection in Healthcare"[4] or;
- "Health Canada Infection Control Guidelines: Hand Washing, Cleaning, Disinfection and Sterilization in Health Care".[5]

More information on Additional Precautions can be found in the corresponding respiratory or enteric control measures sections. Additionally, see attachments below for details of specific precautions to use with various organisms:

- Attachment – Reference Table of Agents Commonly Responsible for Outbreaks of Respiratory Infections in LTC Facilities.
- Attachment – Reference Table of Agents Commonly Responsible for Outbreaks of Enteric Infections in LTC Facilities.

[4] http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/99vol25/25s4/index.html
[5] http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/98pdf/cdr24s8e.pdf

Outbreaks

Outbreaks in Long Term Care and Integrated Facilities
Generic Protocol – Limiting the Spread

In addition to the environmental management aspects, effective containment in long term care (LTC) facilities depends on the management of:

1. Clients/Residents.
2. Staff.
3. Visitors.
4. Facility Programs and Services.

Management of Clients/Residents

Isolation of Cases

Confine (isolate) symptomatic residents/clients to their rooms during the period of communicability. Refer to the documents below for further information on communicability:

- Attachment – Reference Table of Agents Commonly Responsible for Outbreaks of Respiratory Infections in LTC Facilities.
- Attachment – Reference Table of Agents Commonly Responsible for Outbreaks of Enteric Infections in LTC Facilities for the specific pathogen.
- Where possible, symptomatic individuals should be isolated in a single room.
- Individuals infected with the same organism may be cohorted in specific areas of a facility or multi-bed rooms but should not share rooms with residents/clients who are immunocompromised.
- Place infection prevention and control (IPC) signage on the room door indicating the precautions required.

Of particular interest to integrated facilities:

- The movement of residents/clients diagnosed with, or suspected to be infected with, an infectious illness should be restricted to essential diagnostic tests and therapeutic interventions, and if the illness is respiratory to wear a mask if tolerated. Also provide instruction on how to perform respiratory hygiene.

Admissions, Discharges and Transfers of Residents/Patients

- No admissions to, or transfers from, an affected wing/facility should occur for the duration of an outbreak unless required for essential diagnostic tests and therapeutic interventions/appointments.
- In extenuating circumstances, where an admission or transfer back to an outbreak facility may be required, consultation with the Medical Health Officer (MHO)/Infection Control should occur prior to the admission.[1]

Communication:

- If a transfer is essential, the receiving facility should always be notified prior to a transfer that the individual is coming from a facility that is experiencing an outbreak and should also indicate whether the individual is asymptomatic, has or is recovering from the infection.
- In extenuating circumstances, where an admission may be required, consultation with the MHO/IPC personnel should occur prior to the admission. The resident/client and/or family would be informed of the outbreak and the potential risk of exposure and illness to the resident/client and should all be in agreement to proceed with the admission.

- Other individuals who access services in the facility (e.g., outpatient therapy, home care clients – bathing, etc.) should be restricted for the duration of an outbreak unless service is considered essential and cannot be rescheduled to another facility.

[1] The general principle is to not permit transfers back to a facility but where transfers to ER or hospital have been made for essential medical treatment during an outbreak. The resident may be transferred back on an exceptional basis with permission from Infection Control and the MHO.

Individuals with symptoms of the outbreak, who are admitted from the community to a LTC facility on an exceptional basis during a nosocomial outbreak (with permission from Infection Control and the MHO), will be considered as part of the outbreak and the decision to terminate the outbreak will include these cases.

Management of Staff

The management of staff, and other personnel who provide services in a long-term care facility, is an important component in the implementation of outbreak control measures and requires careful consideration and planning. Immunization or chemoprophylaxis may be a recommended measure to prevent and control the outbreak. The causative organism will determine if this measure is necessary.

The following steps should be taken to decrease the spread of the infectious agent in the facility:

- Cohorting essential personnel
- Excluding symptomatic personnel
- Developing policies for the management of non-essential personnel

The combination of the steps above should balance the protection of staff and residents/clients from the infectious agent, without compromising staffing levels that would place residents/clients and employees at increased risk.

Communication:
- Where concerns about staffing levels exist as a result of recommendations for staff cohorting and exclusion, facility management should discuss alternative recommendations with Human Resources and consult the MHO.

Communication:
Facility managers should ensure that staff restrictions have been communicated to:
- Other facility managers.
- Directors.
- Human Resources.
- Scheduling.
- Staff.

Direct Patient Care Personnel

As soon as an outbreak is identified, health care workers (HCWs) providing direct care to residents should:

- Be cohorted to provide care for either infected or non-infected patients within the wing/facility, if possible. They should also be cohorted to the wing/facility for the duration of the outbreak.

Other Facility Staff

As soon as an outbreak is identified, facility staff that **do not** provide direct care to residents should:

- Minimize their contact with isolated individuals and should ensure that appropriate personal protective equipment (PPE) and IPC precautions are utilized when contact occurs.

Employees Working in More Than One Facility

If an individual is required to work in another facility, it should only occur:

- After the maximum incubation period for the organism[2] has passed from the time of their last exposure in the facility;
- If the individual is asymptomatic.

Facilities should discuss these situations with the MHO/IPC personnel.

Facility managers are responsible for reassigning shifts so employees are restricted to working in one facility during an outbreak.

[2] Where no organism has been identified, the MHO/IPC personnel will provide recommendations on the time period for the individual to return to work in another health care facility. This recommendation will be based on the epidemiologic characteristics of the outbreak and the surveillance data available in Saskatchewan.

