Management of Infection and Outbreak due to Viral Respiratory Illness in Nursing Homes

January 2024
Social Development and Department of Health

New Nouveau Brunswick

Contents

ACRONYMS

AGMP	*Aerosol Generating Medical Procedure*
ASTM	*American Society for Testing and Materials*
COPD	*Chronic Obstructive Pulmonary Disease*
DGLDUHC	*Dr. Georges-L. -Dumont University Hospital Centre*
GNB	*Government of New Brunswick*
HH	*Hand Hygiene*
ILI	*Influenza Like Illness*
NH	*Nursing Home*
PCP	*Primary Care Provider*
PCR	*Polymerase Chain Reaction*
PCRA	*Point of Care Risk Assessment*
PH	*Public Health*
PHAC	*Public Health Agency of Canada*
POCT	*Point of Care Test*
PPE	*Personal Protective Equipment*
RHA	*Regional Health Authority*
RMOH	*Regional Medical Officer of Health*
RSV	*Respiratory Syncytial Virus*

1.0 KEY CONTACT INFORMATION

Public Health Communicable Disease Team				
Regions 1-7 Public Health Notifiable Disease Reportable Events Posters. Pdf(gnb.ca)				
Region		**During Business Hours (8:15*am4:30pm Mon-Fri)**	**After Business Hours (Emergency Only)**	**Fax Numbers**
Central	Zone 3 (Fredericton)	CDFredVal@gnb.ca (506) 444-5905	(506) 453-8128	(506) 444-4877
South	Zone 2 (Saint John)	ComDisjPH@gnb.ca (506) 658-5188	(506) 658-2764	(506) 643-7894 or (506) 658-3067
East	Zone 1 (Moncton)	(506) 856-3220	(506) 856-2004	(506) 856-3544
	Zone 7 (Miramichi)	(506) 778-6104/ 778-6102		(506) 778-6756
North	Zone 4 (Edmundston)	(506) 735-2626	(506) 789-2428	(506) 735-2340
	Zone 5 (Campbellton)	(506) 790-4769		(506) 789-2349
	Zone 6 (Bathurst)	(506) 547-2062		(506) 547-2208
**Zone 2 business hours start at 0830.*				

Websites	
General GNB COVID-19 Testing	COVID-19 testing (gnb.ca)
General GNB COVID-19 Resources	Guidance and Support (gnb.ca)
PHAC	COVID-19 for health professionals: Transmission - Canada.ca
General GNB Influenza Resources	Influenza in New Brunswick (gnb.ca)
PHAC	Flu (influenza): Symptoms and treatment - Canada.ca
PHAC RSV Resources	Respiratory syncytial virus (RSV): For health professionals - Canada.ca
	Respiratory syncytial virus (RSV): Symptoms and treatment - Canada.ca
Emails and Phone Numbers	
SD PPE Team	PPETeam/EquipeEPI@GNB.CA
SD COVID Response Team (SD CRT)	SD_CRT@gnb.ca
Influenza & COVID-19 Vaccine Orders (for NHs)	DHVaccLog@gnb.ca

2.0 PURPOSE OF RESPIRATORY ILLNESS GUIDANCE

This document provides guidance for Nursing Homes (NH) to prevent and manage respiratory or influenza-like illness (ILI) within their facility. It is intended to be used year-round. While some respiratory illnesses are more likely to be present over the fall and winter months of “flu season”, other viruses are present all year.

Many different pathogens can cause respiratory illness, such as viruses, bacteria, or fungi. It is often difficult to tell which one is causing the illness because the symptoms are similar. In addition, a person may be infected with more than one pathogen at the same time. This document will focus on viral respiratory illnesses of **COVID-19, Influenza, and Respiratory Syncytial Virus (RSV)** that can spread easily to others in a NH.

Respiratory illness is a leading cause of hospitalization and death among seniors and other vulnerable individuals. Residents may also experience worsening of chronic conditions and loss of independence due to respiratory illness. For these reasons, it is essential that facilities take steps to prevent the spread of respiratory illness, and that residents are provided access to vaccination and therapeutic treatments, such as antiviral mediations, if eligible.

Information in this document should be used to guide development of NH policies and plans **BEFORE** respiratory illness happens in the facility.

3.0 VIRAL RESPIRATORY ILLNESS

3.1 HOW DO VIRAL RESPIRATORY ILLNESSES SPREAD?

Respiratory illnesses are easily spread. When a person who has the virus coughs, sneezes, talks, or sings, they share the virus via tiny droplets or aerosols in the air.

Tiny viral particles may also settle on nearby items. When a person touches the contaminated surface, and then touches their nose, mouth, or eyes without cleaning their hands, they may infect themselves with the virus.

3.2 WHO IS AT RISK FOR MORE SEVERE ILLNESS?

Individuals who live together in a NH often have many features that make them more likely to experience severe illness from a respiratory virus.

- Living together helps viruses spread more easily from person to person.
- The immune system of elderly individuals and those who are immunocompromised may not respond as well as it used to.
- Chronic illnesses like heart diseases, diabetes, and COPD may worsen when a person is ill with a respiratory virus.

- Pre-existing conditions such as obesity may also lead to more severe respiratory illness.
- Individuals whose memory or cognitive abilities have been impacted may struggle to use prevention measures to reduce their risk of illness.

3.3 WHAT MEASURES HELP TO PREVENT SPREAD?

Measures like vaccination, hand hygiene, cough and sneeze etiquette, cleaning high touch surfaces, and masking and distancing from others when ill can help prevent viral respiratory illnesses and many other illnesses from spreading (See Appendix A: Measures to Prevent Illness). Having standard facility-wide measures in place before someone receives a positive test result will support prevention and control. It is equally important to have an outbreak management plan ready if an outbreak is declared.

