

COVID-19

Directive #3 for Long-Term Care Homes under the *Long-Term Care Homes Act, 2007*

Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7

ALL PREVIOUS VERSIONS OF DIRECTIVE #3 FOR LONG-TERM CARE HOMES UNDER THE *LONG-TERM CARE HOMES ACT, 2007* ARE REVOKED AND REPLACED WITH THIS DIRECTIVE.

WHEREAS under section 77.7(1) of the HPPA, if the Chief Medical Officer of Health (CMOH) is of the opinion that there exists or there may exist an immediate risk to the health of persons anywhere in Ontario, he or she may issue a directive to any health care provider or health care entity respecting precautions and procedures to be followed to protect the health of persons anywhere in Ontario;

AND WHEREAS pursuant to subsection 27(5) of O. Reg 166/11 made under the *Retirement Homes Act, 2010*, as part of the prescribed infection prevention and control program, all reasonable steps are required to be taken in a retirement home to follow any directive pertaining to COVID-19 that is issued to long-term care homes under section 77.7 of the HPPA;

AND HAVING REGARD TO the emerging evidence about the ways this virus transmits between people as well as the potential severity of illness it causes in addition to the declaration by the World Health Organization (WHO) on March 11th, 2020 that COVID-19 is a pandemic virus and the spread of COVID-19 in Ontario, and the technical guidance provided on March 12th, 2020 by Public Health Ontario on scientific recommendations by the WHO regarding infection prevention and control measures for COVID-19;

AND HAVING REGARD TO residents in long-term care homes and retirement homes being older, and more medically complex than the general population, and therefore being more susceptible to infection from COVID-19;

AND HAVING REGARD TO the immediate risk to residents of COVID-19 in long-term care homes and retirement homes, the necessary, present, and urgent requirement to implement additional measures for the protection of staff and residents, including, but not limited to, the active screening of residents, staff and visitors, active and ongoing surveillance of all residents, screening for new admissions, managing visitors, changes to when an outbreak of COVID-19

is declared at a home, including when it is over, and specimen collection and testing for outbreak management;

I AM THEREFORE OF THE OPINION that there exists or may exist an immediate risk to the health of persons anywhere in Ontario from COVID-19;

AND DIRECT pursuant to the provisions of section 77.7 of the HPPA that:

All previous versions of Directive #3 for Long-Term Care Homes under the *Long-Term Care Homes Act, 2007* are revoked and replaced with this Directive.

Directive#3 for Long-Term Care Homes under the *Long-Term Care Homes Act, 2007*

Date of Issuance: August 28, 2020

Effective Date of Implementation: August 28, 2020

Issued To: Long-Term Care Homes under the *Long-Term Care Homes Act, 2007* referenced in section 77.7(6), paragraph 10 of the *Health Protection and Promotion Act*.

Introduction:

Coronaviruses (CoV) are a large family of viruses that cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS-CoV), Severe Acute Respiratory Syndrome (SARS-CoV) and COVID-19. A novel coronavirus is a new strain that has not been previously identified in humans.

On December 31st, 2019, the World Health Organization (WHO) [was informed](#) of cases of pneumonia of unknown etiology in Wuhan City, Hubei Province in China. A novel coronavirus (COVID-19) [was identified](#) as the causative agent by Chinese authorities on January 7th, 2020.

On March 11th, 2020 the WHO announced that COVID-19 is classified as a [pandemic](#). This is the first pandemic caused by a coronavirus.

Symptoms of COVID-19

For signs and symptoms of COVID-19 please refer to the [COVID-19 Reference Document for Symptoms](#) issued August 6th, 2020 or as amended.

Complications from COVID-19 can include serious conditions, like pneumonia or kidney failure, and in some cases, death.

Required Precautions and Procedures

Long-term care homes must immediately implement the following precautions and procedures:

- **Active Screening of All Staff and Visitors.** Long-term care homes must immediately implement active screening of all staff, visitors and anyone else entering the home for COVID-19 with the exception of first responders, who should, in emergency situations, be permitted entry without screening.

