

## COVID-19 Outbreak Management Protocol for Long-Term Care and Seniors' Assisted Living Settings

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February 2, 2022

### Purpose/Scope

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This document provides guidance for managing COVID-19 cases and contacts during an outbreak in a long-term care (LTC) facility or seniors' assisted living (AL) units/facilities that are located within or functionally connected to a LTC setting.

This guidance does not apply to mental health facilities/settings.

### Definitions

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- **Health-care associated COVID-19<sup>1</sup> case:** A person diagnosed with COVID-19 based on any of the criteria below and best clinical judgement:
  - The person was identified as a probable or confirmed COVID-19 case with symptom onset 10 days or less after discharge from a facility **AND** epidemiological investigation is more suggestive of acquisition in the facility than from outside the facility. Factors to consider include:
    - an established epidemiological/genomic link to the facility;
    - exposure outside the facility;
    - the interval between exposure(s) and symptom onset; and
    - the use (or not) of personal protective equipment (PPE).
  - OR**
  - The person developed COVID-19 associated signs and symptoms more than 10 days after admission to a facility **AND** the person had no known exposure to COVID-19 outside the facility within 10 days prior to symptom onset.

#### <sup>1</sup> Notes:

- The purpose of this definition is to identify when a COVID-19 case is associated with a facility, including persons who were admitted to or discharged from an acute care facility. These are surveillance definitions and should not be used to make judgements on the clinical diagnosis or clinical management of residents.
- The application of this definition should be done on a case-by-case basis, following a case investigation.
- For the definition of a probable or laboratory-confirmed COVID-19 case, as well as associated signs and symptoms of COVID-19, please see BC Centre for Disease Control's [case report form for COVID-19](#).



**OR**

- Staff whose COVID-19 infection was attributed to a workplace exposure by workplace health and safety (WHS), public health, or infection prevention and control (IPC).

**OR**

- The person developed COVID-19 associated signs and symptoms 10 days or less after admission to a facility **AND** there is an established epidemiological link between the person and a probable or confirmed COVID-19 case(s) or environmental source in the facility that the person was admitted to as determined by public health or IPC.
- **Outbreak:** The occurrence or suspicion of an increase in cases of health-care associated COVID-19 that are epidemiologically linked to a care unit or health-care facility over a defined time period.

### Enhanced Monitoring/Surveillance and Infection Prevention and Control Measures

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There may be circumstances where the cases of COVID-19 at a health-care facility do not meet the threshold for an outbreak but enhanced monitoring/surveillance and implementation of additional measures to prevent transmission are deemed appropriate by the MHO (e.g., severity of illness amongst vaccinated residents suggests circulation of a variant that causes more severe illness or a facility with low COVID-19 vaccination coverage amongst residents).

If the MHO determines there is minimal risk amongst residents following a public health investigation and below the threshold to declare an outbreak, the situation may still warrant action to inform the need for additional public health or IPC actions. This action might include, but is not limited to:

- Enhanced monitoring/surveillance (e.g., increased active symptom screening; monitoring unexpected resident deaths in the facility (i.e., deaths at levels above those normally observed in LTC and seniors' AL facilities));
- Enhanced IPC measures (e.g., enhanced cleaning and disinfection; initiation of droplet and contact precautions for residents). IPC measures should be applied and adjusted as necessary based on assessed risks and in discussion between the MHO, the facility and IPC.

### Declaring a COVID-19 Outbreak

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**An outbreak may be declared at the direction of the medical health officer (MHO) or their official designate. A COVID-19 outbreak will not be declared solely on the basis of cases diagnosed among residents or staff.**

Based on the consideration of multiple risk factors, including vaccination coverage rate among residents, the severity of illness amongst cases and the rate of increase in cases, a unit/wing/floor/facility may be placed on outbreak under the direction of the MHO, working with the facility leadership and health authority LTC program and IPC teams. The measures outlined here only apply to areas or facilities that have a declared outbreak.