4.0 STRATEGIES FOR FACILITIES TO PREVENT AND CONTROL VIRAL RESPIRATORY INFECTIONS

There are facility-wide measures that NHs can use to prevent and control the spread of respiratory infections**.**

- Be prepared - make plans to prevent and respond to respiratory illness
- Screen for symptoms of respiratory infections
- Test promptly

4.1 BE PREPARED

- Encourage and support residents and staff to stay up to date with Influenza, COVID-19, and pneumococcal vaccinations. RSV vaccines will not be available in the 2023-2024 season.
- NHs should have an immunization policy for vaccine-preventable diseases. These policies should address residents, staff and all persons carrying on activities within the home. They should be updated and communicated to all concerned each year.
- Policies and/or procedures addressing immunization as well as antiviral treatment and/or prophylaxis in the event of an outbreak should be available.
- Have a communication plan to share information with residents, staff, and visitors about prevention strategies and outbreak protocols.
- Continually evaluate and update your facility's response plan for Case and Outbreak Management for respiratory illness.
- Each facility must have a general visitation policy which includes:
    - No visiting when ill, signage at door stating not to enter if unwell.
    - Visitors should be provided information outlining safe visiting practices, including frequent hand hygiene and respiratory etiquette with each visit, and postponing a visit when ill.

    - Mask use is optional for a visitor; however, a resident may request a visitor to wear a mask. Visitors may expect enhanced masking guidance if the risk of viral respiratory illness activity increases.
    - No age restriction related to visitation within a NH facility.
    - No limit on visitation capacity at one time.
    - No requirement for visitors to provide proof of vaccination or medical exemption.
- It is recommended that NHs have a minimum amount of PPE on hand. Please refer to Table 1.0 for the recommended amount for a 72-hour period where outbreak measures would be in place.
- NHs should have ongoing Hand Hygiene and PPE education for staff, residents, and visitors.

Table 1.0 Emergency PPE Recommended for 72 Hour Period

It is imperative that PPE be used correctly to protect staff and residents. Please note additional use of PPE may be directed by PH in certain situations or based on a point of care risk assessment.

Quantity Recommended for 72 Hours				
Number of Beds	**Face Masks**	**Isolation Gowns**	**Face Shields**	**Gloves**
10	300	300	300	1,050
30	900	900	900	3,150
60	1,800	1,800	1,800	6,300
100	3,000	3,000	3,000	10,500

Note: Contact: PPETeam/EquipeEPI@GNB.CA if additional PPE is required.

4.2 SCREEN FOR SYMPTOMS

The symptoms of a respiratory infection are similar for many viruses, including COVID19, influenza, and RSV. It is often difficult to tell which one is causing the illness because the symptoms are similar.

All residents with **new or worsening onset of fever OR cough OR 2 or more other symptoms of respiratory illness listed in** Table 2.0 should isolate with Contact and Droplet Precautions. (see Appendix C: How to Isolate with Contact and Droplet Precautions).Even though an operator may not know what virus is causing the illness, Contact and Droplet Precautions work well to slow all respiratory viruses from spreading in their facility until test results are available.

Table 2.0 Symptoms of Respiratory Illness

Fever*	Sneezing	Severe Fatigue
Cough	Wheezing	Loss of appetite
Runny/stuffy nose	Headache	Muscle aches/pain
Shortness of breath	Chills	Nausea & Vomiting
Sore throat	Weakness/Dizziness	Diarrhea
Loss of taste	Loss of smell	

***NOTE:** 1-Fever is defined as: a) a single oral temperature of more than 37.8°C OR b) repeated oral temperature of more than 37.2° C OR c) repeated rectal temperatures of more than 37.5 ° C OR d) a single temperature of more than 1.1° C over baseline from any site.

If at least one resident or staff member has developed symptoms, implement additional precautions as you investigate further:

- Passively screen for symptoms.
- Identify the number of residents and staff who have symptoms of respiratory illness. Determine if those affected are limited to one unit/floor.
- A facility specific policy for workplace health must include direction to not work while ill.
- Staff will use a Point of Care Risk Assessment (PCRA) before every resident interaction.
- Isolate all residents with symptoms of respiratory illness as well as those with positive test results.
- Obtain order from PCP to test symptomatic residents as soon as respiratory illness is suspected.
- Contact PH if one or more residents are positive for Influenza or COVID-19. If an outbreak is suspected or determined refer to section 5.0 Suspected or Confirmed Outbreak Management. RSV is not currently a reportable disease in NB, however certain types of clusters must be reported as stipulated under Schedule A of the Reporting and Disease Regulation (i.e., clusters of unknown etiology, Clusters of severe or atypical illness thought to be respiratory borne). Regions17_Public-Health_Notifiable_Disease_Reportable_Events_Posters.pdf (gnb.ca)

4.3 TESTING

Early diagnosis through testing helps eligible residents who have tested positive for COVID-19 or Influenza to begin antiviral therapy as soon as possible. Early detection also allows facility-wide measures to be enhanced to reduce the spread to other

residents. This includes prophylactic antiviral therapies that may be recommended by PH for the more vulnerable close contacts of people who test positive for influenza if an outbreak is declared in the facility.

Nasopharyngeal specimens are the recommended type of sample for PCR testing. Viral collection kits contain special swabs and transport media for sample collection. Each kit contains a swab and a tube filled with a viral transport medium (red capped tube with pink viral transport medium). Swabs/kits are distributed to nursing homes at the beginning of the flu season and can also be obtained by either phoning your regional microbiology laboratory or the microbiology laboratory of DGLDUHC. The inoculated transport medium is essential and must not be discarded. Please label the specimen tube with two identifiers (i.e., name and Medicare number) The specimen must be stored in a refrigerator (please do not freeze the specimen nor keep it at room temperature) until it is sent to your hospital laboratory along with a microbiology requisition form. Your regional laboratory will handle the referral to the DGLDUHC microbiology laboratory.

It is important to notify your local lab at the time of specimen collection that you are investigating a potential outbreak and thus require test results to be reported to both the nursing home and RHA PH as soon as results become available, whether negative or positive.

