Outbreak Management Quick Reference Guide

Institutional Respiratory and Gastroenteritis Outbreak Management

2024 Edition
(revised March 2025)

by: Infectious and Communicable Diseases Program
Hastings Prince Edward Public Health
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Contents

Preamble

This revised Outbreak Management Guide replaces the 2022 guide. This guide summarizes several resources including:

1. Ministry of Health Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, February 2025.
2. Provincial Infectious Disease Advisory Committee (PIDAC) Best Practice Documents:
    a. Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition.
    b. Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition.

PREVENTION and PREPARATION

Immunization

Effective infection prevention and control (IPAC) efforts for preventing respiratory infections are comprised of numerous strategies, the main strategy being seasonal influenza and COVID immunization of residents and staff. The Ministry of Health supports annual influenza and COVID immunization as the primary strategy to minimize the impact of influenza and COVID on residents of LTCHs in Ontario.

Influenza, COVID and pneumococcal immunization of LTCH residents, along with appropriate infection prevention and control practices, reduces the impact of these vaccine-preventable diseases. Residents who provide informed consent (or, if the resident is incapable, informed consent is provided by the resident's substitute decision maker) should receive annual influenza vaccination and recommended COVID booster, unless contraindicated. The Canadian Immunization Guide indicates that one dose of polysaccharide pneumococcal vaccine is recommended for all adults 65 years of age and older, and for adults less than 65 years of age in LTCHs or who have conditions putting them at increased risk of pneumococcal disease (The Canadian Immunization Guide). Individuals with unknown immunization histories for pneumococcal vaccine should receive the vaccine.

LTCHs must have immunization programs in place which should include a policy for influenza, COVID and pneumococcal disease.

LTCH immunization policies should address influenza and COVID immunization requirements for residents, staff, volunteers, students, private pay caregivers and visitors, who conduct activities within the home.

Each home should have policies and procedures related to annual staff immunization as well as resident influenza, COVID and pneumococcal immunization.

<u>Influenza and COVID Immunization of Staff</u>

Availability of on-site vaccination clinics for all staff is recommended to provide optimal access to immunization services. Staff can, of course, also obtain their seasonal influenza immunization or recommended COVID booster from their regular care provider, pharmacist or other source in the community. All staff members who receive the influenza and/or COVID vaccine from a source other than the LTCH must provide proof of immunization. If documentation is not available, the LTCH should consider the staff member unimmunized, and the employer must offer influenza and COVID immunization to the individual.

Only the following should be accepted as proof of influenza and COVID immunization:

- A personal immunization record documenting receipt of the current season's influenza vaccine
- A record of immunization from a health care provider (e.g., pharmacist, physician or public health immunization clinic) documenting receipt of the current season's influenza vaccine
- A Ministry of Health enhanced COVID vaccine certificate with an official QR code

Influenza and COVID Immunization of Residents

To ensure that protection lasts throughout the influenza season, the recommended time for influenza immunization is as early as possible when the vaccine becomes available unless otherwise advised by your local PHU. If the resident is admitted after the LTCH's fall influenza immunization program, but before the influenza season is over, vaccination must be offered, unless the person has already received the current season's influenza vaccine.

Prior to, or upon admission, each resident should be assessed regarding immunization and medical status. If the influenza or COVID immunization status of a resident is not available or if it is unknown, the resident should be considered unvaccinated, and immunization should be offered. A resident or their substitute decision–maker (SDM) may refuse any treatment/medication. Refusal (and reason for refusal) should be documented in the resident's health record.

The immunization record of the resident, including their influenza and COVID immunization status, should be retained in a readily accessible part of their health record. Upon transfer to another LTCH, Acute Care or Chronic Care facility, the residents' recent immunization status should be shared with the receiving health care facility.

Pneumococcal Immunization of Residents

There is considerable overlap in the indications for the influenza and pneumococcal vaccines. Consequently, the LTCHs annual influenza immunization program presents an excellent opportunity to immunize those residents who are eligible for the pneumococcal vaccine according to schedule provided in the Canadian Immunization Guide.

The pneumococcal vaccine may be administered concurrently with influenza and COVID vaccine, but at a separate anatomic site, using a separate needle and syringe. For more information and recommendations related to pneumococcal vaccination, please refer to the Canadian Immunization Guide

Role of the LTCH Regarding Visitor Immunization Status

Visitors, including family members/substitute decision-makers (SDMs) and friends to the home, should be encouraged to receive their annual influenza immunization and recommended COVID booster. However, it is not the responsibility of the home to verify the immunization status of visitors and family members/SDMs beyond providing information on the importance and role of vaccination and where they may get vaccinated.

Education

The ongoing education of staff, volunteers, residents, residents' families and visitors about infection and outbreak prevention and related strategies is part of a robust infection prevention and control (IPAC) program. At the time of hiring/placement, during staff/volunteer orientation and as appropriate annually thereafter, educational information about influenza as well as policy information related to influenza should be provided.

Education for all Staff and Volunteers

Education/orientation programs for all staff and volunteers (as applicable) should include information on:

- Influenza and COVID Immunization Program:
    - The effectiveness, benefits and risks of influenza and COVID immunization
    - Respiratory virus (including influenza and COVID) morbidity, mortality, transmission.
    - Prevention of influenza and COVID, and the requirement for annual influenza vaccination and COVID booster
    - Mechanisms to reduce disease transmission, for example respiratory etiquette and hand hygiene.

Respiratory infection outbreak management and exclusion policies:

- Policies related to staff and visitor illness recommendations (persons experiencing symptoms of respiratory illness should not be working/visiting the home).
- Influenza and COVID immunization and exclusion policies for staff.
- Influenza and COVID immunization policies and recommendations for family members and visitors (i.e., those experiencing symptoms of respiratory illness should not be visiting the LTCH).
- Respiratory etiquette.

IPAC core competencies and resources:

- Routine Practices and Additional Precautions, including use of personal protective equipment (PPE)
- Cleaning and disinfecting requirements and environmental cleaning
- Just Clean Your Hands, including your Four Moments for Hand Hygiene (HH)
- Chain of transmission: modes of infection transmission

Education of Residents, Residents' Families, Private Pay Caregivers and Visitors

Topics to include in education programs for all residents, residents' families, private pay caregivers, and visitors:

- A review of influenza and COVID immunization policies and recommendations for residents' families, private pay caregivers, and visitors (i.e., those experiencing symptoms of respiratory illness should not be visiting the LTCH).
- Respiratory etiquette:
    - All individuals are advised to practice respiratory etiquette when coughing or sneezing:
        - Turn head away from others
        - Cover the nose and mouth with tissue; or sneeze into your sleeve
        - Discard tissues immediately after use into waste
        - Perform hand hygiene immediately after disposal of tissues

These are minimum requirements for education; the LTCH can provide more information, at their discretion.

Policy and Procedure Preparation

Each home should have a comprehensive set of policies and procedures related to respiratory and gastroenteritis outbreaks. This includes but is not limited to policies and procedures related to illness surveillance, staff and resident education, use of antivirals for residents and staff, immunization requirements, and exclusion policies.

Policies and procedures should address the following topics:

Education and related policies and procedures:

- Annual review of IPAC policy.
- Annual review of policies and procedures related to outbreak prevention and control.

Outbreak-related policies and procedures:

- Procedures for surveillance, early recognition of potential transmission of infectious conditions, and management of an outbreak including the composition and mandate of the OMT.

Immunization-related policies and procedures:

- Annual staff immunization.
- Resident influenza, COVID and pneumococcal immunization.
- Annual reporting of immunization rates to the MOH, if required.

A policy and procedure on exclusion:

- Staff exclusion policies, including refusal of immunization and refusal of antiviral medication in the event of an influenza outbreak.
- Staff exclusion policies regarding COVID and other respiratory or gastroenteritis outbreaks (e.g. when ill with any ARI or diarrhea/vomiting)

Staffing plans and related policies and procedures:

- A staffing contingency plan addressing varying levels of available staff during outbreaks due to illness, refusal or inability to immunize, unwillingness or contraindication to antiviral agents.
- A staffing plan to address adequate staff to patient ratios: as workload increases during an outbreak, staffing plans need to address continued provision of care and full implementation of infection control measures.

Antiviral use related policies and procedures:

- A policy on antiviral use, including: appropriate use, obtaining informed consent from residents or substitute decision-makers, obtaining medical directive signed by Medical Director for antiviral prophylaxis, payment and reimbursement processes, as well as indications for oseltamivir (Tamiflu™) and zanamivir (Relenza™).

- A policy on staff antiviral use.

Specimen collection, laboratory testing and related policies and procedures:

- Process for ordering appropriate specimen kits such as nasopharyngeal and stool kits from the Public Health Laboratory
- Process to rapidly access specimen kits, testing facilities, and results of laboratory tests in the event of a suspected outbreak.
- Policy requiring availability of staff with competencies related to correct technique for the collection of specimens and completing requisition.

Communication related policies and procedures:

- A policy related to communication requirements and processes between the home, HPEPH, laboratory, and other regulators (e.g. MOL, WSIB), as appropriate and ensuring staff on all shifts are aware of these requirements and processes.
- A policy related to ongoing and effective communication with residents, families of residents, staff and the media.

Notification Procedures for Staff Illness

In accordance with the OHSA and its regulations, the following are required steps for communicating staff illness:

1) Reporting to the LTCH's Infection Prevention and Control – IPAC/ ICP/designate. Should clinical staff become aware of any case(s) or cluster(s) of respiratory infection in residents and/or staff, or if daily ARI surveillance identifies such cases, the LTCH's ICP or designate must be promptly notified. Should Occupational Health and Safety (OHS) become aware of a case or cluster of respiratory infections in staff, they must notify the ICP or designate.

2) Reporting to Occupational Health and Safety - Should staff develop any symptoms of respiratory infection, they must report their condition to OHS or delegate. Should IPAC staff become aware of a case or cluster of respiratory infections in staff, they will notify OHS.

3) Reporting to the Ministry of Labour - An employer must provide written notice within 4 days of being advised that a worker has an occupational illness, including an occupationally-acquired infection, or has filed a claim with the WSIB with respect to an occupational illness, to:
    a. the Ministry of Labour,
    b. the joint health and safety committee (or health and safety representative), and
    c. the trade union, if any.

4) Reporting to the Workplace Safety and Insurance Board - Any instances of occupationally-acquired infection shall be reported to the WSIB within 72 hours of the LTCH receiving notification of said illness.

SURVEILLANCE

Surveillance is defined as “the ongoing systematic collection, analysis, interpretation and evaluation of health data closely integrated with timely dissemination of this data to those who need it”. There are two key aspects of surveillance systems: surveillance is an organized, ongoing exercise and surveillance systems go beyond the collection of information and knowledge gained through surveillance must reach those who can use it to direct resources where needed to improve health.

An important goal of surveillance is to ensure early identification of symptoms in residents and staff that precede a potential outbreak or an outbreak in its early stages so that control measures can be implemented as soon as possible. Designated staff reviews the surveillance data for both staff and residents and consults with HPEPH to determine whether the findings meet the criteria for infection in each resident and staff and if a suspected outbreak exists.

Surveillance of Residents

Continuous home-wide surveillance is required to establish baseline levels of infection throughout the year. Suspect outbreaks are recognized when infection meet the provincial definition. It is expected that LTCHs will ensure they have the capacity to recognize and respond to outbreaks during off-hours (weekends, holidays). Targeted surveillance for respiratory symptoms should be implemented during influenza and COVID season (typically November to April) and when influenza-like and COVID-like illness activity has been reported in the local community, which can start as early as September for some common respiratory viruses, such as rhinoviruses. All staff must be aware of the symptoms of respiratory illness, the criteria for a suspected outbreak and the procedures for reporting to the ICP.

