

Ministry of Health

COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units

Version 2.1 – July 23, 2021

Highlights of Changes:

- Purpose of this document.
- Active screening: addition of guidance on how to incorporate mobile apps and other tools into the active screening process.
- Physical distancing and universal masking: references to sector-specific guidance documents for long-term care homes and retirement homes.
- Personal Protective Equipment: updated guidance for eye protection.
- Admissions & transfers: Testing and quarantine requirements have been updated and moved into this document from Directive #3. For fully immunized individuals, testing and quarantine is no longer required in alignment with PIDAC recommendations.
- Removal of Appendix D and all references to immunization threshold-based activities in long-term care homes and retirement homes, to reflect the ongoing progress in COVID-19 immunization coverage rates across the province.

This guidance document provides information for local public health units (PHU) to support their COVID-19 response in the long-term care homes (LTCH) and retirement homes (RH) settings. It is not intended to take the place of medical advice, diagnosis or treatment, legal advice or requirements.

This guidance is intended to complement and provide interpretation of the requirements set forth in [Directive #3 for Long-Term Care Homes](#). To this end, this document provides guidance to public health units on:

- 1. The implementation of the required infection prevention and control measures under Directive #3;**

2. COVID-19 testing and quarantine requirements for admissions and transfers; and
3. Case, contact, and outbreak management in these settings.

For all other guidance, policies, and protocols, please see:

- The Ministry of Long-Term Care's (MLTC) [COVID-19 Guidance Document for Long-Term Care Homes in Ontario](#) for LTCHs; and
- The Retirement Homes Regulatory Authority's (RHRA) [Retirement Home Guidance to Implement Directive #3](#) for RHs.
- The Ministry of Health's (MOH) [Management of Cases and Contacts of COVID-19 in Ontario](#)
- [COVID-19 Fully Vaccinated Individuals: Case, Contact and Outbreak Management Interim Guidance](#)

Specific guidance and operationalization of these requirements vary across LTCH and RH settings due to the inherent differences between these two sectors. In co-located long-term care and retirement homes that are not operationally independent, the policies for the LTCH and RH should align where possible or follow the more restrictive requirements.

In accordance with subsection 27(5) of [O. Reg 166/11](#) made under the [Retirement Homes Act, 2010](#), RHs are required to take all reasonable steps to follow the requirements of Directive #3.

For LTCH, where directives, policies or guidance that apply to a long-term care home are issued by the Office of the Chief Medical Officer of Health, the Minister of Long-Term Care or Ministry of Long-Term Care, such directives, policies or guidance apply despite anything in O. Reg 263/20 and O. Reg 364/20 under the [Reopening Ontario \(A Flexible Response to COVID-19\) Act, 2020](#) (ROA). In the event of any conflict between this guidance document and any applicable emergency orders, or directives issued by the Minister of Health, Minister of Long-Term Care, or the Chief Medical Officer of Health (CMOH), the order or directive prevails.

The updates in this guidance document are based on the scientific evidence and public health expertise available so far across Canada and abroad and are subject to change as the knowledge of COVID-19 vaccines and immunity evolve over time.

Other resources:

- Please consult the Ministry of Health's (MOH) [COVID-19 website](#) regularly for updates to this document, case definition, FAQs, and other COVID-19 related information.
- Please check the [Directives, Memorandums, and Other Resources](#) page regularly for the most up to date Directives.
- Public Health Ontario (PHO) has developed a number of [LTCH](#) and [health care](#) sector-specific resources on COVID-19, including:
 - [Infection Prevention and Control for Long-Term Care Homes: Summary of Key Principles and Best Practices.](#)
 - [COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes.](#)
 - [Prevention and Management of COVID-19 in Long-Term Care Homes and Retirement Homes.](#)

Terms Used in this Document:

- For this document, the term **“staff”** is used to include anyone conducting activities in LTCH or RH, regardless of their employer. This includes, but is not limited to:
 - Staff employed by the home (e.g., health care workers, support staff),
 - Health care workers seeing a single resident for a single episode,
 - Temporary and/or agency staff,
 - Students on placement (e.g., nursing students), and
 - Volunteers.
- The term **“home”** is used to include a LTCH and RH.
- For this document, an individual is considered **“fully immunized”** if:
 - They have received the full series of a COVID-19 vaccine or combination of COVID-19 vaccines approved by Health Canada (e.g., two doses of a two-dose vaccine series, or one dose of a single-dose vaccine series); **and**
 - They received their final dose of the COVID-19 vaccine at least 14 days ago.

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Roles and Responsibilities

Role of the Public Health Unit (PHU)

Prevention and Preparedness

- Advise homes on COVID-19 prevention (including hierarchy of controls) and preparedness for managing COVID-19 cases, contacts and outbreaks, in conjunction with advice provided through the Ministry of Health (MOH), the MLTC, and the Ministry for Seniors and Accessibility (MSAA).

