North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound

Communicable Disease Control
Contrôle des maladies transmissibles
myhealthunit.ca

Institutional Respiratory Outbreak Control Measures

***Notes**: Implement control measures that are applicable to your setting. The term 'resident(s)' refers to residents, patients, and/or clients throughout this document.*

Communications	**Suspect**	**Confirmed**
Notify all staff, students, volunteers, residents, and families of the outbreak as soon as it is confirmed (MOH, p. 25). Outbreaks in Health Care Facilities- What families and visitors need to know fact sheet is available on the Health Unit's website.		
Notify all relevant external partners once an outbreak is confirmed (MOH, p. 42, 47).		☐
Post signs at all entrances, indicating that the facility is experiencing an outbreak (MOH, p. 47, 66).		☐
Complete separate line listings for ill staff and residents daily and fax to the NBPSDHU by **11am** to **705-482-0670.**	☐	☐
Organize an outbreak management team meeting at the facility, with CDC in attendance where possible (MOH, p. 47).		☐
As soon as a vaccine-preventable respiratory outbreak is suspected (e.g., influenza, COVID-19), unimmunized residents and staff who do not have contraindications to the vaccination, should be offered the vaccine (MOH, p. 96).	☐	☐
Infection Prevention and Control (IPAC) Measures		
Implement universal masking in the outbreak area (MOH, p. 30, 45).	☐	☐
Reinforce the importance of Routine Practices including hand hygiene and respiratory etiquette with staff, students, visitors, volunteers, and residents (MOH, p. 36, 46).	☐	☐
Conduct enhanced symptom assessment of all residents in the outbreak area to facilitate early identification and management of ill residents (MOH, p. 65).	☐	☐
Symptomatic residents are encouraged to stay in their room and should be placed on Droplet and Contact Precautions for (MOH, p. 51): **COVID-19** - 10 days from symptom onset or date of specimen collection, if asymptomatic (whichever is earlier/applicable) and until symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever is present. If after at least 5 days, the resident is asymptomatic or their symptoms have been improving for 24 hours (or 48 hours if gastrointestinal symptoms) and no fever is present, they may leave their room if they are independently and consistently able to wear a well-fitted mask at all times outside of their room. They should remain on additional precautions for the full 10 days (MOH, p. 64). **Other Viruses**- 5 days after symptom onset or until symptoms have resolved (whichever is shorter). Depending on the period of communicability for the causative agent, residents may be encouraged to wear a well-fitted mask when receiving direct care and when outside of their room for 10 days from symptom onset. This may include avoiding group dining and group activities (MOH, p. 51).	☐	☐
Symptomatic residents on additional precautions may leave their room if they are supported to minimize spread of infection including one-to-one support outside of their room with staff wearing PPE, resident consistently wearing a well-fitted medical mask, performing hand hygiene, physical distancing, and avoid touching surfaces (MOH, p. 31, 51, 64).	☐	☐
Staff providing direct care should wear eye protection (goggles, face shield, or safety glasses with side protection), gown, gloves, a well-fitted medical mask or a fit-tested, seal-checked N95 respirator (or approved equivalent). A fit-tested, seal-checked N95 should be made available to staff as part of their point of care risk assessment (MOH, p. 46, 65; PIDAC, 2024).	☐	☐
Cohort residents and staff as much as possible (e.g., assign some staff to only care for ill residents while others care for well residents or assign staff to specific floors/units) (MOH, p. 29, 36, 41, 58, 67).	☐	☐
Weekly IPAC audits on hand hygiene, PPE usage, and cleaning and disinfection should be conducted for the duration of the outbreak (MOH, p. 41).		☐
Contact Management		
For 7 days after last exposure to an individual with symptoms, **all resident close contacts** should wear a well-fitted mask, if tolerated, and physically distance from others as much as possible when outside of their rooms. They should not visit	☐	☐