POCT supplies can be obtained by contacting the PPE team email inbox at *PPETeam/EquipeEPI@GNB.CA*

4.31 TESTING AND ISOLATION OF SYMPTOMATIC RESIDENTS

Isolate any symptomatic resident using Contact and Droplet Precautions and refer to Appendix C: How to Isolate with Contact and Droplet Precautions. Contact the primary care provider (PCP) to obtain an order for testing. The PCP may choose to do a PCR test for Influenza, RSV and COVID-19 if clinically indicated or if eligible for influenza or COVID-19 antiviral medication. (*Note: a positive POCT is also acceptable to begin antiviral treatment for COVID-19*). Refer to Appendix E for swabbing techniques. If results are positive, maintain isolation according to Table 3.0. If results are negative and symptoms persist, maintain isolation until resident starts to improve, is fever free x 24 hours without the use of fever reducing medication, and is free of vomiting and diarrhea x 48 hours.

If a resident is suspected or confirmed positive for COVID-19, Influenza, and/or RSV and is receiving an Aerosol Generating Medical Procedure (AGMP), the resident should be in a private room with the door closed. Staff entering the room are to wear appropriate PPE which includes an N95 mask. Examples of an AGMP include (but are not limited to) CPAP/BIPAP, High flow oxygen &/or humidity, nebulizer therapy, CPR,

and intubation. See Table 4.0 Low flow Oxygen Delivery for examples of low flow oxygen therapy (These examples would NOT require the use of N95 mask).

Table 3.0 Length of Resident Isolation Based on Type of Respiratory Illness

Length of Resident Isolation Based on Type of Respiratory Illness*				
		COVID-19	**Influenza**	**Other Respiratory Illness (i.e., RSV)**
Length of Isolation Contact and Droplet Precautions	Isolation (Without antiviral)	Isolate 5 days from earliest positive test result (POCT or PCR). If no testing done, isolate for 5 days from onset of symptoms. Cease after day 5, if fever free x 24 h without fever reducing medication, 48 h free of vomiting and diarrhea, **and symptoms improving.** Use Enhanced Precautions** for an additional 5 days.	Isolate for 7 days after symptom onset. Cease after day 7, if fever free x 24 h without fever reducing medication, 48 h free of vomiting and diarrhea, **and symptoms improving**.	If Covid-19 & Influenza have been ruled out*, isolate symptomatic resident until fever free x 24h without fever reducing medication, 48 h free of vomiting and diarrhea, **and symptoms improving.**
	Isolation (With antiviral)	Same as above	Cease following 72 hours of antiviral treatment and no symptoms for 24 hours	Same as above; no antivirals available

	Immunocompromised	Consult Regional Public Health unit	Consult Health Care Provider	Consult Health Care Provider

*In outbreak units, symptomatic individuals may not be PCR confirmed, but can be presumed to have a certain illness. This should be documented, and these individuals should be managed based on the presumed illness.

***Enhanced Precautions for Residents:**

- Wear a well fitted medical grade mask when awake; if possible.
- Perform hand hygiene frequently.
- Maintain physical distancing and limit non-essential contact with other residents (as able).
- Avoid gatherings or activities with others.
- Eating/drinking must be performed in resident's room or a private area. If unable to find a place to eat or drink alone, ensure there is two meter distancing from others while mask is off or consider staggering lunch hour for residents who are positive and negative etc.
- Use private or designated washroom; if possible.
- Staff to clean high touch areas after use.

Table 4.0 Low Flow Oxygen Delivery

Device	Low Flow Rate
Nasal Prongs	1-6 L/Minute
Simple O2 mask	6-10 L/Minute
Non-Rebreather mask	10-15 L/Minute
Oxymask	1-15 L/Minute

4.32 ANTIVIRAL TREATMENT AND PROPHYLAXIS

Use of antivirals requires forward planning, and consultation with, and participation of, a health care provider.

Covid: Paxlovid™ is an anti-viral medication intended for those who are at

risk to experience more severe illness from COVID-19. Eligibility assessment for Paxlovid antiviral treatment for COVID-19 may be obtained through the primary care provider. The eligibility form can be found here: PaxlovidEligibilityForm.pdf (gnb.ca)

Influenza:

Antiviral treatment: Eligibility assessment for influenza antiviral treatment (Oseltamivir), may be obtained through the PCP . This drug can help to reduce the severity of influenza symptoms and how long they last. For treatment to be most effective it should be initiated immediately, but no later than 48 hours after onset of illness. For individuals with risk factors and illness of more than 48 hours duration, treatment with antivirals may be considered .

Antiviral prophylaxis: Influenza antiviral prophylaxis (Oseltamivir), may be recommended by the RMOH to prevent the spread of influenza once an outbreak has been declared in a facility. Symptom-free residents who are at risk for more severe illness may be prescribed influenza antiviral prophylaxis to help prevent infection if taken shortly after exposure.

4.33 TESTING AND WORK MODIFICATION FOR SYMPTOMATIC STAFF

Symptomatic staff members should stay home. Refer to Table 5.0 for work modification.

If seeking confirmation of illness using POCT:

- If initial POCT result is negative and symptoms persist or worsen, retest with POCT in 24 hours and again in 48 hours. If at any time symptoms have resolved, further testing is not required.
- If third test remains negative, staff may return to work when the individual is fever free for 24hrs without using fever reducing medications, free of vomiting & diarrhea for 48 hours, and symptoms are improving.