Case and Contact Management/Outbreak Management

- Receive and investigate reports of suspected or confirmed cases and contacts of COVID-19 in accordance with the [Health Protection and Promotion Act, 1990](#) (HPPA), [Public Health Management of Cases and Contacts of COVID-19 in Ontario](#) and the [COVID-19 Fully Vaccinated Individuals: Case, Contact and Outbreak Management Interim Guidance](#).
- Enter cases, contacts, and outbreaks in the provincial surveillance system, in accordance with data entry guidance provided by PHO.
- Determine if an outbreak exists and declare an outbreak.
- Provide guidance and recommendations to the home on outbreak control measures in conjunction with advice provided by MOH, as well as MLTC and/or MSAA as relevant.
- Make recommendations on who to test, in alignment with the [COVID-19 Provincial Testing Guidance](#) update, facilitate a coordinated approach to testing, in collaboration with Ontario Health, including provision of an investigation or outbreak number.
- Host and coordinate outbreak meetings with the home, MLTC/RHRA, Ontario Health, Infection Prevention and Control (IPAC) Hubs, etc.
- Issue orders by the medical officer of health or their designate under the HPPA, if necessary.
- Declare the outbreak over.

Coordination and Communication

- In the event that a case or contact resides in a PHU that is different than that of the home, discussions between the respective PHUs should take place to coordinate contact follow-up and delineate roles and responsibilities.
 - The PHU of the home is typically the lead PHU for home follow-up.
 - Request support from the Ministry of Health's Emergency Operations Centre (MEOC) if coordination between multiple PHUs is required for outbreak management.
- Notify the MEOC (EOCOperations.moh@ontario.ca) of:
 - Potential for significant media coverage or if media releases are planned by the PHU and/or LTCH/RH.
 - Any orders issued by the PHU's medical officer of health or their designate to the LTCH/RH and share a copy.
- Engage and/or communicate with relevant partners, stakeholders and ministries, as necessary.

Role of the Ministry of Health (MOH)

- Provide legislative and policy oversight to PHUs and their Boards of Health.
- Issue guidance to PHUs on the management of COVID-19 cases, contacts, and outbreaks, and provide clear expectations of PHUs' roles and responsibilities.
- Provide ongoing support to PHUs with partner agencies, ministries, health care professionals, and the public, as necessary.
- Support PHUs during investigations, through the MEOC and/or the Office of the Chief Medical Officer of Health (OCMOH), with respect to coordination, policy interpretation, communications, etc. as requested.
- Support and coordinate teleconferences, if needed, via the MEOC.
- Receive notification through the MEOC:
 - If the PHU believes there is potential for significant media coverage.
 - If orders are issued by the Medical Officer of Health or their designate to the home.

Role of MLTC and MSAA

- Provide legislative and policy oversight to homes.
- Communicate expectations and provincial-level guidance on COVID-19 related policies, measures, and practices to homes.
- Provide ongoing support and communications to homes with partner agencies, ministries, and the public, as necessary.
- For MLTC only: Support the procurement of supplies of personal protective equipment (PPE).

Role of Public Health Ontario (PHO)

- Provide scientific and technical advice to PHUs to support case and contact management, outbreak investigations, and data entry.
- Develop evidence-informed resources, programs, and approaches to inform the supports provided by IPAC Hubs.
- Provide advice and support to IPAC Hubs to expand pre-existing IPAC networks.
- Advise on and support laboratory testing as needed.
- Work with MOH and other government and health system partners on a coordinated approach to strengthening IPAC programs and individual capacity.
- Provide scientific and technical advice to MOH and PHUs, including multi-jurisdictional teleconferences.

Role of the long-term care home (LTCH) and the retirement home (RH)

- All homes are required to report that a person is or may be infected with an agent of a communicable disease to their local PHU, as per subsection 27(2) of the HPPA.
 - COVID-19 is a designated disease of public health significance and a communicable disease ([O. Reg. 135/18](#)). As such, all suspected and confirmed cases of COVID-19 are reportable to the local PHU under the [HPPA](#).
 - LTCHs are required to immediately report any COVID-19 case or outbreak (suspected or confirmed) to the MLTC using the Critical Incident System during regular working hours or calling the after-hours line at 1-888-999-6973 after hours and on weekends.

