

Respiratory Virus Outbreaks

Considerations for Public Health Planning



Report

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Public Health Ontario

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Introduction

It is important to plan for and be prepared to respond to co-circulating respiratory viruses such as SARS-CoV-2, influenza and respiratory syncytial virus (RSV). Planning ahead and preparing for potential outbreaks can help facilities respond to outbreaks in a timely manner, mitigate any possible operational challenges within the facility and minimize morbidity and mortality during an outbreak. This planning should include settings that typically manage outbreaks of respiratory pathogens such as long-term care homes, retirement homes and hospitals, but should also consider other settings such as shelters, group homes, correctional facilities and other congregate living settings that may be less familiar with managing respiratory virus outbreaks and may have fewer resources to manage outbreaks. Respiratory infection outbreaks in institutions and public hospitals, including those caused by respiratory viruses, are reportable to local Public Health Units (PHUs).¹ Institutions, as defined in the *Health Protection and Promotion Act*, include a range of settings and “any other place of a similar nature”,² therefore PHUs may receive reports from a variety of congregate living settings. In this document, ‘facility’ is used to describe the range of congregate living settings that may seek support from PHUs for respiratory virus outbreaks. While the range of facilities listed above may have clients, residents or patients, the term residents will be used in this document to describe those who reside in a facility.

Purpose and Methods

This document outlines some key considerations for PHUs in supporting the facilities in their jurisdiction to prepare for and respond to respiratory virus outbreaks and the mix of viruses that may circulate during a typical respiratory virus season. The document brings together information from multiple sources to help inform and support respiratory virus outbreak management. It was developed based on a review of existing guidance and is intended to complement existing guidance issued by the Ministry of Health.

Potential Scenarios

A number of potential scenarios can be envisioned when considering the causative organisms of [acute respiratory infection \(ARI\) outbreaks](#)¹ in facilities. Facilities should be prepared to respond to any of the following scenarios among residents and staff with ARIs who undergo diagnostic testing:

- no pathogen identified
- only influenza detected
- only SARS-CoV-2 detected
- only other respiratory virus detected (e.g., RSV, entero/rhinovirus, seasonal coronavirus, parainfluenza, human metapneumovirus, adenovirus)
- any combination of the above respiratory viruses

Gastrointestinal symptoms in residents or staff may suggest a gastrointestinal outbreak or possibly a COVID-19 outbreak, although **gastrointestinal** symptoms (particularly without symptoms such as fever, cough, or shortness of breath) are a much less common presentation for COVID-19.³ Public health measures implemented to control respiratory viruses will not prevent the introduction of enteric pathogens into facilities, therefore, in addition to general measures to prepare for respiratory outbreaks, facilities should monitor for and be prepared to respond to enteric outbreaks (see [Recommendations for the Control of Gastroenteritis Outbreaks in Long-Term Care Homes](#)⁴ [or as current]).

Key Planning Considerations

Key planning considerations for the respiratory virus season that PHUs can reinforce with facilities in their jurisdiction are outlined below. Full details of planning considerations can be found in [Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018](#)⁵ (or as current) and [Ontario Public Health Standards: Requirements for Programs, Services and Accountability - Infectious Disease Protocol - Appendix 1: Case Definitions and Disease-Specific Information - Disease: Diseases caused by a novel coronavirus, including Coronavirus Disease 2019 \(COVID-19\), Severe Acute Respiratory Syndrome \(SARS\) and Middle East Respiratory Syndrome \(MERS\)](#).⁶

Immunization Planning

Immunization is widely recognized as one of the most effective interventions for reducing the impact of infectious diseases.⁷ Being vaccinated against COVID-19, influenza, and other vaccine-preventable diseases helps to protect residents, staff and all visitors of facilities from severe disease and hospitalization.