If clinically indicated, staff members can access PCR testing through consultation with their medical care provider. Those who do not have or are unable to contact their medical care provider may access testing through eVisitNB, Telecare 811, or other outpatient services. PCR testing will be done at the location indicated by the Regional Health Authority (RHA). Staff who have obtained a PCR tripanel test for COVID-19, Influenza, and RSV are able to view their results on *MyHealthNB.*

Table 5.0 Work Modification for Symptomatic Staff

Staff with Respiratory Illness of Unknown cause **OR** Critical Staffing Capacity	• Staff are able to work when symptoms are improving and fever free x 24hrs without using fever reducing medication, and free of vomiting/diarrhea for 48 hours. • Required to use Enhanced Work Precautions* until day 10 from onset of symptoms. • When possible, assign employee to positive or recently recovered residents during the period of enhanced work precautions.
Staff with Respiratory Illness- confirmed by POCT/PCR	• Recommend staff refrain from reporting to work for 5 days (day of symptom onset is day 0) and until symptoms are improving and fever free x 24hrs without using fever reducing medication, and free of vomiting/diarrhea for 48 hours. • Required to use Enhanced Work Precautions* until day 10 from onset of symptoms. • When possible, assign employee to positive or recently recovered residents during the period of enhanced work precautions.

****Enhanced Work Precautions***

- Wear a well fitted medical grade mask.
- Perform hand hygiene frequently.
- Maintain physical distancing and limit non-essential contact with other staff, and residents (as able).
- Avoid meeting spaces and lunchrooms.
- Eating/drinking must be performed in a private area. If you cannot find a place to eat or drink alone, ensure there is two-meter distancing from others while your mask is off or consider staggering lunch hour for staff who are positive and negative etc.
- Use washrooms within the organization which are the most frequently cleaned if a designated washroom is not possible.
- Employees should also clean high touch areas after use.

4.34 RETESTING - RECOMMENDATIONS FOR RESIDENTS/STAFF WHO HAVE PREVIOUSLY TESTED POSITIVE FOR COVID -19

POCT testing is recommended for individuals infected with COVID-19 in the previous 90 days who have new or worsening respiratory symptoms. If POCT test is negative, the PCP or RMOH may recommend further testing, based on symptoms and presence/ circulation of other viruses in the community**.**

5.0 SUSPECTED OR CONFIRMED OUTBREAK MANAGEMENT

This section of the document is intended for use by operators and managers of nursing homes to guide their decision-making related to outbreak response.

COVID-19 outbreak: An outbreak in a vulnerable setting may be declared by the MOH, typically when there are two or more positive cases among residents or staff with an epidemiological link within *10 days*.

Influenza and RSV outbreak: An outbreak in a vulnerable setting may be declared by the MOH, typically when there are two or more positive cases among residents or staff with an epidemiological link within *7 days*.

Public Health remains committed to supporting NHs in managing outbreaks. PH will lead and manage outbreaks within NHs if an outbreak is declared. For NHs who have outbreaks that do not include any residents, the home will self-manage using general outbreak management principles unless directed by PH.

It is important for homes to note that not all outbreaks are the same. Therefore, guidance may vary depending on each situation and circumstance. Direction may be adjusted by PH/MOH as needed based on the result of their risk assessment and applicable factors. If homes are unsure why certain directives might be given to them, they should seek to have their questions clarified.

5.1 GENERAL OUTBREAK MANAGEMENT PRINCIPLES

a) PH will declare the start and end to outbreaks. Typically, an outbreak is declared over by MOH for: *COVID-19* -10 days from last exposure and absence of symptomatic or positive individuals; *Influenza & RSV* - absence of symptomatic or positive individuals for 8 days.
b) Resident assessment: daily active monitoring of residents.
c) Staff screening: passively screen before every shift and self-monitor throughout shift.
d) Work modification for staff who meet symptom checker criteria.
e) Enhance cleaning and disinfection of staff areas (break/lunchrooms, workstations etc.)
f) Stringent adherence to masking for staff working on affected unit/area.
g) Ensure staff break/lunch areas do not promote transmission – limit capacity, ensure adequate distancing and barriers, if possible, between staff, wipes for disinfection etc.
h) On any unaffected unit(s), until the outbreak is declared over, all staff, volunteers, visitors and Designated Support Persons (DSPs) are required to wear a medical grade face mask in all resident-facing areas. Medical grade face masks shall remain available for anybody wishing to wear one at any time.

i) Reporting Guidance**:** if an outbreak is confirmed, PH will communicate this to the home.
    - Subsequent cases should be reported in a daily line list that will be sent to Regional PH at an agreed upon time in the day. PH will provide the home with a line list template to use to report the cases.
    - Please complete the New Brunswick Long-Term Care Facility Respiratory Surveillance Form for any respiratory outbreak occurring in your facility and submit the completed form by fax or email to your Regional PH office when an outbreak is first declared as well as at the end of the outbreak.
    - If PH declares an outbreak, please send an email to the centralized team at SD_CRT@gnb.ca as soon as possible with the following details: Name of home, date your outbreak was declared, and any questions you may have.
    - Report incidents as per the NH standards. In addition to reporting to PH and to the SD COVID Response Team, NHs are to continue reporting incidents as per the process and requirements from their respective standards.

j) Refer to the 2023-2024 New-Brunswick Respiratory Season Vaccine Guide for resident vaccination during an outbreak.

5.2 OUTBREAK THAT INCLUDES AT LEAST ONE RESIDENT

5.21 PUBLIC HEALTH - PLAYS ACTIVE ROLE IN OUTBREAK MANAGEMENT

- Initial touchpoint with facility to review the situation, declare the outbreak and adjust/clarify the above guidance as well as any additional guidance required.
- Receive daily line lists to maintain situational awareness.
- Answer questions from facility.
- Involved in determining risk level of exposures.
- Declare outbreak over.

5.22 RESIDENT TESTING DURING AN OUTBREAK

- Once an outbreak has been declared, testing of all symptomatic residents may not be required.
- The purpose of testing is to identify the most likely circulating virus. While there is no testing limit for POCT, facilities should perform no more than 6 PCR tests per outbreak investigation within 10 days, unless otherwise directed by the MOH.
- If several residents have symptoms at the same time, collect only from residents whose symptoms have started less than 48 hours ago, preferably those with the most prominent symptoms.
- Cases (probable) may be identified and managed based on presence (one or more) of new or worsening symptoms.