Active screening must include twice daily (at the beginning and end of the day or shift) symptom screening and temperature checks. Anyone showing symptoms of COVID-19 must not be allowed to enter the home and must be advised to go home immediately to self-isolate and be encouraged to be tested. Staff should contact their immediate supervisor/manager or occupational health and safety representative in the home. Staff responsible for occupational health at the home must follow up with all staff who have been advised to self-isolate based on exposure risk or symptoms.

- **Active Screening of All Residents.** Long-term care homes must conduct active screening and assessment of all residents, including temperature checks, at least twice daily (at the beginning and end of the day) to identify if any resident has fever, cough or other symptoms of COVID-19. Residents with symptoms (including mild respiratory and/or atypical symptoms) must be isolated and tested for COVID-19. For typical and atypical symptoms, please refer to the [COVID-19 Reference Document for Symptoms](#) issued on August 6th, 2020 or as amended.

For residents that leave the home for a short-stay absence, the home must provide a mask. The resident must wear a mask while out, if tolerated, and be screened upon their return, but does not need to be self-isolated.

- **New Admissions.** New admissions from the community or from a hospital (including ALC patients) to a long-term care home or retirement home can occur if:
 1. The receiving home is NOT in a COVID-19 outbreak. Under exceptional circumstances admissions may take place during an outbreak if:
 - It is approved by the local public health unit, and
 - There is concurrence between the home, public health and hospital.
 2. The resident has been:
 - Tested for COVID-19, has a negative result and is transferred to the home within 24 hours of receiving the result, or
 - Confirmed infected and cleared of COVID-19.
 - Residents being admitted who have been cleared of COVID-19 do not need to be re-tested or undergo 14-days of self-isolation.
 3. The receiving home has:
 - Sufficient staffing, and
 - A plan to:
 - Ensure the resident being admitted (except for those who have cleared COVID-19) can complete 14-days of self-isolation, under Droplet and

Contact Precautions, and is tested again at the end of self-isolation, with a negative result. If the result is positive, the resident must complete another 14-days of self isolation, and

- Continue with other COVID-19 preparedness measures (e.g., cohorting).

4. The resident is placed in a room with no more than one (1) other resident. That is, there shall be no further placement of residents in 3 or 4 bed ward rooms.

A resident has been cleared of COVID-19 if they have had lab-confirmed COVID-19 more than 14 days prior to admission to the receiving home.

A negative result does not rule out the potential for incubating illness and all new residents who have not been previously cleared of COVID-19 must remain in isolation under Droplet and Contact Precautions for a 14-day period following arrival. The home must be able to maintain and have a plan in place for isolation of new admissions.

Despite the condition set out in paragraph 2 above, a new admission of a resident who is positive for COVID-19 may be made providing that it is approved by the local public health unit per the [Quick Reference Public Health Guidance on Testing and Clearance](#) and [Public Health Management of Cases and Contacts of COVID-19 in Ontario](#).

- **Re-Admissions.** Hospital transfers to long-term care homes and retirement homes, can occur if:
 1. It is a re-admission to long-term care (the resident is returning to their home).
 2. The home is NOT in a COVID-19 outbreak. Under exceptional circumstances re-admissions may take place during an outbreak if:
 - It is approved by the local public health unit, and
 - There is concurrence between the home, public health and hospital.
 3. The resident has been:
 - Tested for COVID-19 at point of discharge, has a negative result and is transferred to the home within 24 hours of receiving the result, or
 - Confirmed infected and cleared of COVID-19.
 - Residents being admitted who have been cleared of COVID-19 do not need to be re-tested or undergo 14-days of self-isolation.
 4. The receiving home has a plan to:
 - Ensure that the resident being re-admitted (except those who have been cleared of COVID-19) can complete 14-days of self-isolation, under Droplet and Contact Precautions and is tested again at the end of self-isolation, with a negative result. If the result is positive, the resident must complete another 14-days of self isolation, and
 - Continue with other COVID-19 preparedness measures (e.g., cohorting).
 5. The resident is placed in a room with no more than one (1) other resident. That is, there shall be no further placement of residents in 3 or 4 bed ward rooms.