Surveillance of Staff Members

Surveillance for respiratory and gastrointestinal illness among staff should be done throughout the year. All staff should be aware of early signs and symptoms of illness. Ill staff should be asked to report their illness to their manager or to Employee Health/Occupational Health and Safety. The manager or Employee Health/Occupational Health designate must promptly inform the designated Infection Control Practitioner of cases/clusters of employees/contract staff who are absent from work with respiratory or gastrointestinal illness.

Non-Staff Surveillance (includes volunteers, private pay caregivers, and visitors)

All volunteers, private pay caregivers and visitors who conduct activities within the home should self-screen based on the signage posted and exclude themselves from entering the home when they have respiratory or gastrointestinal symptoms (i.e., new cough, new shortness of breath, fever, diarrhea, vomiting). Screening tools and policies are to be posted and followed by all persons entering the LTCH.

LTCH Outbreak Reporting Requirements

Confirmed and suspected outbreaks shall be reported as soon as identified to the Medical Officer of Health by persons required to do so under the HPPA. LTCHs are also responsible for immediately reporting outbreaks of Diseases of Public Health Significance (DOPHS) or communicable disease as defined in the HPPA to the Director under the LTCHA (O. Reg. 79/10, s.107(1)5).

Pursuant to subsection 229 (3) of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007, a designated, trained Infection Control Practitioner is responsible to co-ordinate the IPAC program, which includes surveillance and outbreak management activities. In their absence, a competent person must be designated to continue these functions, including on weekends and during holiday periods. Moreover, staff at all levels of the organization should be trained to monitor for signs and symptoms of acute illness in residents and staff as well as who they should contact.

Public Health Unit Outbreak Reporting Requirements

HPEPH is required to report outbreaks as specified in the provincial case definition. Preliminary report of outbreaks shall be made using the integrated Public Health Information System (iPHIS) or any other method specified by the Ministry of Health within one (1) business day of receipt of initial notification of the outbreak. The final outbreak report shall be submitted within 15 business days of the outbreak being declared over to the Ministry of Health.

INSTITUTIONAL GASTROENTERITIS OUTBREAKS

Introduction

Gastroenteritis outbreaks can be caused by bacteria, viruses, or parasites contracted through the consumption of contaminated foods or beverages, and through contact with contaminated items or infected persons. Many outbreaks can be prevented or have their impact mitigated through intentional, knowledgeable and rapid identification and management of the case to minimize the spread of disease to prevent illness, hospitalization and death.

Viral gastroenteritis is the leading cause of gastroenteritis outbreaks in institutions. In LTCHs, norovirus is the most common cause of such outbreaks. The modes of transmission for norovirus include aerosolization, indirect transmission via contaminated surfaces, person-to-person spread or consumption of contaminated food and beverages. It is of importance to note that contamination of food most often occurs by an infected food handler. Norovirus affects both residents and staff, especially during the winter months when community incidence is also high.

Bacteria and parasites are less frequently implicated in gastroenteritis outbreaks. Such outbreaks often arise from a point source such as bacteria-contaminated food or water. The initial attack rate can be high, but the disease usually does not spread beyond those initially infected. Unlike viral transmission, person-to-person transmission of bacteria and parasites is less common. As a result, there is greater success in controlling outbreaks caused by bacteria and parasites.

Gastroenteritis Outbreak Summary Algorithm

A case should have at least one of the following:
Two or more episodes of vomiting within a 24-hour period
OR
Two or more episodes of diarrhea/watery stools within a 24-hour period
OR
One episode of vomiting and one episode of diarrhea/watery stool within a 24-hour period

Outbreak Definitions

Suspect Gastrointestinal Outbreak - One case of infectious gastroenteritis in the home.

Confirmed Gastrointestinal Outbreak - Two or more cases meeting the case definition with a common epidemiological link (e.g., same unit or floor, same caregiver) with initial onset within a 48-hour period.

Contact HPEPH

Infectious and Communicable Diseases Program - 613-966-5500 ext 349
After Hours (*Evenings – Weekends – Holidays*) - 613-966-5500

Initiate Control Measures

- Isolate ill residents and institute PPE when providing direct care
- Hand hygiene
- Enhanced environmental cleaning
- Exclude ill staff and visitors from the facility

Additional Steps

- Obtain an Outbreak Number from HPEPH
- Initiate Resident and Staff Line List – Upload to FILR
- Collect stool specimens from residents with diarrhea/watery stool. Lab will not test formed stool
- Refrigerate specimens until they can be delivered to hospital for transportation to Kingston PHL
- Communicate with HPEPH daily

Identifying an Institutional Gastroenteritis Outbreak

Case Definition

The case definition contains the criteria to be used during an outbreak to designate a resident or staff member as having infectious gastroenteritis. Individuals who meet the case definition are considered a case – even if laboratory test results are negative. Residents/staff are not considered a case if symptoms are due to another diagnosis or reason (e.g., change in medication, laxatives, dietary change).

To be defined as a case of infectious gastroenteritis **at least one** of the following must be met:

- Two or more episodes of diarrhea or watery stool (take the form of its container) within a 24-hour period, **or**
- Two more episodes of vomiting within a 24-hour period, **or**
- One or more episodes of diarrhea or watery stool (takes the form of its container) and one or more episodes of vomiting within a 24-hour period.

Outbreak Definitions

Suspected Gastroenteritis Outbreak Definition

One case of infectious gastroenteritis in the home. Symptoms should not be attributable to another cause (e.g., medication side effects, laxatives, diet or prior medical condition).

Confirmed Gastroenteritis Outbreak Definition

Two or more cases meeting the case definition with a common epidemiological link (e.g., same unit or floor, same caregiver) with initial onset within a 48-hour period.

General Gastroenteritis Outbreak Control Measures

Early outbreak detection, reporting and implementation of outbreak control measures is essential to prevent further transmission of illness and reduce the length and impact of an outbreak. Please refer to the Ministry of Health *Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (February 2025)* and your assigned outbreak investigator at HPEPH for guidance regarding outbreak management.

GASTROENTERITIS OUTBREAK CONTROL MEASURES	
ADMINISTRATIVE CONTROLS	
Communication	• Post outbreak signs at all entrances to facility for all visitors and staff • Post signs at floor/area entrances when outbreak is isolated to one or more areas • Recommend providing information regarding outbreak status on telephone messaging system • Notify staff of outbreak status • Notify facility physician/medical care provider • Notify additional agencies when appropriate (e.g. Ministry of Labour, Compliance Officer, EMS, Emergency Department, Provincial Transfer Authorization Centre, Community Care Access Centre)
ROUTINE PRACTICES and ADDITIONAL PRECAUTIONS	
Hand Hygiene	
• Educate and reinforce appropriate hand hygiene • Wash with soap and running water. When hands are not visibly soiled, use an alcohol-based hand rub (ABHR) containing 70-90% alcohol • Ensure easy access to hand hygiene supplies and to hand washing sinks dedicated to hand hygiene and used for no other purpose • Food handlers must use liquid soap and water to wash hands in food premises	
Personal Protective Equipment	
• Post additional precaution (contact) signage on rooms of case room • Ensure personal protective equipment (PPE) is easily accessible to staff and visitors • Store PPE in a clean sanitary manner outside of resident room • Provide disposal bin within resident room for proper disposal of used equipment	
Gown	• Protect skin and clothing during activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions • Gowns should only be worn when providing care to residents • Remove gowns before leaving the resident's room or dedicated space or if they become soiled, wet or contaminated
Gloves	• Contact with the body fluids, blood, excretions, secretions or non-intact skin • Glove use does NOT replace hand hygiene • Complete hand hygiene before applying and after removal • Glove use is task specific. Remove and discard gloves immediately following task and before leaving the resident's room or dedicated space
Mask and eye protection	• Protect the mucous membranes of the mouth, nose and eyes when it is anticipated that a procedure or care activity is likely to generate splashes or sprays of blood, body fluids, secretions or excretions or within two meters of a coughing resident • Remove and discard appropriately before leaving the resident's room or dedicated space and complete hand hygiene • Disinfect reusable googles between each use

ENVIRONMENTAL CLEANING	

Enhanced cleaning and disinfection	• Increase routine cleaning of all high-touch surfaces such as door handles, bed railings, hand rails, light switches, elevator buttons, over-bed tables, dining tables and counters
	• Increase the cleaning and disinfecting of all surfaces in the ill resident's immediate environment
	• Cohort environmental cleaning staff when possible
	• If cohorting environmental staff is not possible, clean and disinfect well resident rooms before ill resident rooms
	• Review and follow manufactures instructions regarding chemical concentration and contact time
	• Refer to PIDAC *Best Practices for Environmental Cleaning and Prevention and Control of Infections in All Health care Settings, 2018*
	  ○ *Appendix 2: Cleaning Disinfection Decision Chart for Noncritical Equipment*
	  ○ *Appendix 21: Risk Stratification Matrix to Determine Frequency of Cleaning*
	• Environmental Services should allow for surge capacity during an outbreak (i.e. additional resources such as staffing and supplies). Ensure staff are provided with appropriate policies and procedures for cleaning and disinfecting

RESIDENT CONTROL MEASURES	
Isolation	• Isolate ill residents to their rooms for at least **48 hours after symptoms resolve**. If norovirus is suspected or confirmed it is recommended that isolation of residents is **48-72 hours** after symptoms resolve • Keep privacy curtains drawn in multi-bed rooms • If isolation is not possible consider control measures such as: frequent hand hygiene and increase of environmental cleaning of high touch surfaces
Medical Equipment	• Dedicate equipment to a single symptomatic resident wherever possible. If equipment must be shared, it must be cleaned and disinfected between residents as per manufactures instructions • Use single use equipment wherever possible
Medical Appointments	• Reschedule non-urgent medical appointments • Consult with physician when necessary
Admissions and Transfers	• Generally, admissions of new residents are not advised to a facility or floor/unit during an outbreak. Admissions and return should be made in consultation with HPEPH • Refer to *Appendix 15 – Transfer and Return Algorithm for use during Outbreaks,* • Notify EMS and hospital ICP when transferring ill resident to hospital • Do not transfer well residents into a room with an ill resident
STAFF/VOLUNTEER/STUDENT CONTROL MEASURES	
Ill Staff	• All staff must report illness and are added to staff line list • Excluded from work for at least **48 hours after symptoms resolve** • If the causative agent is known, a disease-specific exclusions period may apply