- One round of mass testing may be prescribed by the MOH. The MOH will determine the timing of such testing if required.
- Testing may be prescribed for the purpose of determining eligibility to treatment.
- Refer to Section 4.33 Retesting - recommendations for residents/staff who have previously tested positive for COVID-19
- Additional testing may be required to rule out co-infections with other respiratory illnesses.

5.23 CONTROL MEASURES TO BE IMPLEMENTED DURING AN OUTBREAK THAT INCLUDES AT LEAST ONE RESIDENT

- Restrict residents to affected wings/units.
- Group activities can continue provided small, consistent groups are maintained. Masking and physical distancing for residents as able. Individuals attending should be symptom free.
- General visitation for non-isolated residents may occur during an outbreak if the facility has implemented control measures and is able to adequately function in outbreak management. Consider including the following measures to reduce transmission:
    - Visitors must be informed of outbreak.
    - Visitors are required to practice hand hygiene upon entering and leaving the facility.
    - Visitors are required to wear a mask for the entire visit. A resident would wear a mask, if able.
    - Visitors go directly to see resident; then exit facility. Do not visit multiple people.
    - Residents on affected wings may not be permitted to leave the facility during an outbreak, unless for medical or emergency purposes.
- There may be circumstances that require further restrictions for visitors in collaboration with the MOH. In such cases, DSPs and Palliative visitation may continue. See Table 6.0
- Visitation for isolated residents should be restricted to DSPs, with the exception of Palliative visitation See Table 6.0
- When residents are sharing a room, and one person is symptomatic, space beds a minimum of 2 meters apart, and privacy curtain must remain pulled. Consider masking residents in that room while awake, as able.
- Given that cohorting residents may not be practical, assigning staff members to care only for residents affected with the same signs and symptoms should be considered, where possible.
- Antiviral medications for COVID-19 or influenza can help to slow transmission in a facility. They reduce the duration and severity of symptoms in people who have tested positive for these illnesses. Antiviral medication for influenza can also help to prevent infection if taken shortly after exposure.

Table 6.0 Visitation during Outbreaks

If the MOH restricts general visitation for units/facilities which are in outbreak, certain types of visitations are still permitted as outlined below.	
Designated Support Persons (DSPs)	Permitted into **affected units/facilities**. These individuals are to be informed that an outbreak is occurring and to visit one resident within the facility only and not go from room to room. DSPs must follow the same infection control measures as staff, including the appropriate use of PPE during visits as indicated. If resident is not on isolation precautions DSP must wear medical grade mask continuously as required as part of outbreak management.
Palliative[1] Visitation	In collaboration with the home, a physician or nurse practitioner determines if the resident's condition is considered end-of-life based on current clinical assessment findings. When death is anticipated as imminent, palliative visitation may occur, with a visitation plan developed in consultation with the care team of the home. Resident/POA/substitute decision maker may have a list of 10 visitors. Homes should develop a safe visitation plan for any palliative visitation which will occur. Safe visiting interventions may include: o Visitors understand the risk of exposure (for self and others). o Visitors follow all related home policies and public health measures in place within the home; and o Visitors remain vigilant in protecting themselves and others while on site, including use of continuous medical grade mask , appropriate hand hygiene, and following isolation precautions as required.

[1] For the purposes of this document, palliative residents, are defined as individuals whose condition is considered end-of-life and death is anticipated as imminent.

6.0 ADMISSIONS & READMISSIONS (RETURN FROM HOSPITAL)

Patient transfers from a hospital outbreak unit to long term care, or from a hospital to a facility experiencing an outbreak, will be made on a case-by-case basis involving the home, the primary care provider, and in consultation with the RMOH prior to discharge. The hospital physician should work with the receiving physician (if different) and the home to arrange the appropriate transfer. Individuals should not be unreasonably denied admission or readmission. When a risk of a respiratory illness has been identified, * no admissions, readmission or transfer will be considered if either of the following criteria are met:

- Inability to isolate the resident (either availability of private room and bathroom, cognitive impairments that would impede isolation or other operational

considerations), applicable to situations where a resident requires isolation upon admission.

- Critical Staffing at the receiving NH facility.

**Exposure is defined as a prolonged close contact (within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period) with the infected HCW/Patient (two days before a positive health care worker/patient's symptom onset date or specimen collection date*

APPENDIX A: ILLNESS PREVENTION STRATEGIES

Immunization

- **Keep Immunizations Up to Date:** Immunization helps to prevent infection and provides protection from severe illness and hospitalization for COVID-19, influenza, and other respiratory illnesses (i.e., pneumococcal). RoutineImmunizationSchedule.pdf (gnb.ca).
- New-Brunswick PH continues to recommend that all eligible NH residents and staff **stay up to date** with their COVID-19 vaccination. This means getting a dose with the updated mRNA vaccine if it has been 6 months (minimum of 3 months) since your last dose or infection (whichever is most recent). Refer to COVID-19 vaccines (gnb.ca).
- A seasonal influenza vaccine is highly recommended for those persons at high risk of influenza-related complications, those capable of spreading influenza to individuals at high risk of complications, and those who provide essential community services. This includes:
    - People of any age who are residents of NH facilities.
    - People ≥65 years of age.
    - Health care and other care providers in facilities and community settings.
- RSV vaccines will not be available in the 2023-2024 season.
- Document evidence of immunization or recent infection for all residents. If immunization status of a resident is unknown or undocumented, they should be considered unvaccinated, and vaccination should be offered according to eligibility. If a resident is not immunized the reason should be recorded (e.g., refusal, allergy).

Masking

- Masks are required based on a point-of-care risk assessment (PCRA).
- Masks are required based on Work Modification for Symptomatic Staff
- Each home should develop policies and procedures to address the need for increased mask usage within their homes.
- During the respiratory season, operators should encourage direct care staff to mask when caring or interacting with residents. Masks will continue to be provided to operators so that they can be made available as necessary
- Operators should ensure that the wishes of the resident or their substitute decision maker regarding masking are respected and communicated. If a resident's preference indicates that all staff (or visitors) wear masks around them, this should be respected and clearly communicated in their care plans.