A resident has been cleared of COVID-19 if they have had lab-confirmed COVID-19 more than 14 days prior to admission to the receiving home.

A negative result does not rule out the potential for incubating illness and all new residents who have not been previously cleared of COVID-19 must remain in isolation under Droplet and Contact Precautions for a 14-day period following arrival. The home must be able to maintain and have a plan in place for isolation of new admissions.

Despite the condition set out in paragraph 3 above, a re-admission of a resident who is positive for COVID-19 may be made providing that it is approved by the local public health unit per the [Quick Reference Public Health Guidance on Testing and Clearance](#) and [Public Health Management of Cases and Contacts of COVID-19 in Ontario](#).

For long-term care homes only: In the case that there is any difference of view between a hospital and long-term care home about the suitability of the return of the resident to the long-term care home, please contact the local placement coordinator/office. If they cannot resolve the issue will be escalated to the ministry.

- **Absences.**

1. **Short stay absences:**

Residents may leave the home's property for a short stay absence for health care-related, social, or other reasons. A short stay absence does not include an overnight stay, with the exception of single-night emergency room visits (see below). Upon return to the home, residents must be actively screened (refer to Active Screening of All Residents above) but are not required to be tested or self-isolate.

Residents must be provided with a medical mask to be worn at all times when outside of the home (if tolerated) and reminded about the importance of public health measures including physical distancing.

- Outpatient medical visits are considered a short stay absence and residents do not require testing or self-isolation upon their return.
- Emergency room visits that take place over a single night (e.g., assessment and discharge from the emergency department spans one overnight period) should also be considered equivalent to an outpatient medical visit that does not require testing or self-isolation upon return. If the resident is admitted to the hospital at any point, or the emergency room visit takes place over two or more nights, homes should follow the steps outlined above under Re-Admissions.

2. **Temporary absences:**

Residents may leave the home's property for a temporary absence (one or more nights) for personal reasons. Upon return to the home the resident will be required to self-isolate for 14 days. For residents who are being discharged from a hospital, please refer to the Re-Admissions section above.

Homes must review and approve all temporary absences based on a case by case risk assessment considering, but not limited to, the following:

- The home's ability to support self-isolation for 14 days upon the resident's return.
- Local disease transmission and activity.
- The risk associated with the planned activities that will be undertaken by the resident while out of the home.
- The resident's ability to comply with local and provincial policies/ bylaws.
- Any further direction provided by the MLTC.

If the home denies a temporary absence request, the home must communicate this to the resident/substitute decision maker in writing, including the rationale for this decision.

3. In the event of an outbreak where residents cannot be placed in other areas of the home that are not part of the declared outbreak area, or there are other exceptional circumstances (e.g., resident safety, advice from local public health unit), temporary short-stay in hospital could be considered for residents to support outbreak management and IPAC measures provided:

- The resident can be isolated under Droplet and Contact Precautions in the hospital for 14 days.
- The resident is tested and results known within 24 hours of the short-stay transfer to the hospital.
- Return to the home should follow the Admission and Re-Admission details above.