- LTCHs must also follow the critical incident reporting requirements in section 107 of [O. Reg 79/10](#) under the [Long-Term Care Homes Act, 2007](#).
- RHs are required to report any outbreak to the Retirement Homes Regulatory Authority, at the same time that the outbreak is reported to the local PHU.
- All homes, as employers under [Occupational Health and Safety Act, 1990](#) (OHSA) and its regulations, have a duty to take every precaution reasonable in the circumstances for the protection of a worker, including in respect of infectious disease.
- Under OHSA, an employer must provide written notice to the Ministry of Labour, Training and Skills Development (MLTSD) within four days of being advised that a worker has an [occupational illness](#) and under the [Workplace Safety and Insurance Act, 1997](#) (WSIA), must report to Workplace Safety Insurance Board (WSIB) and to relevant trade union, if any, within 72 hours of receiving notification of said illness.
- Implement prevention measures found in guidance or as directed by the MOH, MLTSD and their local PHU, as well as MLTC (including Directives issued by Minister of Long-Term Care) and/or MSAA as applicable.
- Coordinate with the local PHU and other stakeholders as appropriate, as part of the investigation of cases, contacts, and outbreaks.
- Maintain accurate records of staff attendance, all visitors, and resident information.
 - Records of staff attendance and visitor logs should be kept for the last 30 days, as well as up to date contact information for staff and visitors.
 - This information should be available to be accessed and shared with the local PHU in a timely manner (within 24 hours) for investigations and communications.
 - Facilitate access for PHUs to staff lists for staff not directly employed by the home (e.g. third party/temporary agency workers).
 - Keep a log of all visitors (i.e., essential visitors including caregivers, general visitors) who enter the home, location(s) visited and dates/times of visit to facilitate contact follow-up if needed.

- Provide PHU with the name(s) and contact information of a designated point of contact for use during and/or after business hours, to ensure timely investigation and follow up cases, contacts and outbreaks.
- In collaboration with the PHU, communicate proactively with the home's staff, visitors, residents, and the resident families about COVID-19 prevention measures and about how ill individuals, cases, contacts and outbreaks will be handled.
- Provide training to home staff, including temporary/agency staff and staff/volunteers from external partners, with respect to outbreak prevention and control measures, including IPAC measures and the use of personal protective equipment (PPE).
- Follow the directions of the local PHU if any staff or residents have COVID-19, are exposed to someone with COVID-19, or if there is a suspect or confirmed outbreak in the home.
- Encourage/[support COVID-19 immunization](#) by providing education to workers.

Role of Ontario Health

- Coordinate local planning among health system partners for testing to ensure the availability of testing resources.
- Deploy testing resources and modalities to meet the testing needs identified by the PHU and the home.
- Collaborate with the PHU and the homes to monitor testing demands and access.
- Work with testing centres to optimize sample collection and distribution to reduce turnaround times.

Role of the IPAC Hubs

- Facilitate access to IPAC training and practice needs for LTCHs and RHs within their catchment area.
- Strengthen current partnerships and broker new ones.
- Support a network of IPAC service providers and experts and work to align local resources to IPAC needs within LTCHs and RHs for both prevention and response.

- Bring forward and escalate issues of concern that are outside of the scope of IPAC through established mechanisms with ministry partners.
- Collaborate with PHO and other government and health system partners to strengthen IPAC programs reflecting field observations.
- Help to support an outbreak control plan by providing IPAC expertise and recommendations.

Role of MLTSD

- Receive notice of an occupational illness from employers under subsection 52(2) of the OHSA. An occupational illness includes any condition that results from exposure in a workplace to a physical, chemical or biological agent to the extent that normal physiological mechanisms are affected, and the health of the worker is impaired; and includes an illness caused by an infection from an exposure at the workplace.
- MLTSD investigates occupational illness notifications to determine if the employer is in compliance with the OHSA and its regulations and that appropriate measures have been taken to prevent further illnesses.
- Proactively inspect workplaces to monitor compliance with the OSHA and its regulations.
- Investigate unsafe work practices, critical injuries, fatalities, work refusals and occupational illness, all as related to worker health and safety. This includes investigation of reports of COVID-19 by employers to MLTSD.
- Issue orders under the OSHA and its regulations.
- The MLTSD Health and Safety Contact Centre (1-877-202-0008) is available for anyone to report health and safety concerns, complaints or to provide notices of [occupational illnesses](#).
- While this document focuses in part on the role of the MLTSD's health and safety program, the ministry also administers the [Employment Standards Act, 2000](#). If workplace parties request information regarding employment standards, they can be referred to the Employment Standards Information Centre: 1-800-531-5551.

Role of external partners

- This includes external organizations who are engaged or brought on to assist with a home's outbreak response including, but not limited to, the Canadian Red Cross.

- Inform the PHU and the home of their engagement to assist with the home's outbreak response.
- Follow the direction of the PHU and assist in the outbreak response as advised by the PHU.
- Follow the direction of the IPAC hubs and assist IPAC hubs as part of the overall outbreak response (e.g., auditing, training, reinforcing of IPAC practices).

COVID-19 Immunization

- To facilitate public health case, contact, and outbreak management, it is strongly recommended that homes:
 - Collect COVID-19 immunization status of their staff and residents through a consent-based process;
 - Ensure that the data is collected, retained and disposed of in a manner that respects privacy, including complying with the [Personal Health Information and Protection Act, 2004](#) (PHIPA) where applicable;
 - Based on the information collected, calculate an immunization coverage rate;
 - Review and update this information periodically; and
 - Share this information with local public health units upon request.
- New admissions to LTCHs and RHs who have not yet received their COVID-19 immunization should be offered COVID-19 vaccination as soon as possible.
- PHUs are asked to continue to support COVID-19 immunization in the LTCH/RH sectors in collaboration with the home and relevant health system partners. Where possible, this includes assisting homes with on-site immunization.
- More information can be found on the MOH's [COVID-19 Vaccine-Relevant Information and Planning Resources](#) webpage.
- MLTC has developed a [COVID-19 Vaccine Toolkit](#), which includes posters, fact sheets, and FAQs to promote COVID-19 immunization in this setting. It is available in multiple languages.