- Homes may expect enhanced masking guidance throughout the year if the risk of viral respiratory illness activity increases.
- During an outbreak, strict adherence to masking will be required.

Practice Respiratory Hygiene

Tiny droplets from a cough or sneeze can make other people sick. Following basic respiratory hygiene (Table 7.0) can help to stop the spread of viruses. Respiratory hygiene should be encouraged for everyone, and particularly for those who have respiratory symptoms.

Table 7.0 Basics of Respiratory Hygiene

Basics of Respiratory Hygiene	
	When you cough or sneeze, turn your head and step away, to give others space.
	Cover your mouth and nose with a tissue. Dispose of tissue in a garbage can. Perform hand hygiene. If a tissue is not available, cough or sneeze into your elbow instead of your hands.
	Wear a well-fitted mask if you have symptoms and others are present in the room, or if you have recently recovered from illness.
	Wash your hands with soap and water or clean with hand sanitizer frequently.

Hand Hygiene

- Hand hygiene is an effective way to reduce the spread of germs on hands and should be part of the daily routine of residents, staff, and visitors. Soap and water should always be used if hands are visibly soiled and after personal toileting. For NHs, it is best practice for alcohol-based hand rubs (ABHR) to contain between 70-90% ethyl alcohol. Consider using an adapted dispenser if clients are likely to ingest alcohol-based products.
- Hand hygiene should be performed throughout the day, not only when visibly soiled. Clean your hands at the point of care, and:
    - before entering the facility

- before meals or before feeding others
- before and after preparing food
- before and after caring for or visiting with others
- before and after using disposable gloves
- after using the toilet; as well as after changing diapers or helping someone toileting
- after blowing your nose, coughing, or sneezing
- after using shared items or electronics.

For proper handwashing methods refer to:
https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/WASH_LAVEZ.pdf

Environmental Cleaning and Disinfection

- Continue regular cleaning and disinfecting of all general surfaces and high touch areas i.e., doorknobs, handrails, etc. with a Health Canada approved cleaning product. It should contain a Drug Identification Number (DIN) and labelled as a broad-spectrum viricide. Follow the cleaning and contact directions provided for the product being used.
- When illness is present in a facility, more frequent cleaning is advised. All surfaces, especially those that are horizontal and frequently touched, should be cleaned and disinfected at least twice daily and when soiled, as per Table 8.0

Table 8.0 Cleaning and Disinfection Guidance

Cleaning & Disinfection	
Area and Description	**Frequency (min)**
Surfaces: in resident rooms and central areas	
Horizontal (e.g. tables)	Twice Daily (and when soiled)
High touch (e.g., telephone, bedside table, overbed table, chair arms, call bell cords or buttons, door handles, light switches, bedrails, handwashing sink, bathroom sink, toilet and toilet handle and shower handles, faucets or shower chairs, grab bars, outside of paper towel dispenser.)	
Low touch (e.g., shelves, bedside chairs or benches, windowsills, headwall units, overbed light fixtures, message or white boards, outside of sharps containers).	Once Daily (and when soiled)
Resident Care Equipment	
E.g., BP cuffs, electronic thermometers, oximeters, stethoscope etc. Hospital grade disinfectant (e.g., cleaner and disinfectant wipes) using the recommended contact time should be used to clean and disinfect smaller resident care equipment. Important Note: Ensure all staff responsible for utilizing resident care equipment is adhering to required cleaning and disinfection practices.	After Each Use
Single Use Devices: discard in a waste receptacle after a single use on one resident. Single person/resident devices: discard after use with one resident (may be more than one use).	
Outside Resident Room (e.g., surfaces that are touched by or in contact with staff)	
Computer carts and/or screens, medication carts, charting desks or tables, computer screens, telephones, touch screens, chair arms. Staff should ensure that hands are cleaned before touching the above-mentioned equipment.	Once Daily (minimum) and when soiled.
Floors and Walls: Kept visibly clean and free of spills and debris.	
Terminal Cleaning and Disinfecting	
Items that cannot be appropriately cleaned and disinfected should be discarded upon resident transfer or discharge. Toilet brushes, unused toilet paper and other disposable supplies should be discarded. Privacy curtains should be removed and laundered upon a resident's discharge or transfer.	After discharge, transfer or discontinuation of contact droplet precautions.
Ensure all staff responsible for environmental cleaning adhere to required cleaning and disinfection practices.	

APPENDIX B: POINT OF CARE RISK ASSESSMENT (PCRA)

RESEAU DE SANTE Horizon HEALTH NETWORK

POINT OF CARE RISK ASSESSMENT (PCRA)

HCWs perform a **PCRA** prior **to contact** with **every** patient, **every** time

- Performing a **PCRA** is the first step in **Routine Practices**. **Routine Practices are to be used** with **all** patients during **all** care to prevent and control transmission of microorganisms in **all** health care settings.
- A **PCRA** will help determine the correct PPE required to protect the HCW in their interaction with the **patient** and **patient environment** even if the patient has been placed on **Additional Precautions** as more PPE may be required.

Prior to EACH PATIENT INTERACTION
ASSESS the risk with the: INTERACTION, TASK, PATIENT, ENVIRONMENT, CONDITIONS

- This will help you decide what, if any, **PPE** you need to wear to protect yourself and to prevent the spread of germs

Will your hands come in contact with mucous membranes, non- intact skin, blood, body fluids, secretions, excretions, contaminated/ soiled items/ surfaces?	Will your clothing or skin become contaminated/ soiled from splashes/sprays of blood, body fluids, secretions, excretions or contact with soiled/ contaminated items/ surfaces?	Will your eyes, face, or mucous membranes be splashed/ sprayed with blood, body fluids, secretions, excretions?
Yes	**Yes**	**Yes**
Put on NON-STERILE GLOVES 	**Put on a Gown** 	**Put on a Surgical/Procedure mask and Eye Protection (Goggles/ Face Shield)** 

Perform Hand Hygiene

- **Before initial patient or patient environment contact.**
- **Before aseptic procedure.**
- **After body fluid exposure risk.**
- **After patient or patient environment contact.**

Refer to Donning and Doffing Poster for the correct order to put on and take off your PPE.