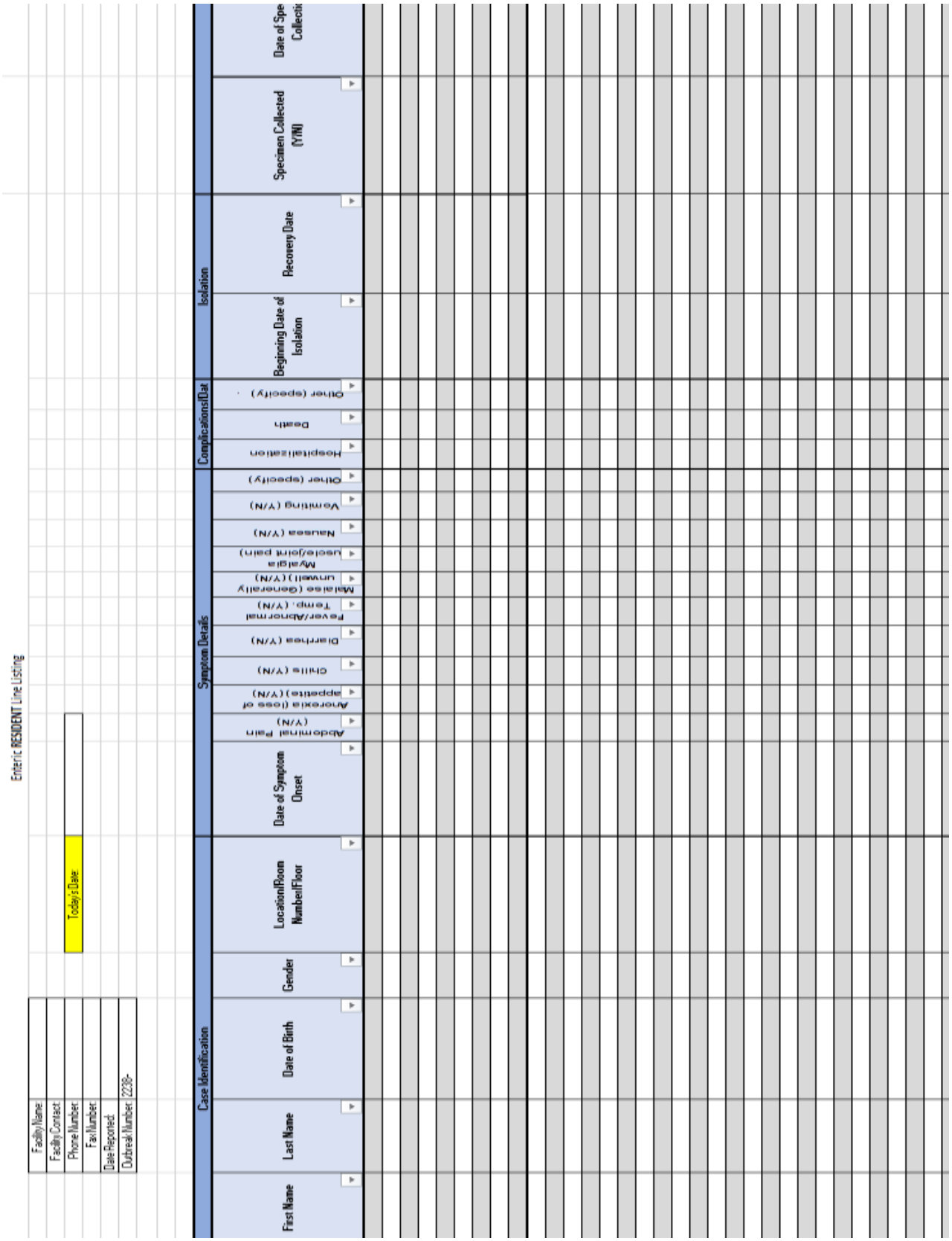
	• Discard all ready-to-eat foods (i.e. food not to be cooked) prepared by dietary staff that became ill while on shift
Well Staff	• Cohort staff (i.e. assign staff to ill residents or specific geographic area) • Staff working in other facilities must notify employer. Staff may be advised to not work in other facility until incubation period has passed
VISITOR CONTROL MEASURES AND FACILITY ACTIVITIES	
Visitors	• Posting signs at entrances outlining screening • Advising everyone not to enter the LTCH when they have gastrointestinal symptoms, respiratory symptoms or known communicable disease. • Advise visitors of potential risk of acquiring illness • Educate visitors regarding hand hygiene • Wear appropriate PPE when providing direct care • Only visit one resident and leave immediately. If visitor must visit more than one resident, visit healthy resident first • Visit resident in room and avoid communal areas
Communal Activities	• Discontinue all communal activities in affected areas (e.g. programs, entertainers, child-care groups and off-site activities) • Conduct on-site programs such as physiotherapy and foot care for residents in their rooms, if possible and wear PPE where necessary. • Activities may continue in non-affected areas • If outbreak is facility-wide restrict all activities and meetings
Facility Closure	• Complete closure of a LTCH to visitation is not permitted unless there is an order issued by the Medical Officer of Health when deemed necessary for resident's safety

Resident and Staff Line List

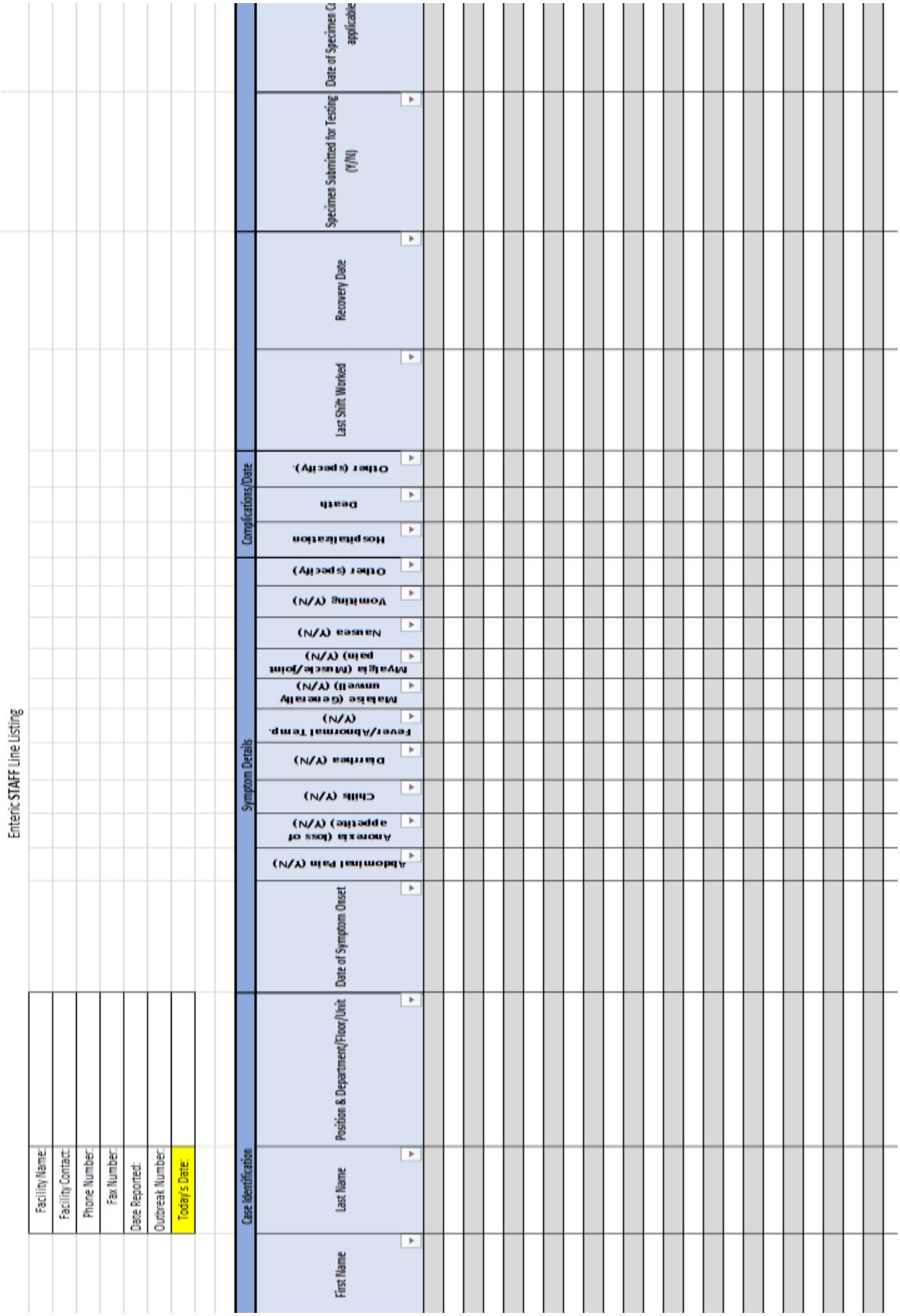
A line list is a table that summarizes information about suspect, probable or confirmed cases associated with an outbreak. Line lists are intended to provide a summarized representation of the outbreak including symptoms, onset dates, isolation, deaths, etc. All individuals that meet the case definition will be added to the resident or staff line list. When completing a line list ensure that:

- Resident and staff line lists are separate
- Cases are added to line list in order of date of symptom onset
- Cases are not removed from line list when symptoms resolve
- Cases are not re-added to line list if symptoms reoccur
- Send completed line list to assigned outbreak investigator and update daily or as necessary through FILR

SAMPLE: Resident Gastroenteritis Outbreak Line Listing



SAMPLE: Staff Gastroenteritis Outbreak Line Listing



Specimen Collection for Gastroenteritis Outbreaks

Determining the causative organism for an outbreak is paramount to ensure appropriate outbreak control measures can be applied to reduce the burden and duration of the outbreak.

HPEPH will encourage specimen collection for all suspect and confirmed outbreaks. When collecting specimens:

- Collect specimens from identified cases who most recently became ill (i.e. symptom onset within 48 hours).
- A total of 4 stool samples can be sent to the laboratory.
- Stool must be loose – formed stool will not be tested.
- Specimens can be dropped off at the Belleville, Picton and North Hastings ER registration desk for transport to Kingston Public Health Laboratory.
- HPEPH encourages all facilities to have specimen cooler bags onsite.

Instructions for Gastroenteritis Specimen Collection:

1. Be Prepared – Complete laboratory requisition, have access to PPE and specimen kit.

2. Remove the specimen collection vial(s) from the biohazard bag.

3. Specimens should be collected as follows:
    a. Incontinent– Collect faeces sample from soiled brief/diaper.
    b. Continent – Instruct the patient to defecate into a clean container/pan and collect.

        NOTE: Faeces specimens that have been in contact with water in toilet are unacceptable.

4. Wear appropriate personal protective equipment. Using the spatula on the lid of each vial, select different sites of the faeces specimen, preferably blood, mucus or pus, and transfer to the vials as follows:

Bacteriology: GREEN-capped Cary-Blair vial with red-coloured transport medium. A collecting device (plastic spatula) is fitted inside the cap.

1. Add faeces up to the line indicated, approximately 2-3 scoops. Do not overfill.
2. Mix into transport medium.
3. Replace and tighten cap.

Virology/Toxin: empty WHITE-capped vial with a plastic spatula.

1. Add faeces up to the line indicated. Do not overfill.
2. Replace and tighten cap.

5. Specimen containers must have minimum 2 unique identifiers matching laboratory requisition. Label the specimen container with the patient's full name, date of collection and one other unique identifier such as the patient's

date of birth or Health Card Number. Failure to provide this information may result in rejection.

6. Complete all fields of the PHOL requisition as shown in Sample Gastroenteritis Laboratory Requisition (on next page).

7. Place specimen containers in the biohazard bag and seal bag.

8. Insert the completed requisition in the pocket on the outside of the sealed biohazard bag.

9. Place all bottles into the plastic bag. Seal the plastic bag by peeling off the blue strip.

10. Remove gloves and perform hand hygiene.

11. Refrigerate specimens immediately - do not freeze.

Storage of unused kits:
The kits can be stored at room temperature with stated expiry date - DO NOT USE EXPIRED KITS.

To order kits or for more information please see:

- Email: PHOL.Warehouse@oahpp.ca
- Fax: 416-235-5753; or
- Phone: 613-417-3322 or toll free 1-855-546-4745, ext. 7
    - Enteric Outbreak Kit order#: 390036

SAMPLE Gastroenteritis Outbreak Investigation Laboratory Requisition

General Test Requisition

Public Health Ontario | Santé publique Ontario

ALL sections of the form must be completed by authorized health care providers for each specimen submitted, or testing may be delayed or cancelled.