Facilities should:

- Consider how to facilitate vaccination of residents, staff and essential visitors with all respiratory virus vaccines that are available (e.g., seasonal influenza, COVID-19 and RSV). This includes providing the vaccine as soon as possible after it is available based on eligibility.
- Consider how to facilitate access to other publicly-funded vaccines available for residents of the facilities.
- Consider collaborating with local PHU or health care partners to facilitate vaccination if needed.
- Ensure that all vaccine providers entering the facility have received education and competency-based training on vaccine administration before providing vaccines to residents.⁸
- Consider how to ensure staff members are aware of any applicable facility policies with regard to unvaccinated staff members during an influenza outbreak.

Additional information on the influenza vaccines is available through the Universal Influenza Immunization Program (UIIP), see the [Ministry of Health](#)⁹ and [Public Health Ontario](#)¹⁰ websites.

Additional information on the COVID-19 vaccines and recommended boosters is available on the [Ministry of Health COVID-19 vaccines](#)¹¹ website. For information on COVID-19, see the [Ministry of Health](#)¹² and [Public Health Ontario](#)¹³ websites.

Information on routine and high-risk vaccination programs is available at [Publicly Funded Immunization Schedules for Ontario](#).¹⁴

Monitoring

Facilities should:

- Be aware of the requirement to monitor residents daily for respiratory and gastrointestinal symptoms.¹⁵
- Educate staff members to monitor themselves for respiratory and gastrointestinal symptoms.
- Know when and how to notify the local PHU, if they identify:
 - a resident, staff member or essential visitor with COVID-19, influenza or another respiratory virus
 - a resident, staff member or essential visitor with exposure to COVID-19
 - a suspect respiratory outbreak defined in the [Ontario Public Health Standards: Requirements for Programs, Services and Accountability - Infectious Disease Protocol - Appendix 1: Case Definitions and Disease-Specific Information - Disease: Diseases caused by a novel coronavirus, including Coronavirus Disease 2019 \(COVID-19\), Severe Acute Respiratory Syndrome \(SARS\) and Middle East Respiratory Syndrome \(MERS\)](#)⁶

Testing

In preparation for the respiratory season, facilities should review the following information on laboratory testing for respiratory viruses, including acceptable test kits:

- [PHO Laboratory Coronavirus Disease 2019 \(COVID-19\) – PCR Test Information Sheet](#)¹⁶
- [Respiratory Viruses Test Information Sheet](#)¹⁷

Facilities that do their own swabbing should have written procedures and medical directives, ensure staff are trained and ensure that the facilities have the correct, non-expired swabs and test kits on hand.

Facilities that do not do their own testing should make plans for on-site or off-site testing, including for ongoing testing during an outbreak if that is required. PHUs may need to provide options for facilitating testing which may include local health care providers or emergency medical services.

Preparing for Antiviral Use

Influenza antiviral medications are routinely recommended for treatment and prophylaxis during influenza outbreaks in long-term care homes, retirement homes and hospitals. Influenza antivirals may also be indicated in influenza outbreaks in other closed facilities (settings with fixed resident populations with limited turn over or where the unit can be closed), particularly if the facility houses large numbers of residents at high risk for influenza complications.¹⁸ It is important to ensure antiviral medications for treatment and prophylaxis begin as quickly as possible during an influenza outbreak. For a list of risk factors for influenza complications see Health Canada's [Influenza vaccines: Canadian Immunization Guide](#).¹⁹

COVID-19 antivirals are recommended for treatment of eligible residents who test positive for COVID-19 and are at higher risk for severe COVID-19 outcomes.²⁰ For a list of risk factors for COVID-19 complications see Health Canada's [People who are at risk of more severe disease or outcomes from COVID-19](#).²¹

Facilities should:

- Develop a plan to rapidly obtain antiviral medications for treatment and prophylaxis during an influenza outbreak. The plan can include having a medical directive for the provision of antiviral medications, or if this is not possible, the ability to obtain individual orders for residents from their physician or nurse practitioner. If possible, individual orders for antiviral treatment and prophylaxis should be obtained in advance of the influenza season and kept in the resident's file.
 - Note that checking creatinine clearance and dose adjustments for oseltamivir are only required for those known to have renal impairment, and are not required for others receiving the medication for treatment or prophylaxis.
- Be aware of [antiviral options](#)²² for treatment of COVID-19 and develop a plan for the timely provision of treatment to residents with COVID-19.²³
- Have an arrangement with a local pharmacy and/or assigned pharmacy to obtain antiviral medications as quickly as possible, including on weekends and holidays.
- Ensure that health care providers can be reached rapidly in the event of an outbreak, including on weekends and holidays.