other unaffected areas of the home or interact with residents who have not been exposed (MOH, p. 52-53). This may include avoiding group dining and group activities (MOH, p. 51-53, 64).		
Ideally, **all roommate close contacts** are placed in a separate room from the ill resident (case). When this is not possible, the use of physical barriers (curtains or a cleanable barrier) to create separation between the case and roommate is recommended. Roommate close contacts should isolate and be placed on Additional Precautions. Individuals who remain asymptomatic may discontinue isolation after a minimum of 5 days of isolation (MOH, p. 52).	☐	☐
Staff Measures		
Asymptomatic staff who are identified as close contacts of **COVID-19** should wear a well-fitting medical mask for 10 days after last exposure to reduce the risk of transmission. They should not remove their mask when in the presence of other staff (i.e., not eating meals/drinking in a shared space such as conference room or lunchroom) (MOH, p. 69).	☐	☐
Staff, students, and volunteers should always self-monitor for signs and symptoms of an infectious disease. Active screening for symptoms should occur prior to each shift during the outbreak, where possible (MOH, p. 45, 69).	☐	☐
Exclude symptomatic staff, students, and volunteers (whether COVID-19 or other viruses) from working until symptoms have been improving for 24 hours (48 if gastrointestinal symptoms) and no fever present. For 10 days after the date of specimen collection or symptom onset, whichever is earlier/applicable, they should adhere to workplace measures for reducing risk of transmission, including masking for source control and avoid caring for residents at highest risk of severe illness (MOH, p. 58).	☐	☐
If staff work in multiple settings/locations, it is recommended that they advise the other settings of the confirmed outbreak to determine if they should continue working in multiple places (MOH, p. 68).		☐
Environmental Cleaning and Disinfection		
Clean and disinfect common areas (MOH, p. 38-40): • At least once daily for low touch surfaces (e.g., shelving, windowsills). • Minimum twice daily for high touch surfaces (e.g., door handles, light switches, handrails, phones, elevator buttons, staff equipment, etc.) treatment areas, dining areas, and lounge areas. • Immediately for any visibly dirty surfaces. For more information refer to PIDAC's (2018) Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings to help assess cleaning requirements.	☐	☐
Non-critical medical equipment (stethoscope, blood pressure cuffs) should be dedicated. If unable to dedicate, shared equipment should be cleaned and disinfected between resident use (MOH, p. 38).	☐	☐
Admissions and Transfers		
Symptomatic resident transfers to other LTCHs during an outbreak should only be done in consultation with the Health Unit and if appropriate IPAC measures can be put in place (MOH, p. 32).		☐
Review/discuss the Nipissing/Northeast Parry Sound Health Care Providers Outbreak Protocol, on page 3, for repatriation of residents or admission of new residents. A three-way conference call with the Health Unit may be initiated if necessary.		☐
The return of residents, who were line-listed and were part of the outbreak, is permitted provided appropriate accommodation and care can be provided.		☐
If necessary, residents who do not have an acute respiratory infection (ARI) may be admitted or transferred to a floor/unit with an outbreak, provided the following conditions are met (MOH, p. 57): • Resident (or substitute decision-maker) is made aware of the risks of the admission/transfer and consents to the admission/transfer. It is important to note the resident should not face any unintended consequences in terms of placement should the resident (or substitute decision-maker) choose not to consent, • Resident is admitted or transferred to a private room, where possible, • Attending physician should be consulted.		☐
Advise hospital Infection Control Practitioner (ICP)/other facility, EMS workers, or transfer agencies of outbreak prior to any transfer or outpatient procedures, even if resident is not from affected area (MOH, p. 33-34).	☐	☐
If resident from a LTCH/RH is being admitted to the North Bay Regional Health Centre, complete the North Bay Regional Health Centre Outbreak Transfer Notification Form and fax to the Infection Control Department.	☐	☐
Activities and Visitors		
Institutions cannot restrict or deny absences for medical, palliative, or compassionate reasons at any time (MOH, p. 65).	☐	☐
Symptomatic residents or those on Additional Precautions are not recommended to participate in in-person group or social activities with others (MOH, p. 34).	☐	☐