Verify that **all testing requirements** are met before collecting a specimen.

For **HIV, respiratory viruses, or culture isolate** requests, use the dedicated requisitions available at: publichealthontario.ca/requisitions

For Public Health Ontario's laboratory use only:

Date Received (yyyy-mm-dd): | PHO Lab No.:

Submitter / Health Care Provider (HCP) Information

Licence No.: CPSO 109375 | Lab / Hospital or Facility Name: Hastings Prince Edward Public Health

HCP Full Name: Dr. Ethan Tournishey | Address: 179 North Park St

City: Belleville | Postal Code: K8P 4P1 | Province: ON

Tel: 613-966-5500 x349 | Fax: 613-966-1813

Copy to Other Lab / Health Unit / Authorized Health Care Provider (HCP)

Licence No.: | Other Lab / Health Unit / Facility Name:

HCP Full Name: | Address:

City: | Postal Code: | Province:

Tel: | Fax:

Patient Setting

- [ ] Clinic / Community
- [ ] ER (Not Admitted / Not Yet Determined)
- [ ] ER (Admitted)
- [ ] Inpatient (Non-ICU)
- [ ] ICU / CCU
- [x] Congregate Living Setting

Testing Indication(s) / Criteria

- [x] Diagnosis
- [ ] Screening
- [ ] Immune Status
- [ ] Follow-up / Convalescent
- [ ] Pregnancy / Perinatal
- [ ] Impaired Immunity
- [ ] Post-mortem

Other (Specify):

Signs / Symptoms

- [ ] No Signs / Symptoms
- ★ **Onset Date (yyyy-mm-dd):**
- [ ] Fever
- [ ] Rash
- [ ] STI
- [x] Gastrointestinal
- [ ] Respiratory
- [ ] Hepatitis
- [ ] Meningitis / Encephalitis

Other (Specify):

Relevant Exposure(s)

- [ ] None / Not Applicable
- Most Recent Date (yyyy-mm-dd):
- Occupational Exposure / Needlestick Injury (Specify): [ ] Source [ ] Exposed

Other (Specify):

Relevant Travel(s)

- [ ] None / Not Applicable
- Most Recent Date (yyyy-mm-dd):

Travel Details:

Patient Information

Health Card No.:

Date of Birth (yyyy-mm-dd): | Sex: [ ] Male [ ] Female

Medical Record No.:

Last Name (per health card):

First Name (per health card):

Address: | Postal Code:

City: | Tel:

Investigation / Outbreak No. from PHO or Health Unit (if applicable):

Specimen Information

★ **Date Collected (yyyy-mm-dd):** | **Submitter Lab No.:**

- [ ] Whole Blood
- [ ] Serum
- [ ] Plasma
- [ ] Bone Marrow
- [ ] Cerebrospinal Fluid (CSF)
- [ ] Nasopharyngeal Swab (NPS)
- [ ] Oropharyngeal / Throat Swab
- [ ] Sputum
- [ ] Bronchoalveolar Lavage (BAL)
- [ ] Endocervical Swab
- [ ] Vaginal Swab
- [ ] Urethral Swab
- [ ] Urine
- [ ] Rectal Swab
- [x] Faeces

Other (Specify type AND body location):

Test(s) Requested

Enter each assay as per the publichealthontario.ca/testdirectory:

1. Enteric Outbreak
2.
3.
4.
5.
6.

For routine hepatitis A, B or C serology, complete this section instead:

Hepatitis A
- [ ] Immune Status (HAV IgG)
- [ ] Acute Infection (HAV IgM, signs/ symptoms info)

Hepatitis B
- [ ] Immune Status (anti-HBs)
- [ ] Chronic Infection (HBsAg + total anti-HBc)
- [ ] Acute Infection (HBsAg + total anti-HBc + IgM if total is positive)
- [ ] Pre-Chemotherapy Screening (anti-HBs + HBsAg + total anti-HBc)

Hepatitis C
- [ ] Current / Past Infection (HCV total antibodies)

No immune status test for HCV is currently available.

The personal health information is collected under the authority of the Personal Health Information Protection Act, s.36 (1)(c)(iii) for the purpose of clinical laboratory testing. If you have questions about the collection of this personal health information please contact the PHO's Laboratory Customer Service at 416-235-6556 or toll free 1-877-604-4567. F-SD-SCG-1000, version 004.1 (January 2024).

Ontario

Foodborne Illness Outbreak Investigation

Most enteric outbreaks in facilities are caused by viruses which are acquired through person-to-person transmission. However, other bacteria and parasites from can cause gastrointestinal disease. During a gastroenteritis outbreak it is important that foodborne, waterborne or other potential microbial sources of illnesses are identified.

Retaining Food Samples
Although not legislated, consideration should be given to implementing a policy of retaining 100 grams (solid), or 100 ml (liquid) samples of ready-to-eat, potentially hazardous foods from each meal for 7 days. Food samples should be frozen at or below -18◦C until the outbreak investigator determines an appropriate time to discard.

Food Retention Policy:
Once a potential outbreak has been identified, food samples should not be discarded.
What to include in your food retention policy:

- Types of food to be retained.
- Date of production.
- Retention period (or date of discard).
- Location of retained food samples.
- Type of retention container.
- Quantity of food to be retained.
- Labeling requirements such as: date, type of food and time of meal.

Declaring the Gastroenteritis Outbreak Over

Public Health shall declare whether an outbreak is over in consultation with the facility. Public Health shall use the most current available epidemiological data and best practices/guidance documents to determine when an outbreak can be declared over. The Medical Officer of Health retains the final authority to determine if an outbreak is over. The specific period varies by causative agent, but often is set at:

- Unknown causative organism - **48 hours after the symptoms of the last case have resolved** and all appropriate precautions were taken, there was no confirmed etiologic agent and Kaplan's Criteria was used.

- If norovirus is suspected/confirmed - **five days** after no new cases added to line list (one incubation period (2 days) plus one period of communicability (3 days)).

- Lab confirmed causative agent (e.g., Salmonella, E. coli, listeria) – outbreak declared over when one incubation period and one period of communicability have lapsed.

INSTITUTIONAL RESPIRATORY OUTBREAKS

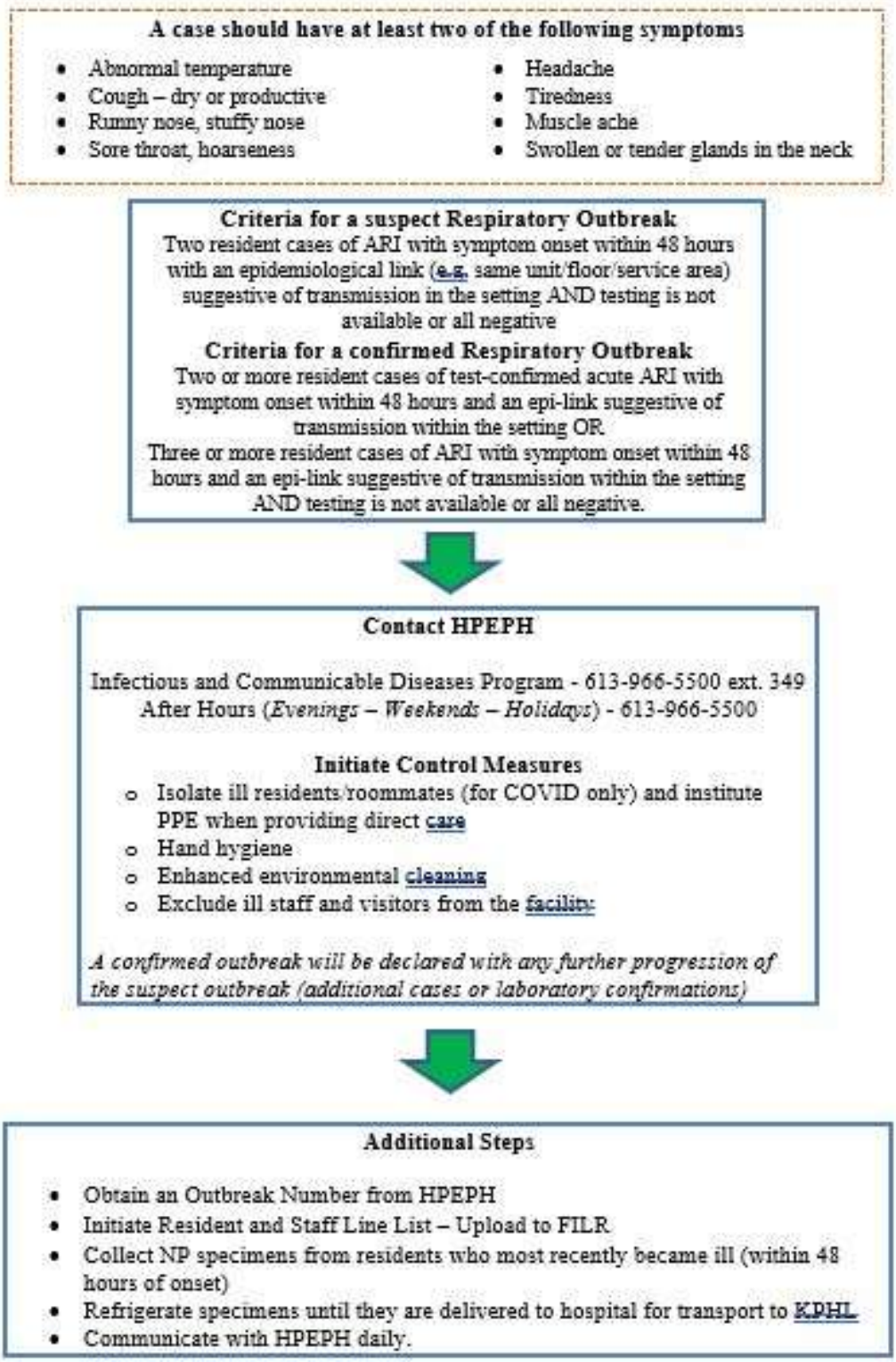
Introduction

Respiratory infection outbreaks occur in institutional facilities throughout the year but are more common from the fall to early spring. These can lead to substantial morbidity and mortality and are disruptive and costly. Respiratory tract infections are commonly diagnosed infections in residents. In Ontario, based on data from Public Health Ontario Laboratory (PHOL), the most common respiratory viruses causing respiratory infection outbreaks are influenza A and B, COVID-19, entero/rhinovirus, non-COVID-19 coronavirus, RSV, parainfluenza, and metapneumovirus. Occasionally more than one infectious agent may be identified in an outbreak.

Residents in institutional facilities are predisposed to Acute Respiratory Infections (ARIs) in part because they may be elderly, may have chronic illnesses which weaken their immune system, and may have chronic lung or neurological diseases which impair their ability to clear secretions from their lungs and airways. However, residents are also at risk because many viral and bacterial respiratory pathogens are easily transmitted in an institutional environment.

Early detection together with the timely implementation of outbreak control measures that are carefully adhered to, can effectively minimize transmission of infection, thereby preventing or more quickly bringing an outbreak under control.

