

REFERENCE GUIDE

(ARCHIVED) De-escalation of COVID-19 Outbreak Control Measures in Long-term Care and Retirement Homes

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Introduction

The purpose of this resource is to help guide long-term care and retirement homes as they prepare for the de-escalation of infection prevention and control (IPAC) measures towards the end of and/or following a COVID-19 outbreak. It provides considerations that are based on various situations. However, each situation should be managed on a case-by-case basis by the outbreak management team, including the attending physician and in consultation with the local public health unit.

Long-term care and retirement homes face unique challenges in declaring COVID-19 outbreaks over when compared with other respiratory outbreaks. Discussions related to planning and implementing the de-escalation of IPAC measures as a COVID-19 outbreak nears the end should be done in consultation with the local public health unit. The effectiveness of control measures should continue to be assessed. Enhanced surveillance for cases and adherence to IPAC measures should continue.

This guide is to be used in addition to—and does not replace—the advice, guidelines, recommendations, directives, or other direction of provincial Ministries and local public health authorities.

Key principles and assumptions that helped guide the considerations below, include:

- The COVID-19 outbreak is under control as evidenced by no ongoing transmission, outbreak control measures are fully in place and personal protective equipment (PPE) and staffing resources are stable.
- New admissions, re-admissions and transfers are generally not permitted during an outbreak.¹
- All group activities/gatherings have been discontinued during an outbreak.¹

- Outbreak decisions and de-escalation measures are made in consultation with the local public health unit.
- Following a COVID-19 outbreak, a home will transition from outbreak control measures to current non-outbreak COVID-19 [directives and guidance](#) for long-term care and retirement homes (e.g., active screening of all residents and staff, restricting non-essential visitors, limiting staff to one facility).²
- Best practices for [environmental cleaning](#) are followed including enhanced environmental cleaning of high-touch surfaces during the outbreak,¹ terminal cleaning of resident environments after discontinuation of droplet and contact precautions,³ and intensive cleaning of common areas when an outbreak is declared over.
- Foundational IPAC practices continue to be applied by staff, volunteers and essential visitors in the home including [Routine Practices](#)⁴ (risk assessments, hand hygiene, PPE) and [environmental cleaning](#).³
- Clear communication is provided to staff, families, volunteers and essential visitors when de-escalation steps are taken and/or when the outbreak is declared over. Support and education focused on risk assessment and IPAC measures such as universal masking for source control,² Routine Practices and Additional Precautions⁴ and non-outbreak COVID-19 guidance and directives are provided by the home.

Considerations

Residents

Discontinuation of Droplet and Contact precautions for resident(s) in an outbreak area previously positive for COVID-19

Detailed criteria for the clearance of cases and discontinuation of Droplet and Contact precautions for residents are listed in the Ministry's [Quick Reference Public Health Guidance on Testing and Clearance](#) document.⁵ Once cleared, the resident is no longer infectious and their Droplet and Contact precautions may be discontinued for their care.⁵

Staff should continue to monitor residents previously positive for COVID-19 for new symptoms of illness (e.g., respiratory and/or enteric). If new symptoms appear, testing can be considered to rule out the potential for co-infection(s) or subsequent infection(s) **with other pathogens**. Ensure staff adhere to Routine Practices and Additional Precautions when caring for all symptomatic residents.⁴ Individuals who develop new symptoms compatible with COVID-19 that occur after a previously positive and cleared COVID-19 illness should be discussed with the local public health unit for further investigation and guidance. Consideration of retesting of previously positive and cleared individuals is made in accordance with the Ministry's [Quick Reference Public Health Guidance on Testing and Clearance](#) document.