Infection Prevention and Control

The consistent use of infection prevention and control practices (e.g., hand hygiene, point-of-care risk assessment [PCRA], routine practices, additional precautions) by all staff with all resident care will lessen infection transmission within a facility.²⁴

Facilities preparing for the respiratory season should perform an organizational risk assessment (ORA). [The Infection Prevention and Control \(IPAC\) Checklist for Long-Term Care and Retirement Homes](#)²⁵ or the [Outbreak Preparedness, Prevention and Management in Congregate Living Settings](#) checklist²⁶ may be used to perform a comprehensive assessment of IPAC practices.

ROUTINE PRACTICES

Routine Practices are based on the premise that all residents, their secretions, excretions and bodily fluids and their environment are potentially infectious and the same safe standards of practice should be used routinely with all residents.²⁴

Key elements of routine practices include a PCRA, hand hygiene, use of personal protective equipment (PPE), control of the environment (e.g., placement of resident, environmental cleaning), engineering controls (e.g., hand hygiene stations, point-of-care sharps containers) and administrative controls (e.g., policies and procedures, staff and resident education, healthy workplace policies, respiratory etiquette, auditing practice with feedback).

POINT-OF-CARE RISK ASSESSMENT (PCRA)

As part of preparations for the respiratory season, staff are to be provided education and training on the performance of a PCRA.²⁴ A PCRA is to be done before each interaction with a resident and assesses the following:

- The resident's infection status (including colonization).
- The characteristics of the resident (e.g., ability to follow direction).
- The type of care activities to be performed (e.g., provide medications, help to the toilet, do a glucometer reading).
- The resources available for control (e.g., access to hand hygiene, availability of PPE, access to a sharps container).
- The health care provider immune status.

The PCRA informs the selection of PPE. For example, if a resident has developed a new cough, the health care provider's PCRA would indicate they should clean their hands and don a medical mask/N95 respirator (or equivalent) and eye protection before providing the required care. The use of gowns and gloves may also be considered based on the situation. When care is completed, the health care provider should remove their PPE and clean their hands.

HAND HYGIENE

Hand hygiene is an effective strategy to prevent the transmission of infections and is a required practice for all health care workers.²⁶ In preparation for the respiratory season, facilities should:

- Ensure staff receive education and training with respect to [The 4 Moments for Hand Hygiene](#).²⁸
- Consider how residents and health care providers will have easy access to hand hygiene facilities throughout the facility. For example, are hand hygiene facilities available on entry to the building, common resident areas (e.g., resident dining room), resident rooms, at-point-of-care, and staff common areas (e.g., break room).

- Ensure hand hygiene facilities are either a dedicated hand hygiene sink with soap, water and paper towels or alcohol based hand rub (ABHR) with an alcohol concentration of 70–90%.
 - Hand sanitizing with ABHR is the preferred method (when hands are not visibly soiled). Hand washing with liquid soap and running water must be performed when hands are visibly soiled.

