POLICY IFC-50: Management of COVID-19

Infection Control

Approval Date: **March 18, 2020**
Approval Authority: **Administrator, Norview Lodge**
Effective Date: **March 18, 2020**
Revision Date/s: **March 18, 2020, June 4, 2020, August 21, 2020, November 23, 2020, March 1, 2021, March 25, 2021, April 12, 2021, April 26, 2021, May 5, 2021, June 4, 2021, June 21, 2021, June 23, 2021, July 16, 2021, August 6, 2021, August 27, 2021, August 30, 2021, December 22, 2021, December 30, 2021, January 14, 2022, February 28, 2022, March 14, 2022, April 11, 2022, June 15, 2022, September 6, 2022, September 12, 2022, October 12, 2022, March 22, 2023, March 31, 2023, June 26, 2023 June 28, 2023**

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.

Common Signs:

- **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)

Clinical Features of COVID-19 that can be diagnosed by a health care provider include:

- Clinical or radiological evidence of pneumonia.

<u>Outbreak Case Definition</u>

A Confirmed Outbreak in the home is defined as:

- Two or more residents/patients who are epidemiologically linked (e.g., within a specified area/unit/floor/ward), both with positive results from a polymerase chain reaction (PCR) test OR rapid molecular test OR rapid antigen test within a 7-day period where both cases have reasonably acquired their infection in the setting.

A Suspect Outbreak in the home is defined as:

- One positive PCR OR rapid molecular test OR rapid antigen test in a Resident who has reasonably acquired their infection within the home.

Declaring the outbreak over

- In consultation with the outbreak management team and the local public health unit, the outbreak may be declared over when no new cases, which were reasonably acquired in the setting, have occurred for 7 days, and there is no evidence of ongoing transmission.

Role of Public Health in Outbreaks

- Only the local public health unit can declare an outbreak and declare when it is over.
- The IPAC Lead and/or delegate will follow the direction of the public health unit in the event of a suspect or confirmed COVID-19 outbreak.
- The IPAC Lead and/or delegate will follow any guidance provided by the local public health unit with respect to any additional measures that must be implemented to reduce the risk of COVID-19 transmission.
- The local public health unit is responsible for managing the outbreak response.
- Local public health units have the authority and discretion as set out in the Health Protection and Promotion Act to coordinate outbreak investigation, declare an outbreak based on their investigation, and direct outbreak control measures.

Prevention and Control Measures

Surveillance/Screening for Staff/Visitors and Those Entering the LTC Home

- The home will have 1 entrance for all Visitors. (The front entrance).
- Staff will use the employee entrance to enter and exit the building.
- 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.
- All caregivers, students, volunteers, and visitors must complete passive screening upon entry to the home using the COVID-19 Screening Form.
- Staff must passively screen via the COVID-19 Screening Form at the start of their shift only.
- Anyone showing symptoms or signs of COVID-19 shall not be allowed to enter the home and should go home to self-isolate immediately. The IPAC Lead and/or designate will follow up with staff.
- Emergency First Responders who, should in emergency situations be permitted in without screening.
- All Residents are screened on admission and with any transfer to the home.
- Screening of all Residents occurs every shift for typical and atypical symptoms of COVID-19. EMAR documentation re: completed on Days/Evenings.
- All persons entering the home must sign into the Visitor logbook located at the front entrance. Visitor log for contact tracing is retained for 30 days.
- Any staff or visitor who fails passive screening will not be allowed into the home.

- Staff will be required to follow up with the IPAC Lead and/or their department Supervisor to notify them of illness and follow return to work plan.
- Visitors 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.
- Visitors who test positive for COVID-19 and/or have symptoms compatible with COVID-19 should avoid non-essential visits to anyone who is at a higher risk of illness for 10 days following symptom onset and/or positive test (whichever is earlier)

There are 3 exceptions where individuals who fail screening may be permitted entry into the home:

1. Staff with post-vaccination related symptoms may be exempt from exclusion from work.
2. 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.
3. General visitors who test positive for COVID-19 and where visits cannot be avoided (eg. 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.

Handwashing

All staff, visitors and Residents are encouraged 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.