Prevention of Disease Transmission

Homes can help prevent and limit the spread of COVID-19 by ensuring that general IPAC practices (e.g., [hand hygiene](#) and [respiratory etiquette](#)) are in place while also respecting the physical, mental, emotional, and psychosocial well-being of residents. Factors such as the physical/infrastructure characteristics of the home, staffing availability, and the availability of personal protective equipment (PPE) should all be considered when developing home-specific policies. **The measures outlined below should be carried out at all times regardless of the COVID-19 situation in the home.**

- **Note:** MOH's [Control of Respiratory Infection Outbreaks in Long-Term Care Homes](#) is the foundational document for respiratory outbreak-related guidance on the preparedness, prevention, and management of respiratory-related outbreaks in long-term care homes. The information in this document is intended to supplement these foundational principles with COVID-19 specific advice/recommendations.

Active Screening for Anyone Entering the Home

- Active screening is required regardless of immunization status and prior to permitting the entry (including for outside visits) of:
 - All staff, including students, and volunteers;
 - Essential and general visitors
 - Residents returning from an absence; and
 - All other persons.
- As per [Directive #3, first responders in emergency situations are exempt from this requirement and must be permitted entry.](#)
- Homes should have a screener at the entrance who is able to conduct active screening during business hours and change of shift. Outside of these times, the home's charge nurse/administrator should develop processes and procedures to ensure that all persons entering the home are screened and visits are logged. In either case, homes must ensure that screening occurs in accordance with all laws, including Directive #3 for Long-Term Care Homes, and the COVID-19: Long-term care home surveillance testing and access to homes Directive, issued by the Minister of Long-Term Care (Minister of Long-Term Care's Surveillance Directive).

- Homes may use mobile apps or other tools to facilitate the active screening process. However, the active part of the screening process requires the individual being screened to interact with the screener prior to being permitted entry.
 - For example, a staff may complete an online screening tool and have their results be sent electronically to the screener or demonstrate their results to the screener prior to entry to fulfill the interactive component.
- At a minimum, homes should ask the questions listed in the [COVID-19 Screening Tool for Long-Term Care Home and Retirement Homes](#).
 - Temperature checks as part of active screening at entry are no longer required by Directive #3.
- A summary chart of screening practices can be found in [Appendix A](#).
 - For symptoms, refer to the [COVID-19 Reference Document for Symptoms](#).

Daily Symptom Assessment of Residents

- See [Appendix A](#) for details on the daily symptom assessment of residents.
- All residents must be assessed at least once daily, including temperature screening, to identify any new or worsening COVID-19-like symptoms.
 - Homes are strongly encouraged to conduct symptom assessment more frequently (e.g., at every shift change), especially during an outbreak to facilitate early identification and management of ill residents.
 - This can take place at the same time as routine vital signs check, where applicable.
- Homes should be aware that elderly individuals may present with subtle or atypical signs and symptoms of COVID-19. As much as possible, it is important for homes to understand a resident's baseline health and functioning and ensure routine monitoring of their status to facilitate early identification and management of ill residents.

Passive Screening and Signage

- Signage should indicate signs and symptoms of COVID-19 for self-monitoring and provide steps that must be taken if COVID-19 is suspected or confirmed in a staff member, visitor, or a resident. A list of COVID-19 symptoms, including atypical symptoms, can be found in the [COVID-19 Reference Document for Symptoms](#).

- Homes should also post signage throughout the home to remind all persons in the home to physically distance, wear their masks when indicated, perform hand hygiene, and follow respiratory etiquette as per routine measures for respiratory season.

Asymptomatic Testing as Part of Active Screening

- This refers to the practice of routinely testing (using rapid antigen tests or laboratory-based PCR) asymptomatic individuals who are neither experiencing COVID-19 symptoms nor have been exposed to a known COVID-19 case. The rationale for this type of testing is to create an additional level of protection, *in addition to* active screening, through the early identification and management asymptomatic cases. **This does not replace, and should not supersede, routine IPAC practices nor is it equivalent to diagnostic molecular testing.**
- LTCHs and RHs should refer to their sector-specific requirements or policy on asymptomatic testing for screening purposes, including:
 - The Minister of Long-Term Care's Directive: [COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes](#) for LTCH;
 - The [Testing in Retirement Homes memo](#) for RH; and
 - Ministry of Health's [COVID-19 Provincial Testing Guidance](#).
- For more information on rapid antigen testing, please see
 - [COVID-19 Guidance: Considerations for Antigen Point-of-Care Testing](#);
 - [Point-of-Care Testing Use Case Guidance](#);
 - [Appendix 9: Management of Individuals with Point-of-Care results](#).
- Individuals who have previously been diagnosed with and cleared of COVID-19 infection should:
 - Where required, resume asymptomatic testing for screening after 90 days (from the specimen collection date) from their prior laboratory-confirmed COVID-19 infection.
 - If there is uncertainty about the validity of the COVID-19 infection (e.g., asymptomatic infection with high cycle threshold value result), resume asymptomatic surveillance testing immediately.
 - Homes should be aware that individuals who have previously been infected with COVID-19 may continue to test positive on laboratory-based PCR tests for several weeks after infection.