For more information visit [Public Health Ontario's Hand Hygiene](#)²⁹ website.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

In preparation for the respiratory season, facilities should:

- Ensure all staff are educated and trained on the correct way to don and doff PPE. See the following resources for information and videos to support this education:
 - [Putting on full personal protective equipment](#)³⁰ (video)
 - [Taking off full personal protective equipment](#)³¹ (video)
 - [Recommended steps: putting on full personal protective equipment \(PPE\) / taking off personal protective equipment \(PPE\)](#)³² (poster)
- Consider how the facility will ensure staff have easy access to PPE (i.e., point-of-care).
- Consider how the facility will ensure there is a sufficient supply of PPE, taking into consideration the amount of PPE required based on the number of staff members and potential usage in non-outbreak and outbreak scenarios. Estimate the number of days of supplies using the [PPE Burn Rate Calculator](#).³³

ADDITIONAL PRECAUTIONS

In preparation for the respiratory season, staff of a facility should be aware of the Appendix N, Clinical Syndromes/ Conditions with Required Level of Precautions, in PIDAC'S [Routine Practices and Additional Precautions In All Health Care Settings, 3rd edition](#)²⁴, for a list of microorganisms/diseases that require Additional Precautions. This will be a helpful reference should an outbreak occur.

ENVIRONMENTAL CLEANING

During an outbreak there may be a requirement for additional or enhanced environmental cleaning of a health care setting to stop the spread of the causative agent.⁵ As such, facilities should:

- Plan for sufficient resources devoted to environmental services to ensure effective cleaning at all times, including surge capacity for high-demand periods (e.g., outbreaks, high occupancy, high turnover).³⁴
- Ensure all environmental service workers receive education and training with respect to correct techniques for the management of cleaner/disinfectants, mops, cloths, cleaning equipment, process for cleaning rooms, and IPAC best practices including the correct use of PPE.³⁴
 - Frequency of environmental cleaning may be determined according to the Risk Stratification Matrix in Appendix 21 of PIDAC'S [Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, April 2018](#).³⁴

EDUCATION

IPAC education should be provided to all staff as part of their initial employment orientation and as ongoing education on a scheduled basis.²⁴

IPAC education should also be provided to residents and teaching should include correct hand hygiene, and other practices that prevent the spread of microorganisms, such as respiratory etiquette and not sharing personal items.²⁴

Planning for Cohorting

Advise facilities to develop/review plans for cohorting of residents and staff in a respiratory virus outbreak, including how off-site locations can be used. See [Cohorting in Outbreaks](#).³⁵

Planning for Staffing Shortages

Facilities are to consider how staffing shortages will be managed, including alternate sources of staffing.

Communications

Communications are always important during an outbreak, but will be particularly important during the respiratory virus season. Facilities should consider developing/reviewing plans for:

- Communications and coordination with local PHU.
- Updating residents, staff, families, substitute decision makers and visitors regarding current planning including collecting up to date contact information for the residents.
- Communicating to residents, staff, families and visitors in the event of an outbreak.
- Communications to health care providers affiliated with the facility, health care facilities in the area, similar organizations, relevant Ministries and others in the event of an outbreak, as appropriate.

Management of Respiratory Virus Outbreaks

During the respiratory virus season a facility may have an outbreak caused by a single respiratory virus or by more than one respiratory virus. For example, an outbreak may be caused by COVID-19 plus another respiratory virus, or COVID-19 plus individuals with ARI but no identified organism, or outbreaks caused by other viruses at the same time (e.g., influenza and RSV), among other possibilities. Concurrent outbreaks occur when there are two or more respiratory virus outbreaks occurring at a facility at the same time. In these instances, more than one virus may be identified at the start of the outbreak, or one or more additional viruses may be detected as the outbreak progresses. In the event that there are concurrent outbreaks in a facility, the priority is to manage all ill residents, and prevent transmission in the affected areas with the outbreak response for each of the identified viruses (or for residents with ARI but no virus identified).

Outbreak responses are generally similar for COVID-19, influenza and other respiratory viruses with the exceptions noted in [Table 1](#), particularly the use of antiviral medications for influenza outbreaks. The general management of respiratory outbreaks, including case and contact management, is outlined in the [Ontario Public Health Standards: Requirements for Programs, Services and Accountability - Infectious Disease Protocol- Appendix 1: Case Definitions and Disease-Specific Information- Disease: Respiratory Infection Outbreaks in Institutions and Public Hospitals](#).¹

The principles for managing concurrent outbreaks are outlined below in Table 1. Each outbreak is managed independently with areas of overlap between the outbreaks identified. Co-infection with multiple respiratory viruses in the same individual is possible, and those residents should be managed for both infections.