Management of Non-Facility Regional Staff, External Professionals and Service Providers

As soon as an outbreak is identified, health care professionals (Physiotherapy, Occupational Therapy, Laboratory, Speech Language Pathology, Home Care, Podiatry, etc.) and other personnel/service providers who are not employees of the facility, but regularly provide services or access supplies within the facility, should be informed that there is an outbreak in the facility. These personnel should be excluded from the facility for the duration of the outbreak except for instances where they are required to:

- Provide essential therapeutic services to residents that cannot be postponed without adversely affecting the health of the resident; these individuals should minimize their contact with isolated individuals and should ensure that appropriate PPE and IPC precautions are utilized when contact occurs;
- Provide essential services (maintenance, etc.) to maintain the safe operation of the facility;
- Access supplies for the provision of essential care in the community.

Management of Volunteers and Students

In principle, non-essential volunteers and students should be excluded from the facility for the duration of the outbreak except in the instances where facility management and IPC personnel/MHO have mutually identified exceptions.

Communication:

- As soon as an outbreak is identified, volunteers who are not employees of the facility should be informed that there is an outbreak in the facility.
- Students and their preceptors should be informed that there is an outbreak in the facility.

If a volunteer or student is permitted to work in an outbreak facility, they should:

- Minimize their contact with isolated individuals and ensure that appropriate PPE and infection control precautions are utilized when contact occurs.

Management of Visitors during Outbreaks

The MHO, in consultation with IPC personnel will provide recommendations for visitor restrictions and visitor exclusions during an outbreak in a LTC/Integrated health care facility. The management of visitors to a LTC/Integrated health care facility during an outbreak will depend on a number of factors including the features of the outbreak and the suspected causal organism. The recommendations will initially be based on the epidemiologic properties of the suspected organism and refined once a specific causative organism has been identified. Ensuring the safety of residents/clients, employees and the public is also an important consideration in the decision to restrict visitors. During outbreaks, staff shortages combined with increased health care needs of residents/clients, make it difficult to ensure that the education regarding IPC measures and the PPE required can be provided for all visitors.

In general, efforts to limit individuals visiting the affected unit/ward/facility during an outbreak should be considered. Depending on the extent of the outbreak, it may be preferable to initially close the unit/ward/facility to all visitors while the entire complement of outbreak measures are implemented and until nosocomial transmission is reduced. Ill visitors should not be permitted in the facility except in exceptional circumstances on compassionate grounds.

Visitors should be encouraged to postpone visits wherever possible and while closure may not be required in large urban facilities, in smaller rural settings visitors often see several residents/clients during any given visit and can serve as a vehicle for transmission and the continued introduction of the organism into the facility. In these settings, visitors should be restricted to visit only one resident. Controlling the outbreak and protecting employees, residents/clients and the public must be balanced with the emotional hardship to both the residents/clients and the relatives that may be caused with prolonged closures.

Visitors should not participate in any social activities in the affected unit/ward/facility that may be occurring during an outbreak. For most outbreaks, social activities will be suspended. Visitation by outside groups (e.g., entertainers, meetings, community groups, etc.) shall not be permitted. Also, visitation of multiple residents/clients should be restricted.

Visiting Permitted on Compassionate Grounds

- IPC personnel should be consulted regarding individuals who must visit terminally ill or palliative residents/clients.
- Visitors who have symptoms of a respiratory or enteric infection should not visit patients unless it is essential.
- Visitors shall be advised of the potential risk of acquiring illness while visiting the facility.
- Visitors should be instructed on general IPC measures (e.g., hand hygiene, etc.) and how to prevent transmission of the specific organism. Visitors should also be instructed on the specific IPC measures and the PPE required.
- Visitors need to be informed that their visit must be restricted to their family member and that ill residents/clients should be visited in their room only. Visitors should also be informed that they are not to enter or visit the rooms of other residents/clients and should exit the facility immediately after visiting their family member.
- Visitors who are coughing or sneezing that cannot be excluded from the facility (palliative/compassionate care visiting) should be provided with masks.
- When visiting is permitted for compassionate reasons, consideration should be given to maintaining a one metre spatial separation between the visitors and the resident/client with a viral respiratory tract infection.

Communication:

- Family members/visitors should be aware of this visitor restriction policy, prior to an outbreak.
- Family members of ill residents shall be contacted and advised of their relative's illness.
- The facility should have a procedure or policy for notifying immediate family members or next of kin that an outbreak is occurring at the facility.
- The facility should post outbreak notification signs and other appropriate signage at all entrances to the facility during the outbreak.
- Information on visitor restrictions should be placed on the health region's web site.
- Health care facilities may choose to inform local media outlets (e.g., newspapers and/or local radio stations) of the visitor restrictions during an outbreak.

Management of the Facility Programs/Services

A review of all activities conducted within the outbreak facility/wing should occur. Strong consideration should be given to the suspension of all non-essential activities. The extent of the suspension will depend on the specific characteristics of the facility, the causative organism, and the extent of the outbreak and the success of the initial IPC measures.

Many respiratory infections can be transmitted before an individual develops symptoms. Activities that bring together community members and LTC residents/clients during an outbreak should be restricted to prevent the ongoing introduction of infections from the community and spread of the facility outbreak to the public and subsequently to other health care settings.

Communication: Facility managers should

Initially, the suspension of all non-essential activities in the facility/wing should be considered until the outbreak is under control or the outbreak is declared over. This may include:

- Outside groups coming into the facility for non-essential activities and meetings;
- Personal services (hair salon, aesthetician, etc.);
- Community events or meetings within the facility (craft and bake sales, pot lucks, birthday parties, breakfast clubs or cooking groups, aquasize, aerobics, weights, etc.);
- Day care (children);
- Adult day programs;
- Pet therapy.