**The requirements in this Directive related to short-stay absences and temporary absences are not meant to apply to retirement homes. The requirements related to resident absences for retirement homes should continue to be guided by applicable Retirement Home Regulatory Authority and Ministry for Seniors and Accessibility requirements and policies, as amended from time to time.*

- **Ensure appropriate Personal Protective Equipment (PPE).** Long-term care homes are expected to follow COVID-19 [Directive #5 for Hospitals within the meaning of the Public Hospitals Act and Long-Term Care Homes within the meaning of the Long-Term Care Homes Act, 2007](#).
- **Staff Masking.** Long-term care homes should immediately implement that all staff wear surgical/procedure masks at all times for source control for the duration of full shifts. This is required regardless of whether the home is in an outbreak or not. When staff are not in contact with residents or in resident areas during their breaks, staff may remove their surgical/procedure mask but must remain two metres away from other staff to prevent staff to staff transmission of COVID-19.
- **Managing Visitors.** The aim of managing visitors is to balance the need to mitigate risks to residents, staff and visitors with the mental, physical and spiritual needs of residents for their quality of life.

Homes must have a visitor policy in place that is compliant with this Directive and is guided by applicable policies, amended from time to time, from the MLTC and MSAA. At minimum, visitor policies must:

1. Be informed by the ongoing COVID-19 situation in the community and the home and be flexible to be reassessed as circumstances change.
2. Be based on principles such as safety, emotional well-being, and flexibility and address concepts such as compassion, equity, non-maleficence, proportionality (i.e., to the level of risk), transparency and reciprocity (i.e., providing resources to those who are disadvantaged by the policy).
3. Include education about physical distancing, respiratory etiquette, hand hygiene, infection prevention and control practices (IPAC) and proper use of PPE.
4. Include allowances and limitations regarding indoor and outdoor visiting options.
5. Include criteria for defining the number and types of visitors allowed per resident when the home is not in an outbreak, in accordance with MLTC and MSAA policies. When the home is in an outbreak, only essential visitors (as defined below) are permitted in the home.
6. Include screening protocols, specifically that visitors be actively screened on entry for symptoms and exposures for COVID-19, including temperature checks and not be admitted if they do not pass the screening.
7. Include visitor attestation to not be experiencing any of the typical and atypical symptoms.
8. Comply with the home's IPAC protocols, including donning and doffing of PPE.
9. Clearly state that if the home is not able to provide surgical/procedure masks, no family visitors should be permitted inside the home. Essential visitors who are provided with appropriate PPE from their employer, may enter the home.
10. Include a process for communicating with residents and families about policies and procedures including the gradual resumption of family visits and the associated procedures.
11. State that non-compliance with the home's policies could result in a discontinuation of visits for the non-compliant visitor.
12. Include a process for gradual resumption of family visitors that stipulates:
 - a. Visits should be pre-arranged.
 - b. Family visitors to begin with one visitor at a time.
 - c. Must only visit the one resident they are intending to visit, and no other resident.
 - d. Family visitors should use a face covering if the visit is outdoors. If the visit is indoors, a surgical/procedure mask must be worn at all times.
 - e. Family visits are not permitted when:
 - i. A resident is self-isolating or symptomatic, or
 - ii. A home is in an outbreak.

13. Specify that essential visitors:

- a. Be defined as including a person performing essential support services (e.g., food delivery, inspector, maintenance, or health care services (e.g., phlebotomy)) or a person visiting a very ill or palliative resident.
- b. Providing direct care to a resident must use a surgical/procedure mask while in the home, including while visiting the resident that does not have COVID-19 in their room.
- c. Who are in contact with a resident who is suspect or confirmed with COVID-19, must wear appropriate PPE in accordance with Directive #5 and Directive #1.
- d. Are the only type of visitors allowed when:
 - i. A resident is self-isolating or symptomatic, or
 - ii. A home is in an outbreak.

- **Limiting Work Locations.** Wherever possible, employers should work with contractors and volunteers to limit the number of work locations that contractors and volunteers are working at, to minimize risk to residents of exposure to COVID-19. In addition, with respect to employees, long-term care home employers must also comply with Ontario Regulation 146/20 and retirement home employers must also comply with Ontario Regulation 158/20, both made pursuant to the *Reopening Ontario (A Flexible Response to COVID-19) Act*.
- **Staff and Resident Cohorting.** Long-term care homes must have a plan for and use, to the extent possible, staff and resident cohorting as part of their approach to preparedness as well as to prevent the spread of COVID-19 once identified in the home.