Respiratory Outbreak Summary Algorithm



Identifying an Institutional Respiratory Outbreak

Case Definition

To be determined a case, at least **two** of the following symptoms must be identified as new for the individual:

- Fever/abnormal temperature $\geq$ 37.5 ^{o}C or $\leq$35.5 ^{o}C
- Runny nose or sneezing
- Stuffy nose (i.e. congestion)
- Sore throat, hoarseness or difficulty swallowing
- Dry cough
- Swollen or tender glands in the neck (cervical lymphadenopathy)
- Tiredness (malaise)
- Muscle aches (myalgia)
- Loss of appetite
- Headache
- Chills

Outbreak Definitions

Suspect respiratory infection outbreak:

- Two patient/resident cases of ARI with symptom onset within 48 hours with an epidemiological link (e.g. same unit/floor/service area) suggestive of transmission in the setting AND testing is not available or all negative

Confirmed respiratory infection outbreak:

- Two or more patient/resident cases of test-confirmed acute respiratory infections (ARI) with symptom onset within 48 hours and an epidemiological link (e.g. same unit/floor/service area) suggestive of transmission within the setting.
  OR
- Three or more patient/resident cases of ARI with symptom onset within 48 hours and an epidemiological link suggestive of transmission within the setting AND testing is not available or all negative.

Respiratory Outbreak Control Measures

Early outbreak detection, reporting and implementation of outbreak control measures is essential to prevent further transmission of illness and reduce the length and impact of an outbreak.

Please refer to the Ministry of Health *Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, February 2025* and your assigned outbreak investigator at HPEPH for guidance regarding outbreak management.

RESPIRATORY OUTBREAK CONTROL MEASURES	
ADMINISTRATIVE CONTROLS	
Communication	• Post outbreak signs at all entrances to facility for all visitors and staff • Post signs at floor/area entrances when outbreak is isolated to one or more areas • Recommend providing information regarding outbreak status on telephone messaging system • Notify staff of outbreak status • Notify facility physician/medical care provider • Notify additional agencies when appropriate (e.g. Ministry of Labour, Compliance Officer, EMS, Emergency Department, Provincial Transfer Authorization Centre, Community Care Access Centre)
ROUTINE PRACTICES and ADDITIONAL PRECAUTIONS	
Hand Hygiene	
• Educate and reinforce appropriate hand hygiene • Wash with soap and running water. When hands are not visibly soiled, use an alcohol-based hand rub (ABHR) containing 70-90% alcohol • Ensure easy access to hand hygiene supplies and to hand washing sinks dedicated to hand hygiene and used for no other purpose • Food handlers must use liquid soap and water to wash hands in food premises	
Personal Protective Equipment	
• Post additional precaution (droplet-contact/airborne) signage on rooms of case room • Ensure personal protective equipment (PPE) is easily accessible to staff and visitors • Store PPE in a clean sanitary manner outside of resident room • Provide disposal bin within resident room for proper disposal of used equipment	
Gown	• Protect skin and clothing during activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions • Gowns should only be worn when providing care to residents • Remove gowns before leaving the resident's room or dedicated space or if they become soiled, wet or contaminated
Gloves	• Contact with the body fluids, blood, excretions, secretions or non-intact skin • Glove use does NOT replace hand hygiene • Complete hand hygiene before applying and after removal • Glove use is task specific. Remove and discard gloves immediately following task and before leaving the resident's room or dedicated space
Mask and eye protection	• Universal masking/eye protection in outbreak areas based on MOH/PHU recommendations • Staff should upgrade to a fit-tested N95 respirator for outbreaks attributable to COVID, when entering the room of a suspect or confirmed case, or when recommended by PH • Protect the mucous membranes of the mouth, nose and eyes when it is anticipated that a procedure or care activity is likely to generate splashes or sprays of blood, body fluids, secretions or excretions or within two meters of a coughing resident

	• Remove and discard appropriately before leaving the resident's room or dedicated space and complete hand hygiene • Disinfect reusable googles between each use
ENVIRONMENTAL CLEANING	
Enhanced cleaning and disinfection	• Increase routine cleaning of all high-touch surfaces such as door handles, bed railings, hand rails, light switches, elevator buttons, over-bed tables, dining tables and counters • Increase the cleaning and disinfecting of all surfaces in the ill resident's immediate environment • Cohort environmental cleaning staff when possible • If cohorting staff is not possible, clean and disinfect well resident rooms before ill resident rooms • Review and follow manufactures instructions regarding chemical concentration and contact time • Refer to PIDAC *Best Practices for Environmental Cleaning and Prevention and Control of Infections in All Health care Settings, 2018* o *Appendix 2: Cleaning Disinfection Decision Chart for Noncritical Equipment* o *Appendix 21: Risk Stratification Matrix to Determine Frequency of Cleaning* • Environmental Services should allow for surge capacity during an outbreak (i.e. additional resources such as staffing and supplies). Ensure staff are provided with appropriate policies and procedures for cleaning and disinfecting
RESIDENT CONTROL MEASURES	
Isolation	• For non-COVID outbreaks, isolate ill residents to their rooms until **5 days from symptom onset OR until symptoms have completely resolved, whichever is shorter**. Resident cases should mask until day 10 from symptom onset. • For COVID outbreaks, isolate positive residents for 5 days after onset of illness and if symptoms are improving x 24 hours, and resident must don a well-fitted mask outside of their room for the duration of the 10 days • Roommates of COVID and non-COVID cases with ongoing exposure should isolate for 5 days then mask until day 10 • Other close contacts (tablemates) should mask for 7 days • Keep privacy curtains drawn in multi-bed rooms • If isolation is not possible consider personal control measures such as: frequent hand hygiene, wearing surgical mask and increase of environmental cleaning of high touch surfaces
Medical Equipment	• Dedicate equipment to a single symptomatic resident wherever possible. If equipment must be shared, it must be cleaned and disinfected between residents as per manufactures instructions • Use single use equipment wherever possible
Medical Appointments	• Reschedule non-urgent medical appointments • Consult with physician when necessary
Admissions and Transfers	• PHU approval is not required for admissions/transfers from acute care but consultation is recommended when IPAC advice or risk mitigation is needed

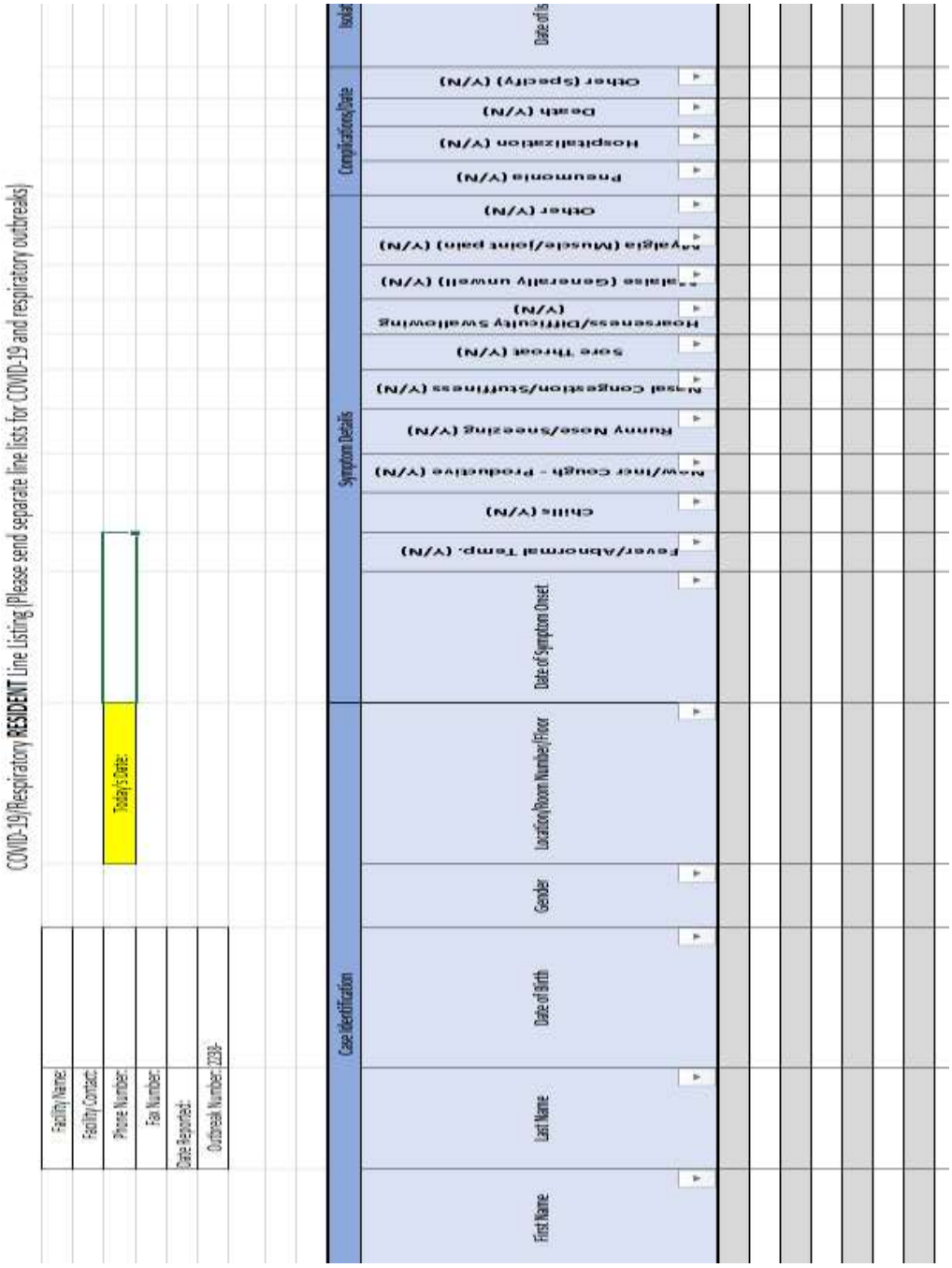
	• Generally, admissions of new residents are not advised to a facility or floor/unit during an outbreak. Admissions and return should be made in consultation with HPEPH • Obtain a Medical Transfer (MT) authorization number from the Provincial Transfer Authorization Centre (PTAC) before transferring a resident to acute care
STAFF/VOLUNTEER/STUDENT CONTROL MEASURES	
Ill Staff	• All staff must report illness and are added to staff line list • For all respiratory outbreaks, staff should be excluded until symptoms have been improving for 24 hours and no fever present • For the 10 days after symptom onset, staff should adhere to IPAC measures to reduce transmission (masking, solo breaks)
Well Staff	• Cohort staff (i.e., assign staff to ill residents or specific geographic area) • Staff working in other facilities must notify employer. Staff may be advised to not work in other facility until incubation period has passed (3 days from last day worked in the facility)
VISITOR CONTROL MEASURES AND FACILITY ACTIVITIES	
Visitors	• Respiratory self screening tool and exclusion policies located at entrance of facility • Advise ill visitors not to enter facility at any time • Advise visitors of potential risk of acquiring illness • Encourage seasonal influenza immunization and routine COVID booster • Educate visitors regarding hand hygiene and respiratory etiquette • Wear appropriate PPE when providing direct care • Only visit one resident and leave immediately. If visitor must visit more than one resident, visit healthy resident first • Ill residents may participate in 1:1 activities with essential caregivers and visitors, including going outdoors but precautions should be followed
Communal Activities	• Discontinue all communal activities in affected areas (e.g., programs, entertainers, child-care groups and off-site activities) • Activities may continue in non-affected areas • If outbreak is facility-wide restrict all activities and meetings
Facility Closure	• Complete closure of a LTCH to visitation is not permitted unless there is an order issued by the Medical Officer of Health when deemed necessary for residents' safety.
INFLUENZA CONFIRMED OUTBREAK ADDITIONAL CONTROL MEASURES	
Prophylaxis and Treatment	• **During a confirmed influenza outbreak refer to *Appendix B: Antivirals/Therapeutics* for resident and staff Tamiflu recommendations.**