Screening Outcomes: What to do

- If a staff or a visitor is showing symptoms of COVID-19 at screening or has not passed the screening, they must not be allowed to enter the home. They should be instructed to self-isolate immediately and be encouraged to get tested for COVID-19 (as applicable).
- Any staff who does not pass their screening should contact their immediate supervisor/manager or occupational health and safety representative in the home.
 - Staff responsible for occupational health and safety in the home should follow up with all staff who have been screened positive to provide advice on work restrictions.
 - Staff with post-immunization related symptoms may be exempt from exclusion from work as per the [Managing Health Care Workers with Symptoms within 48 Hours of Receiving COVID-19 Vaccine](#) guidance.
 - Staff who may be exempt from quarantine after a high-risk exposure due to their vaccination status or prior COVID-19 infection may still be required to be off of work and must discuss any work restrictions with their manager/Occupational Health. Managers/Occupational Health should note where workplace policies may differ from public health guidance.
- Residents with [symptoms compatible with COVID-19](#) or those who have not passed screening on return to the home following an absence must be placed in isolation under Droplet and Contact Precautions and tested for COVID-19.
- Please refer to [Appendix B](#) for the required precautions for PPE when providing care.

Note: Any staff providing care for and testing residents with suspected or confirmed COVID-19 must use precautions listed in [Directive #1 for Health Care Providers and Health Care Entities](#), [Directive #5 for Hospitals and Long-Term Care Homes](#), as well as [PHO's Technical Brief on IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19](#).

Hand Hygiene

- Access to handwashing stations and/or [alcohol-based hand sanitizers should be available at multiple, prominent locations in the home](#), including entrances and common areas to promote frequent hand hygiene.

- All staff, visitors, and residents should be reminded through training and signage to:
 - Clean hands by washing with soap and water or using an alcohol-based (70-90% alcohol) hand sanitizer.
 - Wash hands with soap and water if hands are visibly dirty.
 - If gloves are being used, perform hand hygiene prior to putting on gloves.
 - After use, gloves should be placed in the garbage. After removing them, then clean hands again.
- Homes should ensure adequate supplies are maintained.

Physical Distancing

- As per Directive #3, homes must ensure that physical distancing (a minimum of 2 metres or 6 feet) is practiced by all individuals at all times, except for the purposes of providing direct care to a resident(s). Please refer to following documents for sector-specific exceptions for physical distancing.
 - **LTCHs** must follow [MLTC's COVID-19 Guidance Document for Long-Term Care Homes in Ontario](#), effective July 16, 2021 or as current.
 - **RHs** must follow RHRA's [Retirement Homes Policy to Implement Directive #3](#), effective July 16, 2021 or as current.
- In instances where physical distancing is not possible (e.g., in the provision of direct care), staff, caregivers, and/or visitors must wear appropriate PPE based on the nature, duration, and type of interaction.
- In instances where physical contact is permitted (e.g., between a resident and a fully immunized caregiver), staff, caregivers, and/or visitors must continue to practice hand hygiene, masking, and physical distancing from other residents and visitors.
- Homes must continue to reconfigure physical space and modify activities to optimize and support physical distancing. This includes:
 - Posting signage in common areas re: maximum capacity;
 - Moving furniture around or removing unnecessary furniture/equipment;
 - Placing visual markers on the floor to guide physical distancing;
 - Reviewing opportunities to reduce the number of staff present together at the same time within break facilities and common areas; and

- Reviewing opportunities to consolidate and streamline residents' medication administration schedules to as much as possible to minimize the number of times staff need to enter a resident's room.

Masking

For staff and essential visitors:

- Universal masking is required for the purpose of *source control* to help prevent the spread of the potentially infectious respiratory droplets and aerosols of the person wearing the mask to others
- Universal masking means wearing a mask at all times, whether or not a home is in an outbreak and regardless of one's COVID-19 immunization status. Physical distancing measures must be maintained even when wearing a mask.
- As per Directive #3, homes must provide resources and training for staff, residents, and visitors on proper mask use (e.g., how to wear and remove a mask).
- For guidance on universal mask use, refer to Public Health Ontario (PHO)'s [COVID-19: Universal Mask Use in Health Care](#) and [COVID-19: Universal Mask Use in Health Care Settings and Retirement Homes](#) documents.