Table 1: Key distinctions in managing outbreaks of COVID-19, influenza and other respiratory viruses*

Features	Influenza	COVID-19 (SAR-CoV-2)	Other non-influenza and non-COVID-19 respiratory viruses (e.g. RSV)
Testing performed to detect the virus	<p>For respiratory infection outbreaks, only the first four submitted samples from individuals with an ARI are generally eligible for testing with the full multiplex respiratory virus PCR (MRVP).^{a,b}</p> <p>Beyond the first four individuals tested, other respiratory outbreak specimens from individuals with ARIs will be tested for influenza, SARS-CoV-2 and RSV using the FLUVID assay.^a</p> <p>Asymptomatic residents and staff are not tested for influenza or other non-COVID-19 respiratory viruses.</p>	<p>Every person with symptoms compatible with COVID-19⁶ is tested.^{c,d}</p> <p>For respiratory infection outbreaks, only the first four submitted samples from individuals with an ARI are generally eligible for testing with the full multiplex respiratory virus PCR (MRVP).^{a,b}</p> <p>Beyond the first four individuals tested, other respiratory outbreak specimens from individuals with ARIs will be tested for influenza, SARS-CoV-2 and RSV using the FLUVID assay.^a</p> <p>Asymptomatic residents and staff in an outbreak area may be tested only when a COVID-19 outbreak is declared, as directed by public health.^c</p>	<p>For respiratory infection outbreaks, only the first four submitted samples from individuals with an ARI are generally eligible for testing with the full multiplex respiratory virus PCR (MRVP).^{a,b}</p> <p>Beyond the first four individuals tested, other respiratory outbreak specimens from individuals with ARIs will be tested for influenza, SARS-CoV-2 and RSV using the FLUVID assay.^a</p> <p>Asymptomatic residents and staff are not tested for influenza or other non-COVID-19 respiratory viruses.</p>

Features	Influenza	COVID-19 (SAR-CoV-2)	Other non-influenza and non-COVID-19 respiratory viruses (e.g. RSV)
Publicly Funded Vaccine available	Seasonal vaccine available and recommended annually for all age groups through Ontario's publicly funded program. ⁹	Multiple Health Canada authorized vaccines are currently available for use in Ontario for all age groups through the publicly funded program. ³⁶	Publicly-funded RSV vaccine will be available to individuals 60 years and older living in long-term care homes and Elder Care Lodges, and will also be available to some retirement home residents. ³⁷ The RSV vaccine will be available for purchase with a prescription for adults 60 years and older who are not currently covered by the publicly-funded immunization program. ³⁷
Prophylaxis	Antiviral medication may be considered for prophylaxis in outbreaks in closed settings, especially if residents are at high risk of complications. ¹⁸	None	Palivizumab and nirsevimab are monoclonal antibodies that are authorized for prevention of RSV in select infant groups. ³⁸
Cohorting of residents	Cohorting may be considered (see Cohorting in Outbreak ³⁴).	Cohorting may be considered (see Cohorting in Outbreak ³⁴).	Cohorting may be considered (see Cohorting in Outbreak ³⁴).

^a. On the [PHO Laboratory COVID-19 Virus Test Requisition](#)³⁹, the boxes for "COVID-19 Virus" and "Respiratory Viruses" should be marked in the Test(s) Requested section. "Institution / all group living settings" should be marked in the Patient Setting / Type section. The resident's clinical information as well as the outbreak number should be indicated on the requisition.

^b. Additional samples may be requested by contacting Public Health Ontario's laboratory (416-235-6556 or 1-877-604-4567 (toll-free)).

^c. On the [PHO Laboratory COVID-19 Virus Test Requisition](#)³⁹, the box for "COVID-19 Virus" should be marked in the Test(s) Requested section. "Institution / all group living settings" should be marked in the Patient Setting / Type section. The resident's clinical information as well as the outbreak number or investigation number should be written on the requisition.