## Management of residents with suspected or confirmed COVID-19:

- **Residents:**

- Initiate droplet and contact precautions for residents with suspected or confirmed COVID-19. Post appropriate signage outside the resident's room.
- Residents diagnosed with COVID-19 should be placed on droplet and contact precautions for five days following the symptom onset date (whether vaccinated or unvaccinated).
- Droplet and contact precautions for residents with COVID-19 should remain in place until improvement in symptoms **AND** resolution of fever for 24 hours without the use of fever-reducing medication.
- A decision to extend the duration of droplet and contact precautions may be done at the discretion of the MHO or their official designate. Consideration should be given to severity of illness and immunocompromised status of the resident. Please see the [public health case and contact management guidance](#) for more information.
- Requirements for additional measures *after* the droplet and contact precautions period is over (e.g., continued masking and/or avoidance of group settings until 10 days following symptom onset date) are at the discretion of the MHO or their official designate.

- **Resident contacts:**

- All roommate close contacts should be placed on droplet and contact precautions.
- The duration of precautions should be based on guidance from the MHO or their official designate. Please see the [public health case and contact management guidance](#) for more information.
- In general, other contacts within the unit and facility do not need to be placed on droplet and contact precautions, unless assessed to have significant close contact with the case and advised by the MHO or their official designate to implement droplet and contact precautions.
- Consideration should be given to those with recent COVID-19 infection in determining the need for residents to be placed on droplet and contact precautions.

- **Monitoring:**

- Continue symptomatic monitoring of all facility residents during the outbreak.
- If symptoms consistent with COVID-19 are identified among residents, immediately take a nasopharyngeal swab or swish-and-gargle sample for polymerase chain reaction (PCR) lab testing.
- The facility should maintain a **line list** with core information on diagnosed cases (name, symptom onset date, test date as well as date of birth and personal health number, if available).

- **Meetings:**

- The facility should convene internal meetings as required to support case management, communications and other operational needs. Contact regional health authority infection prevention and control (IPC) teams for support, as needed.
- At the direction of the MHO, additional support meetings may be scheduled with LTC operations, IPC and leadership personnel from the affected LTC/seniors' AL facility.



- **Infection prevention and control guidance:**

- Continue to follow ongoing IPC requirements for the routine operation of LTC/seniors' AL facilities, as outlined in the [Infection Prevention and Control Requirements for COVID-19 in Long-Term Care and Seniors' Assisted Living](#).

#### Outbreak notifications and site communications

Provide timely on-site and external communication about an outbreak via facility leadership, in collaboration with the MHO, regional health authority LTC program and IPC.

- Post [outbreak notification signage](#) at all facility entrances advising that the facility is currently managing an outbreak and that additional measures are in place.
- Post outbreak notification signage at the entrances of all outbreak units/floors/areas/rooms.
- Within 24 hours of an outbreak being declared and at least every seven days thereafter (at a minimum), email or communicate to all facility staff (including clinical and non-clinical staff, students, contracted staff and volunteers), all non-facility staff, professionals and services providers, and all residents, families and visitors:
  - Advise the aforementioned parties that an outbreak has been declared.
  - Provide key messages about the outbreak and how it is being managed.
  - Advise all parties of any additional measures or requirements that are in place during the outbreak.
  - Advise families and visitors of the presence of COVID-19 in the facility to inform their personal decision making regarding proceeding with or deferring visitation.
  - Advise non-facility staff, professionals and service providers about any outbreak control measures that may affect their provision of services.

#### Additional outbreak control measures

- **Admissions, re-admissions and transfers:**

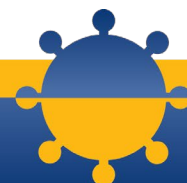
- New admissions, re-admissions or transfers to or from a facility may be considered on a case-by-case basis in consultation with the MHO. Considerations include:
  - The current status of the outbreak and its management (e.g., attack rate, severity of illness, length of time since the last case);
  - Whether the resident would return to an area of the facility that is currently experiencing an outbreak;
  - The degree of protection for the resident offered by immunization;
  - Whether the resident/substitute decision maker, and most responsible provider/physician if appropriate, are informed of the outbreak and have consented to the move; and
  - The overall benefit vs. risk to the health of the transferring client of immediate vs. delayed placement in the residential facility.
- Admissions, re-admissions and transfers to or from an affected unit *within* a facility during an outbreak may be considered, based on the direction of the MHO or their official designate.