It is unclear whether individuals who have had COVID-19 have durable immunity to future infection. Therefore, care should still be taken to avoid exposure to COVID-19 after being infected and cleared.⁵

Discontinuation of Droplet and Contact precautions for resident(s) in an outbreak area who test negative for COVID-19

Close contacts should be on Droplet and Contact precautions for 14 days following their last unprotected exposure as detailed in the Ministry's [Outbreak Guidance for Long-Term Care Homes \(LTCH\)](#) document.¹ As exposures may be ongoing during an outbreak while new cases are still arising, this typically means negative residents remain on Droplet and Contact precautions for the duration of the outbreak.

Assessment of Droplet and Contact precautions for resident(s) in an outbreak area previously positive for COVID-19 where they meet the clearance criteria but remain in the room with COVID-19 positive roommate(s) on precautions (i.e., the roommate(s) have not yet met the clearance criteria)

Assess resident placement to determine if it is reasonable and feasible for the cleared resident or the roommate(s) to be moved to another room, so that cleared residents are separated from not-yet-cleared COVID-19 positive residents.⁶ Moving to another room allows the previously positive and cleared resident to no longer be exposed to the infectious roommate(s) and the discontinuation of Droplet and Contact precautions for the cleared resident.

OR

If alternate accommodation is not available, to prevent exposure of the cleared resident to their roommate(s) who remain on precautions, a risk assessment should be performed that includes but is not limited to the following considerations:

- Residents, staff and essential visitors are aware and there is clear signage to indicate which residents continue to require Droplet and Contact precautions.
- Staff understand why a resident with COVID-19 is now sharing a room with another resident not on precautions (i.e., that this is different from a resident case sharing a room with a roommate who has never had COVID-19).
- When feasible, care is to be provided for the cleared resident first prior to moving to the infectious resident. There is a defined area for donning PPE and performing hand hygiene when moving from the cleared resident to the infectious resident(s).
- The physical layout of the room allows for sufficient space between resident environments (bed, furniture, fixtures, shared washroom).
- Resident environments can be separated by partitions or drawn curtains dividing the residents' environment.⁶
- Shared washrooms in resident rooms are reassessed to ensure each resident has their own toileting facilities (toilet or commode).
- Mitigation strategies are available for residents who wander.¹ See scenario for wandering residents below.
- Environment of the resident previously positive for COVID-19 is terminally cleaned.³
- Staff is aware that both terminal and routine environmental cleaning is to be performed by working from the previously positive and cleared resident's environment towards the environment of the resident(s) who remain on precautions (following the principle of cleaning from "clean" to "dirty").³

New admissions, re-admissions and transfers

In general, admissions, re-admissions and transfers from hospital are not permitted during an outbreak. However, they may be considered if the LTCH, hospital and local public health unit are in agreement and it is approved by the local public health unit.⁷ Staff screen all new admissions, re-admissions and transfers for symptoms and potential exposure to COVID-19.² Testing criteria for all new admissions, re-admissions and transfers is outlined in the Ministry of Health's [Directive #3 for Long-Term Care Homes](#).

All new residents, re-admissions and transfers are placed on Droplet and Contact precautions upon admission.¹

Ambulating residents outside of their rooms when outbreak measures remain in place

In consultation with the local public health unit, a risk assessment should be performed regarding when to resume ambulating residents outside of their rooms that includes but is not limited to the following considerations:

- outbreak status (e.g., duration, evidence of reduced transmission, number and location of cases, date of last new case)
- staff resources (e.g., direct care providers, environmental service staff)
- resident population/health status
- resident quality of life/care needs
- identified areas for ambulation

After determining that resident ambulating can be resumed, the following recommendations can be integrated into care routines:

When resident on Droplet and Contact precautions:

- Resident is to be supervised while out of the room to ensure no breaches of precautions.⁸
- Resident to don procedure/surgical mask, if tolerated.⁷
- Resident to perform hand hygiene or is assisted with hand hygiene prior to ambulation.⁸
- When staff are assisting with ambulation, staff to use Droplet and Contact precautions.⁸
- Schedule time/location for ambulating to limit interaction with other residents and staff, especially non-isolated residents.
- Enhance cleaning/disinfection of high-touch surfaces following resident movement.
- Ensure residents maintain safe physical distancing (>2 metres).
- Reconfigure or reduce furniture in common areas to promote safe physical distancing.