^d. Closed facilities have been defined as having "a fixed residential population with limited turnover or units that can be closed." Prophylaxis is recommended for long-term care and similar settings with residents at higher risk of influenza complications.¹⁸

*For more information on differences between common respiratory viruses please see, PHO's document [Key Features of influenza, SARS-CoV-2 and other respiratory viruses](#)⁴⁰.

Ongoing Monitoring

Control of outbreaks will require close ongoing monitoring for symptoms in residents, staff and essential visitors. If an area of the facility is determined not to be affected by the outbreak (non-outbreak area), close monitoring of that area will be required in order to rapidly detect spread to that area. Determining if there is a non-outbreak area will require careful analysis and consideration of the physical layout of the facility and the connectivity and movements of staff, residents, and visitors. Defining the outbreak area as broadly as possible at the onset of the outbreak may be prudent (i.e., consider declaring the outbreak in the whole facility).

Declaration of an Outbreak

COVID-19: Declare the COVID-19 outbreak based on the [provincial outbreak definition](#).⁶

Influenza or other non-COVID-19 respiratory viruses: Declare the influenza or other respiratory infection outbreak based on the [provincial case definition](#).⁵

Testing

Respiratory symptoms in residents, staff and/or essential visitors associated with the facility should trigger an outbreak investigation. Residents with clinically compatible signs and symptoms of ARI³⁵ (even with minimal symptoms) should be offered testing for respiratory viruses as soon as possible. Only the first four submitted samples from residents with ARI are generally eligible for the full [MRVP](#)¹⁷ that tests for COVID-19, influenza, RSV and other seasonal respiratory viruses. If molecular testing for symptomatic residents cannot be performed within 24 hours of receipt at the laboratory, [rapid influenza testing](#)¹⁷ may be considered if available.

Additional testing for influenza, COVID-19 and RSV may be requested using the FLUVID assay for all symptomatic residents and staff in a facility in outbreak. Further full MRVP testing for other non-COVID-19 viruses in subsequent residents with ARI (after the first four specimens tested) may be considered if it assists with outbreak management and following consultation with Public Health Ontario's Laboratory.

The Public Health Ontario Customer Service Centre should be contacted (416-235-6556 or 1-877-604-4567 [toll-free]) about additional testing. If additional testing will be done, the tests requested should be clearly stated on the Public Health Ontario test requisition. See the PHO [Respiratory Virus Test Information Sheet](#)¹⁵ for additional information.

If COVID-19 and another respiratory virus are co-circulating in the facility (e.g. influenza or non-influenza), the facility should:

- Test all residents with ARI for COVID-19, influenza and RSV using the FLUVID assay.
- Test all residents with other non-respiratory COVID-19 symptoms⁶ (e.g., new loss of taste and smell and gastrointestinal symptoms) for COVID-19 only.
- Asymptomatic testing for COVID-19 during an outbreak is at the discretion of the PHU.

Line Lists and Counting Cases and Deaths

Line list and case counts are based on the identified virus. If no virus was identified in the resident with ARI (e.g., COVID-19 negative, and not tested or negative for other viruses), count this case as part of the outbreak that best aligns with their most likely source(s) of acquisition based on an assessment of the epidemiological data and the outbreak investigation.

Count co-infected residents for each virus they are positive for (e.g., a resident co-infected with COVID-19 and influenza would be counted as one case of COVID-19 and one case of influenza).

Count deaths in co-infected residents according to the assessment of their cause of death for each virus that they are positive for (e.g., a resident co-infected with COVID-19 and influenza who dies would be counted as a COVID-19 death and an influenza death if both were listed among the causes of death).

Defining the Outbreak Areas

Depending on where each virus is identified in the facility, identify outbreak areas for each viral outbreak. These outbreak areas may be completely separate, may overlap or may include the entire facility for both outbreaks. It is best to define the outbreak areas as broadly as possible (i.e., consider declaring the outbreak in the whole facility).