- Residents without a COVID-19 diagnosis should not be admitted or moved to a room occupied by a case during the infectious period (five days following the symptom onset date), unless the resident to be moved has recently recovered from COVID-19.
- Where transfers are medically necessary (e.g., hospital admissions, emergency) or for urgent/medically necessary appointments (e.g., dialysis), the receiving facility/unit and transporting personnel must be notified of the outbreak status and if the resident is on any additional precautions.
- **Visitors**
  - For guidance on visitation during an outbreak, please see the [Ministry of Health - Overview of Visitors in Long-Term Care and Seniors' Assisted Living](#) document.
- **Group activities** (e.g., communal dining, in-house recreational opportunities) are suspended during an outbreak unless otherwise directed by the MHO or their official designate.
  - A comprehensive safety plan must be in place for all group activities.
  - Residents with suspected or confirmed COVID-19 or who are close contacts of cases and required to be placed on droplet and contact precautions should not participate in communal dining or group activities.
- **Staff cohorting to specific units** should be used where practical.
  - Where possible, consider cohorting health-care workers (HCWs) and staff, with dedicated HCWs and staff for residents with suspected or confirmed COVID-19 and for those who are well, respectively.
  - If dedicated staff for residents with suspected or confirmed COVID-19 are not available, HCWs and staff should first work with the well and then move on to care for residents with suspected or confirmed COVID-19, avoiding movement between floors/units, wherever possible.
  - Where possible, dedicate HCWs and staff to work exclusively on the outbreak unit as much as possible. If cohorting is not possible, those working on multiple units should first work on unaffected unit(s) and finish on the outbreak unit(s).
- **Vaccination:**
  - LTC and seniors' AL facilities should actively promote and support access to vaccination for residents and staff who have not received a complete vaccination series and any recommended booster doses of an approved COVID-19 vaccine.

If a staff person of an LTC/AL facility is diagnosed with COVID-19:

- The **case** (i.e., the staff person) should self-isolate at home and not attend work in-person for five days following the symptom onset date, until there is symptom improvement, resolution of fever for 24 hours without the use of fever reducing medication **AND** the individual feels well enough to work.



- **Staff contacts:**

- Staff contacts of the case should not be isolated and do not need to be excluded from work, regardless of vaccination status.
- Staff contacts of the case must self-monitor for symptoms, regardless of vaccination status. If symptoms develop or worsen during work, follow the guidance in the [COVID-19 Health-Care Worker Self-Check and Safety Checklist](#).

#### Declaring the outbreak over

**An outbreak will be declared over by the local MHO or their official delegate, in consultation with facility leadership and IPC and/or medical microbiology, as appropriate.**

An outbreak is generally declared over one full incubation period after the last date of exposure or positive test date without any new cases or at the discretion of the local IPC and/or MHO or designate. Multiple factors will be considered in determining when an outbreak is declared over such as point-prevalence testing and the time-period adjusted accordingly. As a general guide:

- For COVID-19, one incubation period is generally 10 days after the last date of exposure to an infectious case at the facility.
- The length of time to conclude an outbreak may be reduced or extended at the direction of the MHO or designate.

Once the outbreak is declared over:

- Provide notification of the end of the outbreak to facility staff (including clinical and non-clinical staff, students, contracted staff and volunteers), all non-facility staff, professionals and services providers, and all residents, families and visitors
- Remove any signage specifically related to the outbreak.
- Re-stock any supplies depleted during the outbreak (e.g., PPE, replacement viral specimen kits).
- Perform a terminal/isolation cleaning and disinfection for the affected rooms after discontinuation of additional precautions.
- Debrief with unit/facility leadership and staff to evaluate the management of the outbreak and implement all corrective actions, as required.
- Restore patient/resident flow patterns for discharge and transfer.