April 23, 2020

APPENDIX C: HOW TO ISOLATE WITH CONTACT AND DROPLET PRECAUTIONS

Infection Prevention and Control Precautions must be balanced with supporting a healthy social lifestyle for the resident.

Accommodation

- Isolate in single room, if possible. If isolation in a single room is not possible, space beds a minimum of 2 meters apart, and privacy curtain must remain pulled. Consider masking residents in that room while awake, as able.
- Prioritize residents who cannot maintain spatial separation of ≥ 2 meters from others for a private room / private bathroom.
- The resident's door may remain open if the distance from the resident to the door is ≥ 2 meters; and it is not a risk to other residents who may not adhere to isolation precautions.

Personal Protective Equipment

- If entering an isolation room or bed space of a shared room, be prepared to interact with the resident by wearing all PPE listed in Appendix D.
- Instruct visitors on necessary infection control measures including:
  - How to put on and remove isolation attire
  - Hand Hygiene (alcohol-based hand rub and/or soap and water)

Hand Hygiene

- Clean hands before and after contact with the resident and/or resident's environment with alcohol-based hand rub or with soap and water.
- Do not use the resident's bathroom sink for hand hygiene.

Isolation Supplies

If possible, gather items together to create an isolation kit in advance:	
Alcohol based hand rub 70 – 90% (method of choice for hand hygiene in all healthcare facilities)	Laundry hamper
Long sleeved isolation gowns	Waste containers
Gloves	Pen
Eye protection	Post-it notes
Surgical masks	Isolation Signage (Contact and Droplet Precautions)

Dedicated thermometer, if applicable	Approved disinfectant for equipment cleaning (e.g., accelerated hydrogen peroxide).
Stethoscope, if applicable	

Resident Care Supplies

- Limit the disposable supplies taken into the room to the amount anticipated for use.
- Disposables not used cannot be returned to stock, they must be discarded.
- Provide the resident with tissues, a waste container for used tissues and a mechanism to perform hand hygiene following coughing/sneezing.

Isolation Room Set up

- Post clearly visible signs with the required precautions (both official languages) outside the resident room. A Contact and Droplet precaution sign can be found on Itacit in the “Library” under “Documents.”
- Waste can and laundry hamper in resident room
- Set up the individual personal protective supplies outside the resident room (anteroom or corridor).

Charting

Do not take any part of the resident chart into the room. To transfer information from the resident room:

- Keep dedicated pen and post-it notes inside resident room.
- Write information on post-it and stick-on window/door of resident room.
- Exit the resident room following the Enter/Exit Room Procedure
- Use another pen outside the room to record information on chart/paper.

Equipment

- Use disposable equipment when possible.
- Dedicate reusable equipment to this resident and leave in room.
- Clean and disinfect reusable equipment before removing from the room.

Laundry and Waste

- Tie off the laundry and waste bags before leaving the room.
- Place outside the room for pick-up
- No further special handling is required for laundry and waste.

Food Trays

- Regular dishes and cutlery
- Regular dishwashing procedures.

Room Cleaning

- Twice daily cleaning of all high touch surfaces, bed rails, light switches, bathrooms, bedside tables, walker, wheelchair, cane, and drawer handles remotes, phone, etc.
- If resident is discharged or transferred out of room, carry out discharge cleaning (per facility policy) and discard all magazines, personal care supplies, disposable supplies, etc.

Resident Transport

- Resident remains confined to room except for medically required activities. Reschedule all non-urgent medical appointments. If it is necessary to leave the room for tests/facility transfer/therapy:
    - Sending facility must notify receiving facility of required precautions.
    - Transport Personnel to don Personal Protective Equipment (PPE) to enter resident room.
    - Resident to don a surgical mask and clean clothing.
    - Utilize clean linens on the clean transport-wheelchair/stretcher (the resident's linen should not be used for transport)
    - Assist resident with hand hygiene.
    - When leaving the room with the resident, transport personnel should remove PPE (gowns and gloves), perform hand hygiene and don clean PPE. The surgical mask and eye protection do not need to be changed.
    - Use facility supplied disinfectant (i.e., accelerated hydrogen peroxide) to provide a clean area for hands on the transport equipment.
    - If equipment from the resident's room must also be transported, it must be disinfected and allowed to air dry prior to use.
    - Use a transport route that avoids populated areas.
    - Maintain ≥ 2 meters from others.
    - Use a dedicated elevator, with no other persons in it.
    - Disinfect equipment after transfer.

APPENDIX D: PERSONAL PROTECTIVE EQUIPMENT (PPE)

To be used when providing direct care to a resident who is on isolation precautions due to suspected or confirmed respiratory illness.

ALL PPE MUST BE CHANGED IF IT BECOMES SOILED, WET OR DAMAGED		
Type	**Description**	**Tips**
Masks	Face masks (ASTM level 1) provide a physical barrier that help prevent the transmission of the virus from person to person by blocking large particle respiratory droplets propelled by coughing or sneezing	Must be changed upon exit of an isolation room, UNLESS providing sequential care between POSITIVE residents with the same pathogen OR providing sequential care between asymptomatic residents**.**
N95 respirators	Respiratory protective device designed to have a very close facial fit and efficient filtration of airborne particles.	Edges of the respirator are designed to form a seal around the nose and mouth.
Eye Protection	Eye protection (e.g., goggles, face shields etc.) protect the mucous membranes of the eyes during case/probable case/suspect case care or activities likely to generate splashes or sprays of body fluids including respiratory secretions. **Prescription eyeglasses alone are not adequate protection against respiratory droplets.**	Must be changed (or cleaned if using non disposable eye protection) upon exit of an isolation room, UNLESS providing sequential care between like POSITIVE residents.
Gloves	Disposable single use gloves should be worn when in direct contact with the ill person, cleaning contaminated surfaces, and handling items soiled with body fluids, including dishes, cutlery, clothing, laundry, and waste for disposal.	**Must be changed between each resident. Not a substitute for hand hygiene**; staff must perform hand hygiene before putting on and taking off gloves. Not for continuous use outside of an isolation room. Gloves should be removed, hand hygiene performed, and new gloves applied when they become soiled or torn during care. Double gloving is not necessary.