Resident and Staff Line List

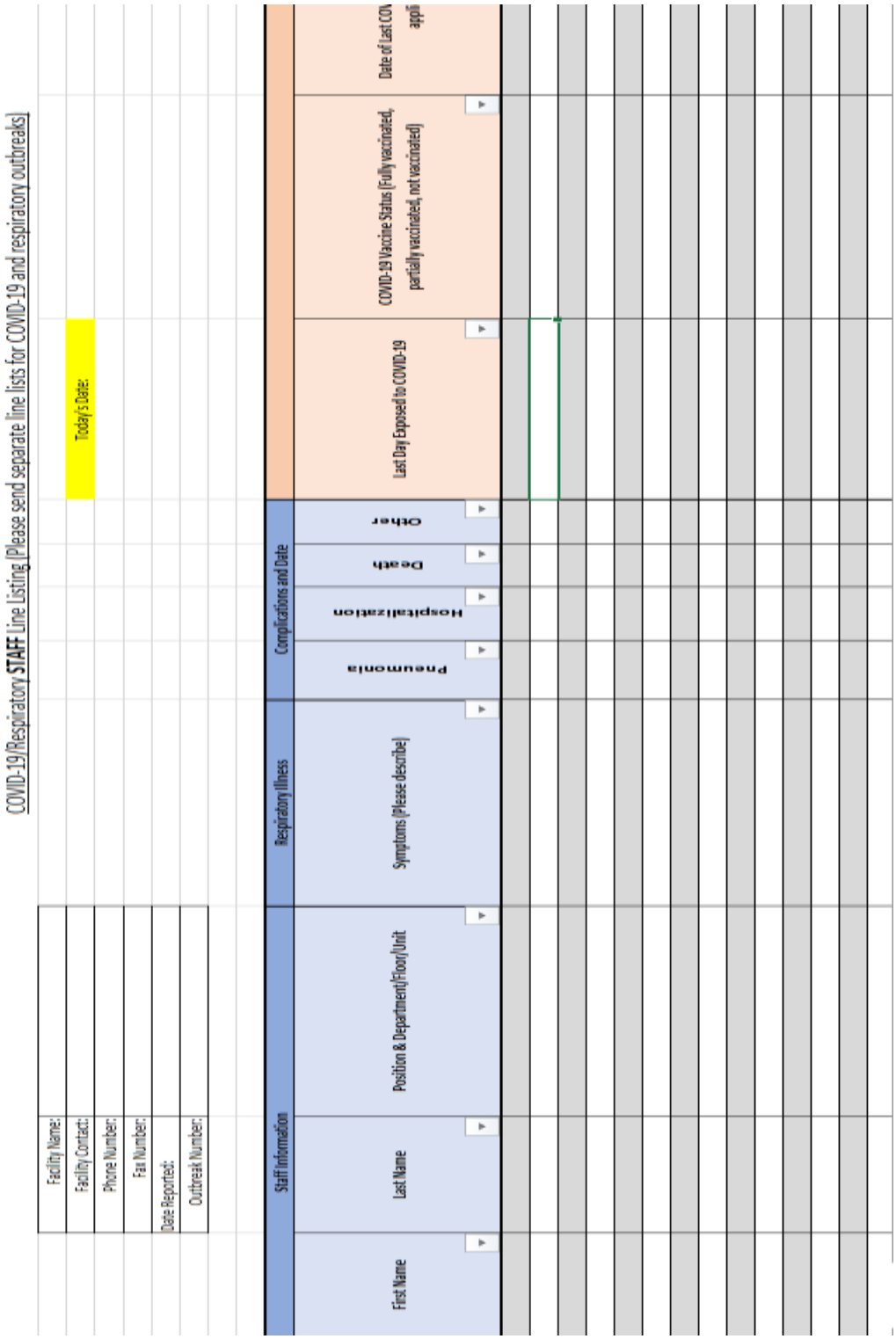
A line list is a table that summarizes information about suspect, probable or confirmed cases associated with an outbreak. Line lists are intended to provide a summarized representation of the outbreak including symptoms, onset dates, isolation, deaths, immunization, antiviral treatment etc. All individuals that meet the case definition will be added to the resident or staff line list. When completing a line list ensure that:

- Resident and staff line lists are separate
- Cases are added to line list in order of date of symptom onset
- Cases are not removed from line list when symptoms resolve
- Cases are not re-added to line list if symptoms reoccur
- Send completed line list through FILR to the assigned outbreak investigator daily or as requested

SAMPLE: Resident Respiratory Outbreak Line List



SAMPLE: Staff Respiratory Outbreak Line List



COVID-19/Respiratory **STAFF** Line Listing [Please send separate line lists for COVID-19 and respiratory outbreaks]

Facility Name:	
Facility Contact:	
Phone Number:	
Fax Number:	
Date Reported:	
Outbreak Number:	

Today's Date:

Staff Information			Respiratory Illness	Complications and Date						
First Name	Last Name	Position & Department/Floor/Unit	Symptoms [Please describe]	Pneumonia	Hospitalization	Death	Other	Last Day Exposed to COVID-19	COVID-19 Vaccine Status [Fully vaccinated, partially vaccinated, not vaccinated]	Date of Last COV appli

Respiratory Specimen Collection

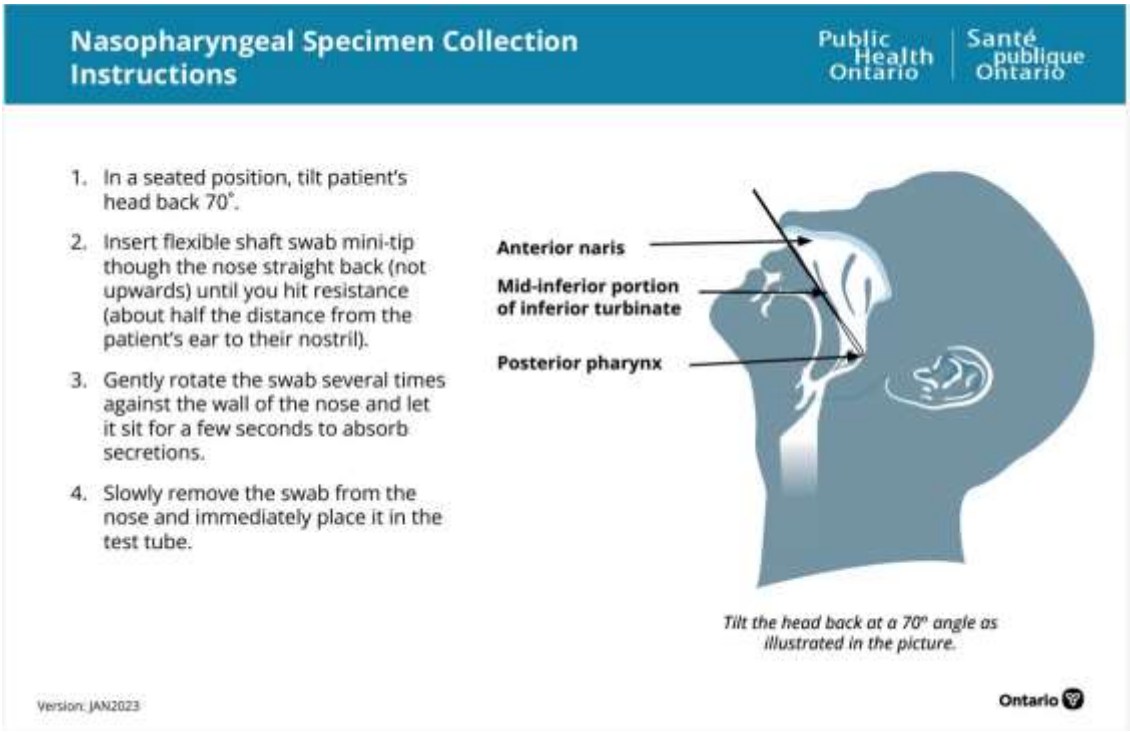
- PHO's laboratory provides testing using 2 different respiratory test panels – these are multiplex respiratory virus PCD (MRVP) and FLUVID.
- MRVP testing is performed on specimens from the first four symptomatic residents in an outbreak.
- FLUVID is performed on all symptomatic residents in an outbreak setting.
- Label specimens correctly to ensure testing by Public Health Lab. This includes including **two unique identifiers** that match the *General Test Requisition,* such as the name of the case, date of birth, and the outbreak number on the nasopharyngeal specimen vial and requisition form. The date specimen is collected should be labelled on the specimen container.
- Nasopharyngeal specimens must be refrigerated after collection until transport to the hospital.

Specimen Collection Instructions:

Risk assessment should be conducted for specimen collection procedures in order to identify associated risks and apply appropriate control measures to reduce the risk of disease transmission. This may involve a combination of administrative controls (safe work practices, policies & procedures) and the use of personal protective equipment (i.e., contact and/or droplet precautions).

1. Complete appropriate hand hygiene.
2. Open the pouched seal pack and aseptically remove the sterile swab from the package.
3. Wear appropriate personal protective equipment. Collect the specimen as early as possible, following the onset of symptoms. Follow the procedure in the diagram below.
4. Aseptically remove cap from vial and insert swab in medium.
5. Break swab shaft evenly at the scored line to fit in tube well below the cap and replace cap to vial closing tightly.
6. Specimen containers must have minimum 2 unique identifiers matching laboratory requisition. Label the specimen container with the patient's full name, date of collection and one other unique identifier such as the patient's date of birth or Health Card Number. Failure to provide this information may result in rejection.
7. Complete all fields of the PHOL requisition: include, the patient's full name, date of birth, Health Card Number (must match the specimen label), enter 'Respiratory Virus Detection' and/or the suspected viral agent(s) under test description, patient setting, source of specimen, date of onset, date of collection, physician name and address, and clinical diagnosis. (See sample requisition)
8. Place specimen in the biohazard bag and seal bag.
9. Insert the completed requisition in the pocket on the outside of the sealed biohazard bag.

10. Complete appropriate hand hygiene.
11. To maintain optimum viability, the specimen should be stored and transported at 2 - 8°C or on ice to the laboratory for processing within 48 hours of collection. Institutions are responsible for arranging and paying for transportation of specimens to the laboratory.
12. For further information about specimen collection and testing for a specific viral agent refer to the PHOL Test Directory at https://www.publichealthontario.ca/en/Laboratory-Services/Test-Information-Index



Storage of unused kits:
Kits should be stored at 2-25°C until used. Improper storage will result in a loss of efficacy.

DO NOT USE EXPIRED KITS

To order kits or for more information:
• Email: PHOL.Warehouse@oahpp.ca; or
• Fax: 416-235-5753; or
• Phone: 613-417-3322 or toll free 1-855-546-4745, ext 7
• Virus Respiratory Kit order#: 390082

SAMPLE: Respiratory Outbreak Investigation Laboratory Requisition

General Test Requisition

Public Health Ontario | Santé publique Ontario

ALL sections of the form must be completed by authorized health care providers for each specimen submitted, or testing may be delayed or cancelled.

Verify that **all testing requirements** are met before collecting a specimen.