Resident cohorting may include one or more of the following: alternative accommodation in the home to maintain physical distancing of 2 metres at all times, resident cohorting by COVID-19 status, utilizing respite and palliative care beds and rooms, or utilizing other rooms as appropriate. Staff cohorting may include: designating staff to work in specific areas/units in the home as part of preparedness and designating staff to work only with specific cohorts of residents based on their COVID-19 status in the event of suspect or confirmed outbreaks.

In smaller homes or in homes where it is not possible to maintain physical distancing of staff or residents from each other, all residents or staff should be managed as if they are potentially infected, and staff should use Droplet and Contact Precautions when in an area known to be affected by COVID-19.

Additional environmental cleaning is recommended for frequently touched surfaces, including trolleys and other equipment that move around the home, and consideration given to increasing the frequency of cleaning. Policies and procedures regarding staffing in Environmental Services (ES) departments should allow for surge capacity (e.g., additional staff, supervision, supplies, equipment). See PIDAC's [Best Practices for Prevention and Control of Infections in all Health Care Settings](#) for more details.

- **Triggering an outbreak assessment.** Once at least one resident or staff has presented with new symptoms compatible with COVID-19, the long-term care home should immediately trigger an outbreak assessment and take the following steps:

- a. Place the symptomatic resident or staff under Droplet and Contact Precautions.
- b. Test the symptomatic resident or staff (if still in the home) immediately.
- c. Contact the local public health unit to notify them of the suspected outbreak.
- d. Test those residents who were in close contact (i.e., shared room) with the symptomatic resident and anyone else deemed high-risk by the local public health unit, including staff; test residents and staff in close contact with a symptomatic staff member per risk exposure and local public health unit advice.
- e. Ensure adherence to cohorting of staff and residents to limit the potential spread of COVID-19.
- f. Enforce enhanced screening measures among residents and staff.

1. **Receiving negative test results.** If the long-term care home receives negative test results on the initial person who was tested, the long-term care home can consider ending the suspect outbreak assessment related steps in consideration of other testing completed and in consultation with the local public health unit.
2. **Receiving positive test results.** Long-term care homes must consider a single, laboratory confirmed case of COVID-19 in a resident or staff member as a confirmed respiratory outbreak in the home. Once an outbreak has been declared, residents, staff or visitors, who were in close contact with the infected resident, or those within that resident's unit/hub of care, should be identified. Further testing in the home should be undertaken in collaboration with the local public health unit, using a risk-based approach based on exposures and following the most recent [COVID-19 Provincial Testing Guidance Update](#).

If a resident who was admitted or re-admitted to the home is tested during the 14-day isolation period and the results are positive and the resident has been in isolation under Droplet and Contact Precautions during the entirety of the 14-day period, declaring an outbreak may not be necessary. When only asymptomatic residents and/or staff with positive results are found as part of enhanced surveillance testing of residents and/or staff, it may not be necessary to declare an outbreak. This should only be assessed and done in consultation with the local public health unit.

- **Management of a Single Case in a Resident.** The resident must be in isolation under appropriate Droplet and Contact Precautions, in a single room if possible.

Staff who have had a high-risk exposure to COVID-19 without appropriate PPE and are asymptomatic must self-isolate for 14 days and monitor for symptoms. In exceptional circumstances staff may be deemed critical, by all parties, to continued operations in the home, and continue their duties under work self-isolation. If staff are continuing to work, they must undergo regular screening for symptoms, use appropriate PPE, and undertake self-monitoring for 14 days. Staff who have had contact with medium risk exposure to COVID-19 should be self-monitoring for 14 days. For details refer to the [COVID-19 Quick Reference Public Health Guidance on Testing and Clearance](#) July 29th, 2020, or as amended.