Gown	AAMI Level 2 gowns are used to protect your clothing and skin from becoming contaminated/soiled from: splashes/sprays of blood, body fluids, secretions, or excretions, contact with soiled/contaminated items/surfaces.	**Must be changed between each resident.** Not for continuous use outside of an isolation room. Must be tied at the neck and the back. If clothing exposed underneath, two gowns should be worn, first covering the back (tied in front), second covering front (tied in back).
Donning & Doffing	Proper donning and doffing (putting on and taking off) of PPE is key in preventing the spread of pathogens from one individual to another. **When removing PPE (doffing):** • **PPE below the neck**: gown and gloves, are removed *in the room (close to the door)*. • **PPE above the neck**: eye protection and masks, are changed/removed *outside of the room*.	

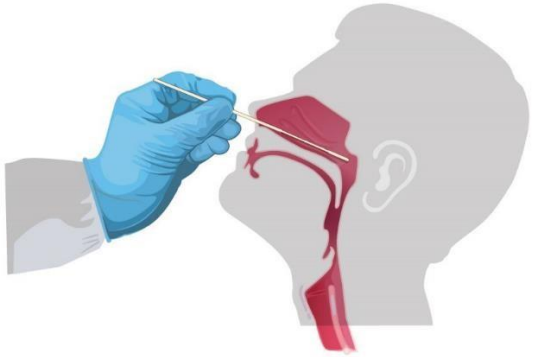
To enter/exit room	
Before entering room, cubicle, or bed space in a shared room: • Perform hand hygiene • Put on gown • Put on surgical mask • Put on eye protection • Put on gloves.	**To exit** room, PPE is removed in the following order prior to exiting the room: • Remove gloves and dispose. Perform hand hygiene. • Remove gown, touching only the inside of gown and place in hamper. Perform hand hygiene • Remove eye protection (front of eye protection is contaminated) *. Perform hand hygiene. • Remove mask-remove by ties (front of the mask is contaminated). Perform hand hygiene. **Note: Re-usable eye protection must be cleaned and disinfected after each use*

NOTE: Posters for donning and doffing PPE are available on iTacit in the "Library" under "Documents"

APPENDIX E: SWABBING TECHNIQUES

Nasopharyngeal

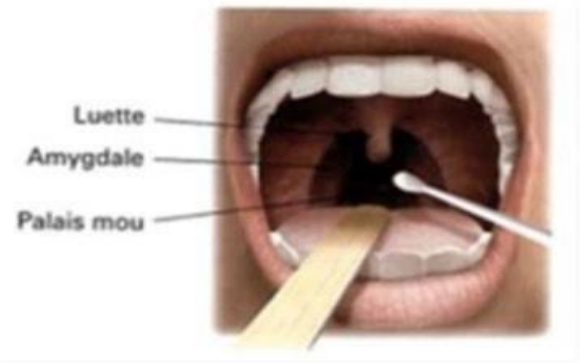
- Tilt patient's head back 70 degrees.
- Gently and slowly insert a minitip swab with a flexible shaft (wire or plastic) through the nostril parallel to the palate (not upwards) until resistance is encountered or the distance is equivalent to that from the ear to the nostril of the patient, indicating contact with the nasopharynx.
- Gently rub and roll the swab.
- Leave swab in place for several seconds to absorb secretions.
- Slowly remove swab while rotating it. Specimens can be collected from both sides using the same swab, but it is not necessary to collect specimens from both sides if the minitip is saturated with fluid from the first collection.
- If a deviated septum or blockage create difficulty in obtaining the specimen from one nostril, use the same swab to obtain the specimen from the other nostril.
- Place swab, tip first, into the transport tube provided.



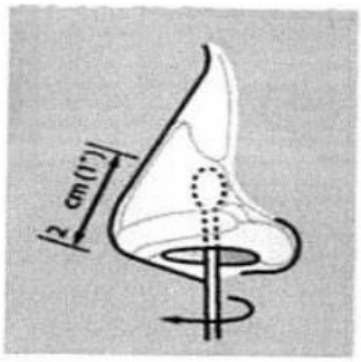
Reference: Interim Guidelines for Clinical Specimens for COVID-19 | CDC

Throat – Nasal POCT

- Advise resident not to eat, drink, vape, smoke, brush teeth or chew gum 30 minutes prior to testing.
- Prepare the test according to package instructions: Tests vary by brand. Note that some swabs are scored to break easily. Hold the swab with the thumb and index finger on the score line to prevent breakage when swabbing.
- Obtain Throat Swab: Swab the tonsil area in the back of the throat for five seconds on each side (avoiding the tongue, teeth and lips).
- Obtain Nasal Swab: Swab the nostrils using the same swab. Gently insert the swab about 1-2 cm into the first nostril, or until resistance is felt. Rotate five times, remove and repeat on the other side. • Process the sample: Place the swab in the tube. Follow the test kit instructions.



(a) Throat technique



(b) Nose technique

References:

- EM/ANB Throat/Nose Specimen Collection.pdf
- Provincial Public Health Laboratory Nova Scotia instructions-alternate-collection-throatand-nares-covid.pdf
- Throat and Nares (Nasal) swabbing for Rapid Antigen Tests | SaskHealthAuthority
- Virus Respiratory (Combined Throat and Both Nostrils) Specimen Collection Instructions | Public Health Ontario