For **HIV, respiratory viruses, or culture isolate** requests, use the dedicated requisitions available at: publichealthontario.ca/requisitions

For Public Health Ontario's laboratory use only:

Date Received (yyyy-mm-dd): | PHO Lab No.:

Submitter / Health Care Provider (HCP) Information

Licence No.: CPSO 109375 | Lab / Hospital or Facility Name: Hastings Prince Edward Public Health

HCP Full Name: Dr. Ethan Toumishey | Address: 179 North Park St

City: Belleville | Postal Code: K8P 4P1 | Province: ON

Tel: 613-966-5500 x349 | Fax: 613-966-1813

Copy to Other Lab / Health Unit / Authorized Health Care Provider (HCP)

Licence No.: | Other Lab / Health Unit / Facility Name:

HCP Full Name: | Address:

City: | Postal Code: | Province:

Tel: | Fax:

Patient Setting

- [ ] Clinic / Community
- [ ] ER (Not Admitted / Not Yet Determined)
- [ ] ER (Admitted)
- [ ] Inpatient (Non-ICU)
- [ ] ICU / CCU
- [x] Congregate Living Setting

Testing Indication(s) / Criteria

- [x] Diagnosis
- [ ] Screening
- [ ] Immune Status
- [ ] Follow-up / Convalescent
- [ ] Pregnancy / Perinatal
- [ ] Impaired Immunity
- [ ] Post-mortem

Other (Specify):

Signs / Symptoms

- [ ] No Signs / Symptoms
- ★ **Onset Date (yyyy-mm-dd):**
- [ ] Fever
- [ ] Rash
- [ ] STI
- [ ] Gastrointestinal
- [ ] Respiratory
- [ ] Hepatitis
- [ ] Meningitis / Encephalitis

Other (Specify):

Relevant Exposure(s)

- [ ] None / Not Applicable

Most Recent Date (yyyy-mm-dd):

Occupational Exposure / Needlestick Injury (Specify): [ ] Source [ ] Exposed

Other (Specify):

Relevant Travel(s)

- [ ] None / Not Applicable

Most Recent Date (yyyy-mm-dd):

Travel Details:

Patient Information

Health Card No.:

Date of Birth (yyyy-mm-dd): | Sex: [ ] Male [ ] Female

Medical Record No.:

Last Name (per health card):

First Name (per health card):

Address: | Postal Code:

City: | Tel:

Investigation / Outbreak No. from PHO or Health Unit (if applicable):

Specimen Information

★ **Date Collected (yyyy-mm-dd):** | **Submitter Lab No.:**

- [ ] Whole Blood
- [ ] Serum
- [ ] Plasma
- [ ] Bone Marrow
- [ ] Cerebrospinal Fluid (CSF)
- [x] Nasopharyngeal Swab (NPS)
- [ ] Oropharyngeal / Throat Swab
- [ ] Sputum
- [ ] Bronchoalveolar Lavage (BAL)
- [ ] Endocervical Swab
- [ ] Vaginal Swab
- [ ] Urethral Swab
- [ ] Urine
- [ ] Rectal Swab
- [ ] Faeces

Other (Specify type AND body location):

Test(s) Requested

Enter each assay as per the publichealthontario.ca/testdirectory:

1. Respiratory Outbreak
2.
3.
4.
5.
6.

For routine hepatitis A, B or C serology, complete this section instead:

Hepatitis A
- [ ] Immune Status (HAV IgG)
- [ ] Acute Infection (HAV IgM, signs/symptoms info)

Hepatitis B
- [ ] Immune Status (anti-HBs)
- [ ] Chronic Infection (HBsAg + total anti-HBc)
- [ ] Acute Infection (HBsAg + total anti-HBc + IgM if total is positive)
- [ ] Pre-Chemotherapy Screening (anti-HBs + HBsAg + total anti-HBc)

Hepatitis C
- [ ] Current / Past Infection (HCV total antibodies) No immune status test for HCV is currently available.

The personal health information is collected under the authority of the Personal Health Information Protection Act, s.36 (1)(c)(iii) for the purpose of clinical laboratory testing. If you have questions about the collection of this personal health information please contact the PHO's Laboratory Customer Service at 416-235-6556 or toll free 1-877-604-4567. F-SD-SCG-1000, version 004.1 (January 2024).

Ontario

Influenza Outbreaks

Use of Influenza Antivirals for Residence and Staff

Antiviral medication is recommended for the management of institutional outbreaks of influenza A and/or influenza B. Antivirals play a key role in outbreak management and control. Research has shown that antiviral drugs are effective for both the prevention (prophylaxis) and early treatment of influenza infection. The use of antiviral medication, in conjunction with other outbreak IPAC measures, can quickly bring influenza outbreaks in health care facilities under control.

Table 1: Antiviral Medication for Prevention and Treatment of *Influenza A & B*	
RESIDENT	
Criteria	**Recommendation**
Lab confirmed case of Influenza A or B, symptomatic <48 hours	Antiviral treatment dose for 5 days If >48 hours consult with medical advisor
Symptomatic <48 hours, but not lab confirmed	Antiviral treatment dose for 5 days, then switch to antiviral prophylaxis dose for the duration of the outbreak
Symptomatic > 48 hours, but not lab confirmed	Consult with Medical Advisor to determine if antivirals are appropriate
Asymptomatic regardless of their vaccination status	Antiviral prophylaxis for the duration of the outbreak
Residents on antiviral prophylaxis who become symptomatic	Switch to antiviral treatment dose for 5 days
STAFF	
Criteria	**Recommendation**
Staff immunized > 2 weeks prior to the outbreak	May continue to work if asymptomatic
Unimmunized staff or Staff immunized <2 weeks prior to the outbreak	**1.** Take antivirals **AND** receive flu vaccine and return to work; antivirals need to be taken for 2 weeks minimum or until the outbreak is declared over, whichever comes first. **2.** Take flu vaccine only and return to work in 2 weeks, or when outbreak is declared over. **3.** If flu vaccine is medically contraindicated or refused – take antivirals only and return to work. Antiviral must be taken for the duration of the outbreak. **4.** *Refuse options 1, 2 and 3 must remain off work until the outbreak is declared over

Declaring the Respiratory Outbreak Over

HPEPH, in collaboration with the facility, shall determine when to declare an outbreak over. In practice, declaring an outbreak over is dependent on:

- The causative organism
- The epidemiology of the outbreak: how aggressive transmission is, how severe illness has been, mortality profile, the number of hospitalizations, etc.
- Whether the last case was a resident or staff member.

In general, declaring an outbreak over is based on the period of communicability and the incubation period. Viral respiratory outbreaks may be declared over if no new cases have occurred in 8 days from the isolation of the last case. This “8-day rule” is based on the period of communicability (5 days) and an incubation period (3 days) for influenza and in general, may apply to many other respiratory viruses, including COVID-19, associated with respiratory infection outbreaks.

For novel viruses, where the period of infectivity is unknown, HPEPH may consider using two incubation periods to declare the outbreak over.

Please note that the Medical Officer of Health or designate retains the final authority to determine if an outbreak is over.

SAMPLE Letter - Antivirals for Staff Working in Long-Term Care or Retirement Homes during an Influenza Outbreak

Dear Health Care Provider:

Your patient works at a health care facility that is currently experiencing a confirmed Influenza outbreak. To reduce the spread of influenza the Ministry of Health guideline *Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, February 2025* states that all non-immunized staff are required to receive antiviral prophylaxis if they wish to continue working throughout the duration of the outbreak.

An assessment is also needed to determine appropriateness (risks, benefits) and contraindications to taking Oseltamivir. It is recommended that staff members receive appropriate antiviral prophylaxis currently recommended by Ministry of Health i.e., Oseltamivir (Tamiflu) 75 mg (1 tab) **once daily** until the influenza outbreak in the staff member's respective long-term care or retirement home is declared over.

If a staff member is a candidate for prophylaxis, Hastings Prince Edward Public Health (HPEPH) recommends prescribing a minimum of two weeks of medication. However, staff members will need prophylaxis until the influenza outbreak is over, which could be longer than two weeks.

Please contact the HPEPH, Infectious and Communicable Diseases Program at 613-966-5500 ext. 349 for further information.

Regards,

Infectious and Communicable Diseases Program
Hastings Prince Edward Public Health

SAMPLE Consent Form for the Administration of Tamiflu ™

Consent Form for the Administration of Tamiflu ™

Influenza is a serious contagious illness that circulates during the winter months. In healthy young people, influenza causes fever, cough, headaches, a stuffy nose and a sore throat. In the elderly and in people with chronic heart or lung disease or a compromised immune system, influenza can cause serious illness and may be complicated by life-threatening bacterial pneumonia and death.

Benefits of Tamiflu ™

Tamiflu is an anti-viral drug that is recommended for use in the prevention and treatment of influenza. The drug has been proven to have a positive effect on the control of influenza, particularly during outbreaks in institutional settings by:

- reducing the severity of illness for those who are ill with influenza.
- preventing new cases from developing when given prophylactically.

Side Effects of Tamiflu ™

Tamiflu is generally well tolerated. The most common side effects are nausea and vomiting after the first dose.

The safety of Tamiflu has not been established in pregnant women. The drug may be excreted in breast milk. Tamiflu should not be given in these instances unless the physician feels the benefits outweigh the risks.

For more complete information on this medication, consult the latest edition of the *Compendium of Pharmaceuticals and Specialties*.

CONSENT

I have read the above information and understand the benefits and possible risks associated with Tamiflu. I have had a chance to ask questions, which were answered to my satisfaction. I request that Tamiflu be given to me either prophylactically or as a treatment against influenza. I will not hold my physician or _____ liable for any subsequent illness that may appear to be the result of the administration of Tamiflu.

_____ _____

Signature of Resident/Staff/Guardian Date (YYYY/MM/DD)

_____

Name of Resident/Staff/Guardian

This form is an example only. Please have your legal counsel review it to ensure it meets legal requirements.

ADMISSION, TRANSFER and VISITING RECOMMENDATIONS

Admissions and Returns from Hospital

New Admissions and Return from Hospital

PHU approval is not required for admissions/transfers from acute care, but PHU consultation is recommended when IPAC advice or risk mitigation is needed.
From the perspective of susceptibility to disease transmission, the admission of new residents from the community is generally not advised during an outbreak.

The facility and HPEPH should discuss the situation and consider all relevant factors to assess if new admissions from the community are being considered, such as:

- What is the status of the outbreak at the LTCH? What is known about the outbreak pathogen (if identified) and its severity?
- Does the resident's Primary Care Provider agree to the admission/return based on a review of the current health status of the resident? And are they aware of the outbreak?
- Is the resident protected from the outbreak pathogen through appropriate IPAC measures? If the outbreak is due to influenza, is the resident protected by immunization and/or an antiviral drug?
- Are appropriate accommodations available for the resident? Will the resident return to an outbreak affected area of the LTCH?
- Has the resident or their substitute decision-maker been given information about the admission to the LTCH?

The admission of a resident from the community to a facility during outbreaks is generally restricted in an effort to protect susceptible individuals from being exposed to respiratory infections such as influenza, and gastrointestinal infections such as norovirus. Admissions to LTCHs are not automatically prohibited. They must be considered carefully with respect to resident safety and quality of life, as well as system capacity of the admitting facility.

If the above factors can be met, then the following recommendations may be followed:

To unaffected areas, admissions are allowed.

To affected areas, admissions will be allowed if Public Health and the facility are <u>in agreement</u> that the above conditions can be met.

Transfer to Hospital

For LTCHs only, all inter-facility resident transfers should not take place without the sending facility obtaining a Medical Transfer (MT) authorization number from the Provincial Transfer Authorization Centre (PTAC). **Life threatening emergencies DO NOT require authorization.**

- To arrange a transfer, the sending facility should login to the online PTAC portal, administered by Ornge at: https://www.hospitaltransfers.com/transfer or call 1-866-869-PTAC (7822).
- If approved an authorization number will be issued immediately and either sent online or by fax.