For residents:

- Residents are strongly recommended to wear masks, as tolerated, in common areas or in a shared space with others (e.g., when within 2 metres of others). Masking may be challenging for some individuals depending on their physical, mental, and/or cognitive capabilities.
- As much as possible, residents who are on Droplet and Contact Precautions due to COVID-19 (e.g., those who are a case or a close contact of a case) should wear a medical (surgical/procedural) mask during the provision of direct care, where masking is tolerated.
- Please refer to following documents for sector-specific policies and exceptions for masking.
 - **LTCHs** must follow [MLTC's COVID-19 Guidance Document for Long-Term Care Homes in Ontario](#), effective July 16, 2021 or as current.
 - **RHs** must follow RHRA's [Retirement Homes Policy to Implement Directive #3](#), effective July 16, 2021 or as current.

Personal Protective Equipment (PPE)

- PPE is intended to protect the wearer to minimize their risk of exposure to COVID-19.
- **The effectiveness of PPE depends on the worker wearing it correctly and consistently. The employer must train workers on the care, use and limitations of any PPE that they use. PPE should not be manipulated or changed without consulting with local Occupational Health and Safety.**
- In addition to source control, medical masks also serve as PPE for staff and essential visitors. Medical masks protect the person who is wearing the mask from becoming exposed to other people's potentially infectious respiratory droplets.
 - Non-medical masks (e.g., cloth masks) cannot be used as PPE.
- Additional PPE is required in specific situations, such as when providing care to a resident who is placed on Droplet and Contact Precautions (e.g., due to symptoms, COVID-19 exposure, or COVID-19 diagnosis), or to provide resident care during a COVID-19 outbreak. Choosing PPE should be guided by the nature, type, and duration of the intended interaction and by a point-of-care risk assessment.
- Eye protection is used to protect the wearer (specifically, their eyes/conjunctival mucosal membranes) from potentially infectious respiratory droplets and aerosols. Eye protection for PPE purpose includes face shields, some safety glasses, and goggles. When choosing eye protection, ensure that it is close fitting around the head and/or with integrated side shields to provide a barrier from the front, the sides, and the top.
 - As per Directive #3, eye protection is required for all staff and essential visitors when providing care to a resident with suspect/confirmed COVID-19 and in the provision of direct care within 2 metres in an outbreak area. In all other circumstances, the use of eye protection is based on the point-of-care risk assessment (PCRA) when within 2 metres of a resident.
 - Where eye protection is used, homes should establish appropriate procedures for [cleaning and disinfecting of re-useable eye protection](#).
- [Appendix B](#) contains more information of PPE precautions based on resident status.
- [Appendix C](#) contains information on how to initiate PPE inquiries to the Ministry.

- Please refer to PHO's Technical Brief on [IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19](#) document for more information on PPE use.
- LTCHs must follow the PPE precautions outlined in [Directive #1 for Health Care Providers and Health Care Entities](#), [Directive #3 for Long-Term Care Homes](#), and [Directive #5 for Hospitals and Long-Term Care Homes](#).

Environmental Cleaning and Disinfection

- Homes should be cleaned regularly (e.g., minimum daily). Cleaning should be performed using a health care grade cleaner/disinfectant with a drug identification number (DIN).
- All common areas (including bathrooms) and high-touch surfaces that are frequently touched and used should be cleaned and disinfected at least twice a day and when visibly dirty. These include door handles, light switches, elevator buttons, handrails, trolleys, and other common equipment in the home.
- Homes should establish appropriate procedures for cleaning and disinfecting Controlled Areas under the [Smoke-Free Ontario Act, 2017](#). This includes implementing a waiting period of 15 minutes following use to allow aerosols from smoking or vaping to settle or ventilate out of the room, as well as cleaning and disinfecting the area between uses.
- Contact surfaces (i.e., areas within 2 metres) of the person who has screened positive should be disinfected as soon as possible. For more information on environmental cleaning, refer to:
 - [Key Elements of Environmental Cleaning in Healthcare Settings](#) (Fact Sheet)
 - [Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, and](#)
 - [PIDAC Routine Practices and Additional Precautions in All Health Care Settings](#).

Cohorting

Grouping of Staff and Residents in Non-Outbreak Settings

- In non-outbreak situations, homes can group residents and staff into small groups for daily activities. This is to minimize potential number of high risk contacts and to reduce the risk of transmission throughout the home in the event that the virus is introduced into the home.
- For residents, homes are strongly encouraged to group residents together for the purposes of dining and indoor social activities. These groups should be kept as consistent as possible and should not differentiate based on the immunization status of the residents.
 - In these groups, residents are not required to mask and practice physical distancing during dining and group activities.
 - To the extent possible, residents should be cohorted within a single floor/unit.
 - Cohort sizes should balance the psychosocial needs of the resident, the home's staffing needs, and take into consideration capacity limits for common areas and inclusion of essential caregivers as required. Homes should consult with their IPAC team and as needed, the local PHU.
 - Each cohort should practice physical distancing from other cohorts and wear masks (as tolerated) if physical distancing from other cohorts cannot be ensured.
- In general, regardless of the immunization status of the home, staffing assignments should ideally be organized for consistent cohorting of staff to specific resident areas to limit interactions of staff to different areas of the home.
 - To the extent possible, staff should be cohorted to work on consistent floors/units even when the home is not in an outbreak.
 - Where possible, change rooms and break rooms should be on the floor to limit mixing of staff between floors/units.
 - Where full cohorting is not possible, partner specific floors/units to share change rooms and break rooms and cross-cover consistently when necessary, rather than staff mixing across the entire facility.