Group activities should be conducted so that the outbreak unit is cohorted separately from unexposed units. The risk of transmission is higher in indoor settings. Where appropriate and possible, encourage outdoor activities (MOH, p. 58, 70).		☐
Small low-risk group activities for asymptomatic residents may continue in the outbreak area with the following measures in place: physical distancing, masking, hand hygiene, cohorting, and monitoring for symptoms (MOH, p. 48). **High-risk** activities are suspended in the outbreak area including large group activities and bus/group outings (MOH, p. 45).		☐
General visitors should postpone all non-essential visits to residents in the outbreak area for its entire duration (p. 34).		☐
Symptomatic residents, or those on Additional Precautions, may continue to interact with essential caregivers/visitors as long as Additional Precautions are followed (MOH, p. 34).	☐	☐
Essential caregivers/visitors should be directed to the reception desk prior to visiting residents. They should be educated on the potential risk of exposure when visiting a symptomatic resident. If an essential caregiver/visitor is symptomatic themselves, they should not enter the setting unless under exceptional circumstances (MOH, p. 34-35).	☐	☐
Meals and Dining		
Symptomatic residents should receive tray meal service in their rooms, where possible (MOH, p. 34, 49).	☐	☐
Use cohorting and physical distancing in communal areas/dining areas (MOH, p. 45). Close buffet lines and have food plated by staff, encourage staggered eating times for diners, pre-set tables with utensils to minimize resident handling, limit/close communal food or snacking areas and sharing of food between residents or staff, individually wrap snacks, and use single-packet condiments when able (MOH, p. 49).		☐
Laboratory Testing		
Physician or healthcare provider order obtained to collect specimens.	☐	☐
Ensure there are an adequate number of specimen kits on site (check expiry dates).	☐	☐
Collect nasopharyngeal (NP) specimens **for all symptomatic** residents. PCR testing for COVID-19, RSV, and Influenza will be done for **all** specimens from symptomatic residents and staff. Up to 4 specimens will be tested with the full respiratory virus panel to assess for other respiratory viruses (MOH, p. 59).	☐	☐
Additional Control Measures for an Influenza Outbreak		
If **suspect outbreak,** consider a cautious approach to starting antiviral prophylaxis. Consider initiating when one lab-confirmed influenza case in a resident or in the context of co-circulation of influenza and COVID-19 (MOH, p. 60).	☐	
Antiviral prophylaxis should be offered to all residents in the outbreak affected area who are not already ill with influenza, whether previously vaccinated or not, until the outbreak is declared over (MOH, p. 60, 97).		☐
Antiviral treatment for ill residents is the responsibility of the attending healthcare provider (p. 99). Healthcare Providers can refer to the most recent PHO's Antiviral Medications for the (applicable year) Seasonal Influenza: Public Health Considerations document and the most recent Association of Medical Microbiology and Infectious Disease (AMMI) guidelines and drug product monographs for prescribing information.	☐	☐
It is recommended that if a resident is being transferred/admitted to an outbreak area that is using antiviral prophylaxis as a control measure, the resident should be started on the antiviral prophylaxis prior to coming (MOH, p. 62).	☐	☐
Unvaccinated asymptomatic staff who work in the area where the influenza outbreak is occurring should take prophylactic antiviral medication until the outbreak is declared over (MOH, p. 98). Unimmunized staff who refuse antivirals during an outbreak should not provide resident care or conduct activities where they have a potential to acquire or transmit infections. The institution/facility may choose to exclude unimmunized staff from work or carrying on activities in the institution/facility unless they take antivirals (MOH, p. 95-96).		☐
If a person taking prophylactic antiviral medication develops symptoms of influenza-like illness, the medication should be increased to the recommended treatment dose. Consideration should be given to obtaining an NP specimen if the individual has been on antiviral prophylaxis for more than four days to determine the presence of a resistant strain or other respiratory virus (MOH, p. 98).		☐
Asymptomatic staff who were vaccinated at least two weeks prior to outbreak declaration or those taking antiviral prophylaxis may work at the outbreak affected home/unit or at other institutions (MOH, p. 62).		☐
Unimmunized staff not receiving prophylactic therapy should wait one incubation period (3 days) from the last day that they worked at the outbreak institution/facility prior to working in a non-outbreak institution, to ensure they are not incubating (MOH, p. 97).		☐

References

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