Before sending an ill resident to acute care, the facility should notify the receiving healthcare facility and the PTAC that the home is experiencing an outbreak.
The goal is to protect sending and receiving facilities, paramedic and private transfer companies and the public by ensuring appropriate personal protective measures are taken thus containing any risk of spreading.

Resident transfers to another LTCH are not recommended during an outbreak. However, exceptions may be made on a case by case basis in consultation with Public Health.

Visitors and Essential Caregivers

NOTE: Visitors and essential caregivers with respiratory or gastroenteritis illness should not visit LTCHs and RHs.

The facility shall post outbreak signs at all entrances to the home indicating the institution is in an outbreak so that visitors and essential caregivers can be advised of the potential risk of acquiring illness within the home. Complete closure of the home to visitors is not recommended, as it may cause emotional hardship to both the residents and the relatives. However, the facility may close to visitors if they feel they are unable to manage the outbreak or Public Health has evidence that the facility cannot manage the outbreak.

General visitors should postpone all non-essential visits to residents within the outbreak area for the duration of the outbreak.
Visitors and essential caregivers should be directed to reception where they should be educated on the potential risk of exposure when visiting a symptomatic resident.
Those visitors and essential caregivers who choose to visit during an outbreak shall be required to:

- Perform hand hygiene on arrival, just before leaving the resident's room, before donning and after doffing PPE and before exiting the facility.
- Use PPE when visiting an ill resident. Staff must instruct visitors and essential caregivers on the correct use of PPE and shall remind them of this requirement if they are observed not using it.

OUTBREAK RESOURCES (Signage and Fact Sheets)

ATTENTION VISITORS

This facility is experiencing an outbreak of respiratory illness.

DO NOT VISIT IF YOU ARE ILL.

If you have a cold or flu-like symptoms such as fever, runny nose, cough or muscle aches, please do not visit until your symptoms are gone.

CLEAN YOUR HANDS.

Clean your hands **before** and **after** your visit.
Alcohol hand rub is conveniently located for your use.

CHECK IN ON ARRIVAL.

Check in with the Nursing Staff when you arrive on a unit.

LIMIT YOUR VISIT TO ONE PERSON.

THANK YOU FOR YOUR CO-OPERATION!

HASTINGS PRINCE EDWARD
Public Health

Attention Visitors

Gastrointestinal Outbreak

Do NOT visit if you:

- Are at high risk of complications from infection
- Have symptoms such as diarrhea or vomiting

If you choose to visit:

- Check with a nurse before entering a resident's room
- Use hand sanitizer when entering and leaving facility

Fact sheets:

Entero/Rhino/Parainfluenza Viruses: https://hpepublichealth.ca/wp-content/uploads/2020/01/CD-65-EnteroRhinoParaInfl-Fact-Sheet.pdf

Influenza: https://hpepublichealth.ca/wp-content/uploads/2020/01/CD-70-Influenza-Fact-Sheet.pdf

Adenovirus: https://hpepublichealth.ca/wp-content/uploads/2020/01/CD-202-Adenovirus-Fact-Sheet.pdf

Human Metapneumovirus: https://hpepublichealth.ca/wp-content/uploads/2020/01/CD-203-Human-Metapneumovirus-Fact-Sheet.pdf

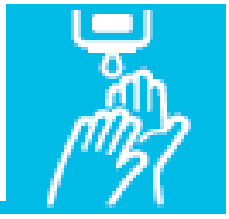
RSV: https://www.hpepublichealth.ca/wp-content/uploads/2022/08/CD-199-RSV-FS-AODA_New-Branding.pdf

Norovirus: https://hpepublichealth.ca/wp-content/uploads/2020/01/CD-194-Norovirus-Fact-Sheet.pdf

COVID-19: https://www.ontario.ca/page/protection-covid-19-and-other-respiratory-illnesses#section-1

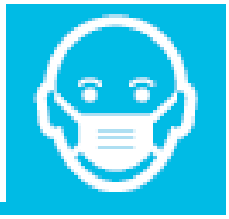
PUTTING ON PERSONAL PROTECTIVE EQUIPMENT

1 PERFORM HAND HYGIENE

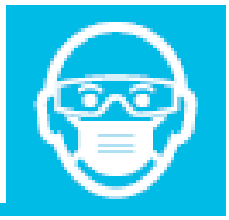


2 PUT ON GOWN

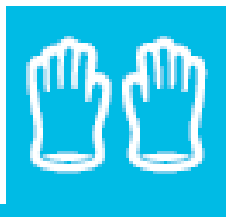
3 PUT ON MASK OR N95 RESPIRATOR



4 PUT ON EYE PROTECTION



5 PUT ON GLOVES



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REMOVING PERSONAL PROTECTIVE EQUIPMENT
1
REMOVE GLOVES
2
REMOVE GOWN
3
PERFORM HAND HYGIENE
4
REMOVE EYE PROTECTION
5
REMOVE MASK OR N95 RESPIRATOR
6
PERFORM HAND HYGIENE

APPENDIX E: PIDAC'S ROUTINE PRACTICES FACT SHEET FOR ALL HEALTH CARE SETTINGS

ROUTINE PRACTICES to be used with ALL PATIENTS	
	**Hand Hygiene** Hand hygiene is performed using alcohol-based hand rub or soap and water: ✓ Before and after each client/patient/resident contact ✓ Before performing invasive procedures ✓ Before preparing, handling, serving or eating food ✓ After care involving body fluids and before moving to another activity ✓ Before putting on and after taking off gloves and PPE ✓ After personal body functions (e.g., blowing one's nose) ✓ Whenever hands come into contact with secretions, excretions, blood and body fluids ✓ After contact with items in the client/patient/resident's environment
	**Mask and Eye Protection or Face Shield [based on risk assessment]** ✓ Protect eyes, nose and mouth during procedures and care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions. ✓ Wear within two metres of a coughing client/patient/resident.
	**Gown [based on risk assessment]** ✓ Wear a long-sleeved gown if contamination of skin or clothing is anticipated.
	**Gloves [based on risk assessment]** ✓ Wear gloves when there is a risk of hand contact with blood, body fluids, secretions, excretions, non-intact skin, mucous membranes or contaminated surfaces or objects. ✓ Wearing gloves is NOT a substitute for hand hygiene. ✓ Remove immediately after use and perform hand hygiene after removing gloves.
	**Environment and Equipment** ✓ All equipment that is being used by more than one client/patient/resident must be cleaned between clients/patients/residents. ✓ All high-touch surfaces in the client/patient/resident's room must be cleaned daily.
	**Linen and Waste** ✓ Handle soiled linen and waste carefully to prevent personal contamination and transfer to other clients/patients/residents.
	**Sharps Injury Prevention** ✓ NEVER RECAP USED NEEDLES. ✓ Place sharps in sharps containers. ✓ Prevent injuries from needles, scalpels and other sharp devices. ✓ Where possible, use safety-engineered medical devices.
	**Patient Placement/Accommodation** ✓ Use a single room for a client/patient/resident who contaminates the environment. ✓ Perform hand hygiene on leaving the room.

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APPENDIX G: SAMPLE SIGNAGE FOR ENTRANCE TO ROOM OF A PATIENT REQUIRING CONTACT PRECAUTIONS IN NON-ACUTE CARE FACILITIES

CONTACT PRECAUTIONS – Non-acute Care Facilities	
	**Hand Hygiene as per Routine Practices** Hand hygiene is performed: ✓ Before and after each resident contact ✓ Before performing invasive procedures ✓ Before preparing, handling, serving or eating food ✓ After care involving body fluids and before moving to another activity ✓ Before putting on and after taking off gloves and other PPE ✓ After personal body functions (e.g., blowing one's nose) ✓ Whenever hands come into contact with secretions, excretions, blood and body fluids ✓ After contact with items in the resident's environment ✓ Whenever there is doubt about the necessity for doing so ✓ Clean the resident's hands before he/she leaves his/her room
	**Resident Placement** ✓ Single room with own toileting facilities if resident hygiene is poor ✓ Door may remain open ✓ Perform hand hygiene on leaving the room or bed space
	**Gown [based on risk assessment]** ✓ Wear a long-sleeved gown for direct care* when skin or clothing may become contaminated
	**Gloves [based on risk assessment]** ✓ Wear gloves for direct care* ✓ Wearing gloves is NOT a substitute for hand hygiene ✓ Remove gloves on leaving the room or bed space and perform hand hygiene
	**Environment and Equipment** ✓ Dedicate routine equipment to the resident if possible (e.g., stethoscope, commode) ✓ Disinfect all equipment before it is used for another resident ✓ All high-touch surfaces in the resident's room must be cleaned at least daily
	**Visitors** ✓ Visitors must wear gloves and a long-sleeved gown if they will be in contact with other residents or will be providing direct care*, as required by Routine Practices ✓ Visitors must perform hand hygiene before entry and on leaving the room

* Direct Care: Providing hands-on care, such as bathing, washing, turning the resident, changing clothing, continence care, dressing changes, care of open wounds/lesions or toileting. Feeding and pushing a wheelchair are not classified as direct care.

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APPENDIX J: SAMPLE SIGNAGE FOR ENTRANCE TO ROOM OF A RESIDENT REQUIRING DROPLET AND CONTACT PRECAUTIONS IN NON-ACUTE CARE FACILITIES

DROPLET + CONTACT PRECAUTIONS – Non-acute Care Facilities

Hand Hygiene as per Routine Practices

Hand hygiene is performed:

- ✓ Before and after each resident contact
- ✓ Before performing invasive procedures
- ✓ Before preparing, handling, serving or eating food
- ✓ After care involving body fluids and before moving to another activity
- ✓ Before putting on and after taking off gloves and other PPE
- ✓ After personal body functions (e.g., blowing one's nose)
- ✓ Whenever hands come into contact with secretions, excretions, blood and body fluids
- ✓ After contact with items in the resident's environment
- ✓ Whenever there is doubt about the necessity for doing so

Resident Placement

- ✓ Single room with own toileting facilities if resident hygiene is poor and if available, or maintain a spatial separation of at least 2 metres between the resident and others in the room, with privacy curtain drawn
- ✓ Door may remain open
- ✓ Perform hand hygiene on leaving the room

Mask and Eye Protection or Face Shield

- ✓ Wear within 2 metres of the resident
- ✓ Remove and perform hand hygiene on leaving the room

Gown and Gloves [based on risk assessment]

- ✓ Wear a long-sleeved gown for direct care* when skin or clothing may become contaminated
- ✓ Wear gloves for direct care*
- ✓ Wearing gloves is NOT a substitute for hand hygiene.
- ✓ Remove gloves on leaving the room or bed space and perform hand hygiene

Environment and Equipment

- ✓ Dedicate routine equipment to the resident if possible (e.g., stethoscope, thermometer)
- ✓ Disinfect all equipment before it is used for another resident
- ✓ All high-touch surfaces in the patient's room must be cleaned at least daily

Resident Transport

- ✓ Resident to wear a mask during transport

Visitors

- ✓ Non-household visitors wear a mask and eye protection within 2 metres of the resident
- ✓ Visitors must wear gloves and a long-sleeved gown if they will be in contact with other residents or will be providing direct care*
- ✓ Visitors must perform hand hygiene before entry and on leaving the room

* Direct Care: Providing hands-on care, such as bathing, washing, turning the patient, changing clothing, continence care, dressing changes, care of open wounds/lesions or toileting. Feeding and pushing a wheelchair are not classified as direct care.