- **Management of a Single Case in Staff.** Even if the staff exposure was to a specific area of the long-term care home, strong consideration must be given to applying outbreak control measures to the entire home.

Staff who have tested positive and are symptomatic cannot attend work. In exceptional circumstances when a staff member has been deemed critical, the staff member who has tested positive and whose symptoms have resolved, or they remain asymptomatic may return to work under work self-isolation after a certain number of days. For details refer to the [COVID-19 Quick Reference Public Health Guidance on Testing and Clearance](#) July 29th, 2020, or as amended.

- **Required Steps in an Outbreak.** If an outbreak is declared at the long-term care home, the following measures must be taken:
 1. For new resident admissions or re-admission refer to Admissions and Re-Admissions above.
 2. If residents are taken by family out of the home, they may not be readmitted until the outbreak is over.
 3. For residents that leave the home for an out-patient visit, the home must provide a mask. The resident must wear a mask while out, if tolerated, and be screened upon their return, but does not need to be self-isolated.
 4. Discontinue all non-essential activities.
- **Testing.** Please refer to the update on [COVID-19 Provincial Testing Guidance Update](#) issued on August 14th, 2020 and published on the Ministry's website, or as amended, for long-term care and retirement homes.
- **Ensure LTC Home's COVID-19 Preparedness.** Long-term care homes and retirement homes, in consultation with their Joint Health and Safety Committees or Health and Safety Representatives, if any, must ensure measures are taken to prepare the home for a COVID-19 outbreak including:
 1. Ensuring swab kits are available and plans are in place for taking specimens,
 2. Ensuring sufficient PPE is available,
 3. Ensuring appropriate stewardship and conservation of PPE is followed,
 4. Training of staff on the use of PPE,
 5. Discuss with each resident and their substitute decision-maker an advanced care plan for the resident, and document the plan as part of community planning with local acute care facilities and EMS,
 6. Communicate with local acute care hospitals regarding outbreak, including number of residents in the facility, and number who may potentially be transferred to hospital if ill based on the expressed wishes of the residents,
 7. Develop policies to manage staff who may have been exposed to COVID-19 and must permit an organization completing an IPAC assessment and report to share the report with any or all of the following: public health units, local public hospitals, LHINs, the Ministry of Long-Term Care in the case of long-term care homes and the

Retirement Homes Regulatory Authority in the case of retirement homes, as may be required to respond to COVID-19 at the home.

- **Communications.** Long-term care homes must keep staff, residents and families informed about COVID-19, including frequent and ongoing communication during outbreaks. Staff must be reminded to monitor themselves for COVID-19 symptoms at all times, and to immediately self isolate if they develop symptoms. Signage in the long-term care home must be clear about COVID-19, including signs and symptoms of COVID-19, and steps that must be taken if COVID-19 is suspected or confirmed in staff or a resident. Issuing a media release to the public is the responsibility of the institution but should be done in collaboration with the public health unit.
- **Food and Product Deliveries.** Food and product deliveries should be dropped in an identified area and active screening of delivery personnel should be done prior to entering the home.

In accordance with subsection 27(5) of O. Reg 166/11 made under the *Retirement Homes Act, 2010* retirement homes must take all reasonable steps to follow the required precautions and procedures outlined in this Directive.

Note: As this outbreak evolves, there will be continual review of emerging evidence to understand the most appropriate measures to take. This will continue to be done in collaboration with health system partners and technical experts from Public Health Ontario and with the health system.

Questions

Long-term care homes, retirement homes and HCWs may contact the ministry's Health Care Provider Hotline at 1-866-212-2272 or by email at emergencymanagement.moh@ontario.ca with questions or concerns about this Directive.

Long-Term Care homes, retirement homes and HCWs are also required to comply with applicable provisions of the [Occupational Health and Safety Act](#) and its Regulations.



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