- Where staff are fully immunized and are working in multiple homes and/or health care facilities as per [O. Reg 146/20](#) and [O. Reg 158/20](#) made under the [Reopening Ontario \(A Flexible Response to COVID-19\) Act, 2020](#) (ROA) for LTCHs and RHs respectively,
 - Homes should maintain a list of all staff who are:
 - Fully immunized; and
 - Working at multiple sites;
 - Each home should work with the staff member to minimize the number of cohorts to which the staff member is assigned; and
 - Homes must continue to ensure strong adherence to IPAC practices in the home.

Cohorting in an Outbreak Setting

- Cohorting is an important part of an overall IPAC approach within a home to limit the potential transmission throughout the home in the event of an introduction of an infection even when a home is not in an outbreak. Please see section on [Outbreak Management](#) on cohorting principles for outbreak situations.

COVID-19 Specific Policies and Procedures

As per [Directive #3](#), all homes are required to have policies and procedures in place to ensure the implementation of strong IPAC controls and precautions that are balanced against residents' individual and collective self-determination, desires, and their need for social interaction, emotional, and physical support. In addition, homes need to have policies and procedures that are flexible and account for various scenarios, from where there is minimal risk of COVID-19 in the home and in the community to where there is a higher risk of COVID-19 in the home and the strictest measures are required to prevent and mitigate uncontrolled spread in the home. PHUs continue to have the discretion to modify or discontinue any activity in the home as part of their outbreak investigation and management.

Admissions and Transfers

- In general, admissions and transfers are permitted when the home is not in an outbreak and the resident is not on Droplet and Contact Precautions due to symptoms, exposure, or diagnosis of COVID-19.

- Admissions and transfers to a home in an outbreak and/or involving a resident who is on Droplet and Contact Precautions may take place only if approved by the local public health unit, and there is concurrence between the home, local public health unit and hospital.
- Any resident being admitted or transferred, regardless of their immunization status, who is identified as having symptoms, exposure, or diagnosis of COVID-19 must be placed on Droplet and Contact Precautions at the home and managed as per the [Public Health Management of Cases and Contacts of COVID-19 in Ontario](#).
- **Testing and quarantine (self-isolation) of fully immunized individuals who are asymptomatic with no known COVID-19 exposures:** As per PIDAC's [Interim Guidance on Infection Prevention and Control for Health Care Providers and Patients Vaccinated Against COVID-19 in Hospital and Long-Term Care Setting](#), **testing and quarantine is no longer required for fully immunized residents who are being admitted, transferred or returning to the home from an absence.**
- **Testing and quarantine of partially immunized or unimmunized individuals who are asymptomatic with no known COVID-19 exposures:** A lab-based PCR test is required at time of admission/transfer (i.e., day 0), and the resident must be placed in quarantine on Droplet and Contact Precautions for a minimum of 10 days. A second negative lab-based PCR test result collected on day 8 is required to discontinue quarantine on Droplet and Contact Precautions on day 10; if this second test is not obtained, quarantine on Droplet and Contact Precautions must be maintained until day 14.
 - Day 0 testing of residents from acute care settings (i.e., hospitals): Individuals can be tested and results must be reported prior to their arrival to the home OR be tested on arrival to the home.
 - Day 0 testing of residents from all other settings (i.e., from the community or return from a Temporary Absence, see below): Individuals must be tested on arrival to the home.
 - At any time, if the test result is positive, continue isolation on Droplet and Contact Precautions and notify the local public health unit. See [Case and Contact Management](#), below.
- **Testing and quarantine of individuals who are within 14 days of receipt of their final dose at the time of their admission or transfer:** follow the same protocols as for partially immunized and unimmunized residents above.

- The rationale is that the individual may have been exposed to the virus and potentially incubating before their immune system has reached the optimum response to the immunization.
- **Testing and quarantine of recently recovered residents who are asymptomatic with no known COVID-19 exposures:** Individuals who are within 90 days (from the date the test was taken) from a prior lab-confirmed COVID-19 infection and have recently recovered are not required to be tested or placed in quarantine on Droplet and Contact precautions on admission/transfer.
 - For clarity, individuals who are outside of the 90 days must undergo lab-based PCR testing and be quarantined on Droplet and Contact Precautions upon their admission/transfer if they are partially immunized or unimmunized as above.
 - If there is uncertainty about the validity of the prior COVID-19 infection (e.g., asymptomatic infection with high cycle threshold value result), residents must still undergo a lab-based PCR test and be isolated on Droplet and Contact Precautions upon their admission/transfer if they are partially immunized or unimmunized.
- Rapid antigen testing is not acceptable for testing of residents for admissions and transfers.