When resident not on Droplet and Contact precautions:

- Resident to perform hand hygiene or is assisted with hand hygiene prior to ambulation.
- Ensure residents maintain safe physical distancing (>2 metres).
- Schedule time/location for ambulating to limit interaction with other residents and staff.
- Reconfigure or reduce furniture in common areas to promote safe physical distancing.

- Staff to use a procedure/surgical mask as a form of source control (universal masking).

Managing and supporting wandering residents within an outbreak area

Encourage IPAC and multi-disciplinary teams (e.g., gerontology, behaviour services, recreational therapy) to work with individual resident's care plan to incorporate redirection strategies to remain inside their room or promote safe physical distancing when outside of their room.

Other management strategies for wandering residents could include:

- Adjusting staff or resident location/room placement to facilitate staff observation when resident leaves their room.
- Use of preventative wandering barriers.¹
- If resident on Droplet and Contact precautions, assist the resident in donning procedure/surgical mask, if tolerated.
- Assisting resident with hand hygiene frequently and when outside of their room.
- Ensuring resident stays within outbreak area and does not move between different cohorted areas, if cohorting has been implemented.

Rooms used for alternate accommodations in order to maintain isolation of affected residents

A risk assessment should be performed regarding when to return rooms (e.g., respite and palliative beds/rooms, recreation rooms) back to pre-outbreak status after they were used for alternate accommodations in order to maintain isolation of affected residents. This includes but is not limited to the following considerations:

- outbreak status (e.g., duration, evidence of reduced transmission, number of cases, date of last new case)
- staff resources (e.g., direct care, environmental service)
- physical layout (number of resident rooms, room types) and occupancy levels
- resident quality of life/care needs
- residents occupying the rooms have met the clearance criteria and are able to return to their regular room
- room is terminally cleaned³

Staff

Exposed, previously COVID-19 positive or symptomatic staff return to work

Detailed criteria for staff return to work are listed in the Ministry's [Quick Reference Public Health Guidance on Testing and Clearance](#).⁵ Staff return to work should be determined in consultation with their health care provider, the home/Occupational Health and Safety and the local public health unit.² Upon return to work, staff should resume adherence to universal masking recommendations, maintain physical distancing (remaining greater than 2 metres from others) except when providing direct care,

perform meticulous hand hygiene and wear any additional PPE, based on [Routine Practices and Additional Precautions](#).

COVID-19 Immunized Exposed Staff

Staff's COVID-19 immunization status should be considered as part of an individual risk assessment. For most exposures involving immunized staff, a 14-day quarantine period at home would not be required except for the highest-risk exposures or for exposures from a source known to be infected with a Variant of Concern (VOC) associated with reduced vaccine efficacy.⁹

Assessment of staff and resident cohorting

Continue to cohort staff to caring for COVID-19 positive/negative/cleared residents in the outbreak area until the outbreak is declared over **OR**

A risk assessment should be performed that includes but is not limited to the following considerations:

- outbreak status (e.g., duration, evidence of reduced transmission, number of cases, date of last new case, resolution of outbreak in defined floor/unit(s))
- staff COVID-19 immunization status.⁹ Refer to PIDACs Interim guidance on infection prevention and control for health care providers and patients vaccinated against COVID-19 in hospital and long-term care settings for more information.
- staff resources (e.g., direct care, environmental services, essential staff required for facility-wide care, staffing care model/assignments)
- staff exposure issues (i.e., work self-isolation)
- staff breaks and lunches (e.g., staggered to help ensure physical distancing)
- physical layout (number of resident rooms, room types) and occupancy levels
- areas where staff and residents from different floors or units mix (e.g., main entrance, elevators, common areas)
- resident quality of life/care needs
- possibility of expanding cohorted areas without entirely discontinuing cohorting (e.g., cohort staff over two floors rather than a single floor)