Cohorting for Outbreaks

Consider cohorting residents and staff in the respiratory virus outbreak as per usual practice based on their test results and exposure to the circulating respiratory virus(es) (see [Cohorting in Outbreaks](#)³⁴).

Antiviral Medications for Influenza Outbreaks

Rapid initiation of antiviral medications for treatment and prophylaxis is key to the control of influenza outbreaks in facilities where they are indicated. Information on the use of antiviral medications are available on [Public Health Ontario's influenza web page](#).¹⁰

- Treat residents with an ARI in the influenza outbreak area with antiviral medications if they are influenza positive or when influenza results are pending or influenza testing has not been done (regardless of COVID-19 results).
- If influenza is detected in a facility where antiviral medications are recommended, consider initiation of antiviral prophylaxis in the potentially affected area for a suspect influenza outbreak (i.e., a single laboratory-confirmed case of influenza).
 - Residents with ARI who were started on treatment while influenza results were pending can be switched to the prophylactic dose if the influenza test comes back negative based on PCR test results.
 - Residents with ARI who were never tested for influenza should complete their treatment course and then be switched to the prophylactic dose until the influenza outbreak is declared over.

- Antiviral prophylaxis should be provided to residents in the influenza outbreak area who have no ARI symptoms (regardless of COVID-19 results).
 - Continue prophylaxis until the influenza outbreak is declared over.

Entering Outbreak Information

COVID-19: Enter COVID-19 outbreaks in Case and Contact Management (CCM), in accordance with the most current versions of the COVID-19 CCM Case and Outbreak User Guide and the COVID-19 CCM Data Entry Scenarios.

Influenza and other respiratory viruses: Enter influenza and other respiratory virus outbreaks in the Integrate Public Health Information System (iPHIS) in accordance with the most current guidance contained in the following resources:

- iPHIS User Guide: [Respiratory Infection Outbreaks in Institutions and Public Hospitals](#)⁴¹, available on Public Health Ontario's [iPHIS Resources webpage](#)⁴²
- [Influenza and Other Respiratory Infection Surveillance Package](#)⁴³ for the current season, available on Public Health Ontario's [Influenza webpage](#)¹⁰

De-escalation of a respiratory outbreak

Outbreak decisions and de-escalation of measures are made in consultation with the local PHU.⁴⁴

- Following a respiratory outbreak, a facility will transition from outbreak control measures to their pre-outbreak state.
- Foundational IPAC practices continue to be applied by staff, volunteers and essential visitors in the home including [Routine Practices](#)²⁴ (e.g., point-of-care risk assessments, hand hygiene, PPE), monitoring the health of residents and [environmental cleaning](#)³⁴.
- Consideration to resuming communal dining and group activities can occur if the outbreak is under control and if there is no evidence of ongoing transmission.
- 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.

Declaring the Outbreaks Over

The criteria used to declare the outbreaks over will be specific for areas affected by COVID-19 and areas affected by other respiratory viruses. The Medical Officer of Health or designate (from the local PHU) in collaboration with the facility will determine when to declare an outbreak over, taking into consideration the period of communicability and incubation period of the infectious agent, as well as the epidemiology of the outbreak.

- For influenza and other non-COVID-19 viruses, [Control of Respiratory Infection Outbreaks in Long-Term Care Homes, 2018](#)⁵
- For COVID-19, see [Ontario Public Health Standards: Requirements for Programs, Services and Accountability - Infectious Disease Protocol - Appendix 1: Case Definitions and Disease-Specific Information - Disease: Diseases caused by a novel coronavirus, including Coronavirus Disease 2019 \(COVID-19\), Severe Acute Respiratory Syndrome \(SARS\) and Middle East Respiratory Syndrome \(MERS\)](#)⁶

Where there is overlap between the outbreak areas, general outbreak measures should continue until criteria are met to declare both the COVID-19 and the influenza/other respiratory virus outbreaks over. However, influenza prophylaxis may be discontinued when criteria are met to declare the influenza outbreak over.

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