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

- Masks are required based on a point of care risk assessment (PCRA), consistent with Routine Practices, and based on the return-to-work protocol following 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 may consider wearing a mask for source control during prolonged direct resident care (>2metres for >15 minutes) both indoors and outdoors.
- Masks are not required in administrative and staff only areas (e.g., lunchrooms, Offices).
- Staff who prefer to continue to wear a mask beyond minimum requirements may do so.
- Residents (or substitute decision-makers) may request that staff members wear a mask when providing care, in alignment with the Residents' Bill of Rights.
- Staff with COVID-19 upon return to work, should follow measures to reduce the risk of transmission for a total of 10 days from their symptom onset/positive test, including wearing a mask and distancing from others before they remove their mask (e.g. to eat or drink)

Masking for caregivers and visitors

- Masks are recommended, but not required, when indoors in all areas of the home (e.g., social activities).
- 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

Additional measures related to masking to prevent transmission during high -risk transmission periods could be implemented based on local/regional context, and province-wide during periods of high risk as identified by Office of the Chief Medical Office of Health, Public Health.

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

<u>Addressing the above noted exceptions:</u>

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.

Any person entering the home shall receive assistance on the application and removal of their mask and/or PPE as required from another person.

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 carefully store the mask in a clean dry area ex. Brown paper bag, taking care to avoid contamination of the inner surface of the mask, and perform hand hygiene before and after mask removal and before putting it on again.

Masks can be stored in closed, breathable containers such as paper bags. Storage is not for more than 1 shift at a time. Paper bags need to be labelled with staff's name and disposed after the storage is complete (1 shift).

- 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.

**While the same mask, 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.

<u>Personal Protective Equipment (PPE) Stewardship</u>

Is under lock and key-management maintains.

Supplies are available in each clean utility room, PPE towers in each Resident home area, and in the Boardroom closets (medical masks, eyewear, rapid tests etc.)

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

Due to symptoms of COVID-19, COVID-19 exposure, or COVID-19 diagnosis, staff will apply appropriate PPE and follow the donning and doffing signs outside of the Residents door.

- Eye protection
- N95 Mask (for suspect or confirmed COVID-19 or a surgical mask when COVID-19 is ruled out.
- Gown
- Gloves

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.

Cohorting

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 cohorting when not in outbreak.

Residents – During an Outbreak:

- During a COVID-19 outbreak, residents may be separated into several cohorts (groups).
- Residents are to remain physically separate (i.e., at least 2 metres from one another) as much as possible, including those within the same cohort.
- Residents ill with COVID-19 are to be placed in single rooms if possible.
- When physical distancing of 2 metres is difficult to achieve in a shared room space, the curtains of both rooms will be drawn to assist in physical separation.
- Residents are co-horted to their Resident home area for all non-essential activities (communal dining, group events, social gatherings).
- An Essential Caregiver may join the Resident for meal times.
- Different cohorts are not to be mixed, and Residents from different Resident home areas should not visit one another.
- Group activities and communal dining should be conducted such that the outbreak unit is cohorted separately from unexposed residents and units. At the discretion of the PHU/OMT, group activities and communal dining for cohorts (exposed separated from unexposed) may resume.
- Wherever possible, continuing group activities for exposed cohorts is recommended to support resident mental health and wellbeing

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 (eg. 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.
- Must permit an organization completing an IPAC assessment and report to share the report with any of the following: public health units, local public hospitals, LHINS, the MLTC in the case of LTCHs as may be required to respond to COVID-19 at the home.
- This policy will be given with orientation to all new employees and reviewed annually via Surge Learning for all staff.
- 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 and will be done in collaboration with the public health unit.
- This policy will be reviewed and tested annually and within 30 days of a COVID 19 outbreak being declared over. A written record of the testing of this policy and any changes of this policy will be kept.
- A copy of this policy is posted on the Norview Lodge Website and hard copies will be made available upon request.

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, 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 may consider wearing a mask during prolonged direct resident care, defined as one-on-one care within two metres of an individual for fifteen minutes or longer. • Staff must conduct a point of care risk assessment when within 2 metres 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 when COVID 19 is ruled out • 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

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: Long-Term Care Homes, Retirement Homes and other Congregate Living Settings for Public Health Units – June 26, 2023

Ministry of Long-Term Care COVID-19 Guidance Document for Long-Term Care Homes in Ontario, June 26, 2023