Activities and Meals

Resuming meals in the dining room

During an outbreak, all meals are eaten in residents' rooms, where possible.¹

Consideration to resuming communal dining can occur if the outbreak is under control and if there is no evidence of ongoing transmission. The following considerations for communal dining include:

- Development of a plan for multiple sittings for meals to reduce number of residents in the dining room at the same time and that 2 metre physical distancing can be maintained between residents.¹

- If multiple floors/units must share dining areas, schedule the sittings so that different floors/units do not mix. Do not mix outbreak and non-outbreak areas.
- Consider cohorting residents from the same outbreak floor/unit during meals based on health status (i.e., one sitting for previously positive and cleared and another sitting for negative residents) and maintain seating assignments where possible.
- COVID-19 positive residents who have not yet been cleared should not use dining areas which are used by non-COVID-19 residents.
- Sufficient number of staff available to attend to the needs of residents. Staff must ensure they are performing diligent hand hygiene, using universal masking and eye protection in accordance to local policy.
- The number of residents per table.
- Environmental cleaning to be undertaken between and after meal sittings and during dining, as needed.

Resuming programs/activities for residents outside of room following the outbreak

A risk assessment should be performed resuming communal resident activities that includes but is not limited to the following considerations:

- The number of residents should be limited to the smallest feasible groups and following provincial/local direction on group sizes.
- Where possible, maintain the same small groups of residents for activities to limit the total number of contacts residents have with each other.
- Residents spaced as far from one another as possible, maintaining a minimum distance of 2 metres between them.
- A suitable indoor space is available where distancing can be maintained.
- Availability and feasibility of outdoor space (e.g., garden, patio) when weather is suitable.
- Residents who wish to go outside of the home are to remain on the home's property and maintain safe physical distancing.¹

Environmental Cleaning

Terminal and intensive cleaning

Resident rooms are terminally cleaned when Droplet and Contact precautions are discontinued.³

Additional intensive cleaning should take place in common areas of the affected floor/unit(s) when the outbreak is declared over.

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Summary of Revisions

New material in this revision is highlighted in the table below.

| Section | Revision | Page | Implementation Date |
|---------------------------------------|--|------|---------------------|
| All | Updated language throughout the document to align with Ontario Ministry of Health Directives (e.g., transfers, clearance) | 1 | May 2021 |
| Considerations (Residents) | Removed specific clearance criteria and direct readers to the Ontario Ministry of Health guidance documents for revised criteria | 2 | May 2021 |
| | Removed sentence regarding re-infection as a result of updated evidence available | 2 | May 2021 |
| | Added additional information regarding the order of care for cleared residents and infectious residents | 3 | May 2021 |
| | Revised wording regarding admissions, re-admissions and transfers for clarity | 3 | May 2021 |
| | Added information regarding the use of preventative wandering barriers | 5 | May 2021 |
| Considerations (Staff) | Added information regarding COVID-19 exposures for immunized staff | 5 | May 2021 |
| | Added information regarding staff COVID-19 immunization status and to direct readers to <i>Interim guidance on infection prevention and control for health care providers and patients vaccinated against COVID-19 in hospital and long-term care settings</i> | 6 | May 2021 |
| Considerations (Activities and Meals) | Added information regarding residents maintain seating arrangements and having sufficient number of staff available to attend to the needs of residents during meals | 6 | May 2021 |
| | Added information regarding maintaining the same small groups of residents for activities | 7 | May 2021 |

| Section | Revision | Page | Implementation Date |
|------------|--|------|---------------------|
| References | <i>Added Interim guidance on infection prevention and control for health care providers and patients vaccinated against COVID-19 in hospital and long-term care settings</i> | 9 | May 2021 |

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