Table 2: Admissions and Transfers Based on Resident Immunization Status

	Testing required?	Quarantine required?
Fully immunized resident	NO	NO
Partially immunized or unimmunized resident	YES <ul style="list-style-type: none"> Negative laboratory-based PCR test required on day 0 Second negative laboratory-based PCR test result collected on day 8 to exit self-isolation on day 10 	YES on Droplet and Contact Precautions <ul style="list-style-type: none"> 10 days of self-isolation with a second negative laboratory-based PCR test result collected on day 8 Otherwise, self-isolate for 14 days following arrival
Resident within 14 days of their final COVID-19 vaccine dose	YES <ul style="list-style-type: none"> Negative laboratory-based PCR test required on day 0 Second negative laboratory-based PCR test result collected on day 8 to exit self-isolation on day 10 	YES on Droplet and Contact Precautions <ul style="list-style-type: none"> 10 days of self-isolation with a second negative laboratory-based PCR test result collected on day 8 Otherwise, self-isolate for 14 days following arrival
Resident within 90 days of a laboratory confirmed COVID-19 infection	NO	NO

Absences

- Any resident on Droplet and Contact Precautions is not permitted to break their quarantine or isolation other than for medical and/or palliative/compassionate reasons. Homes should seek the advice of local public health unit if quarantine or isolation must be broken for these reasons.

- Homes must provide a medical mask to the resident (as tolerated) and remind them to follow public health measures, such as physical distancing and hand hygiene, while they are away from the home in order to minimize potential exposure to COVID-19.
- All residents, regardless of type or duration of the absence, must be actively screened upon their return to the home.
- **Residents returning from a temporary (i.e., overnight) absences must follow the testing and quarantine requirements under Admissions and Transfers, above.**

Case and Contact Management

This guidance document provides supplemental considerations for LTCH and RH settings. For more information on COVID-19 case and contact management, see:

- [Public Health Management of Cases and Contacts of COVID-19 in Ontario](#); and
- [COVID-19 Quick Reference Public Health Guidance on Testing and Clearance](#).

Management of Symptomatic Individuals

- All individuals in a home who are exhibiting [signs or symptoms](#) consistent with COVID-19 must be isolated. This is regardless of the individual's immunization status.
- **When a resident is symptomatic:** Residents must be isolated and placed on [Droplet and Contact Precautions](#), be clinically assessed, and tested for COVID-19 using a laboratory-based PCR test or a rapid PCR test (e.g., ID NOW COVID-19).
 - **If the test result is positive:** see Case Management below.
 - **If the test result is negative:** discontinue precautions if there has not been an exposure. Consider assessing and testing for other respiratory infections as appropriate (e.g., [seasonal respiratory multiplex testing](#)).

¹ Please refer to MOH's [Appendix 9: Management of Individuals with Point-of-Care Testing Results](#) document for more information on interpreting rapid PCR test results. Rapid antigen tests cannot be used for diagnostic purposes in high risk individuals, such as in symptomatic individuals or for contacts of known COVID-19 cases.

- Asymptomatic residents living in the same room or cohort as the case should be tested and placed on Droplet and Contact Precautions immediately along with the symptomatic resident under the direction of the local PHU.
- **When a staff or a visitor is symptomatic:** Symptomatic staff or visitors must not be permitted entry into the home. If they become symptomatic during their shift or visit, they should be isolated until they can safely leave the home's property and/or be asked to leave immediately. They should be instructed to isolate, seek medical assessment as required, and be encouraged to get tested for COVID-19.
 - See Directive #3 for exceptions where individuals who fail screening may be permitted entry into the home.

Case Management

- All individuals who are identified as a [confirmed or a probable COVID-19 case](#) must be isolated. This is regardless of the individuals' immunization status.
- **When a resident is a case:** Residents must be isolated and placed on [Droplet and Contact Precautions](#) to prevent the spread of infection to others in the home.
 - Individuals requiring isolation must be placed in a single room on [Droplet and Contact Precautions](#). Where this is not possible, individuals may be placed in a room with no more than one (1) other resident who must also be placed in isolation under Droplet and Contact Precautions. For the purposes of isolation, there should not be more than two (2) residents placed per room, including 3 or 4 bed ward rooms.
 - Asymptomatic residents living in the same room as the case should be tested and placed on Droplet and Contact Precautions immediately along with the infected resident under the direction of the local PHU (see Contact Management, below).
- **When a staff or a visitor is a case:** Staff and visitors who receive a positive COVID-19 test result while they are at the LTCH/RH must leave the facility immediately and be directed to isolate at their own home.
 - Staff and visitors who are diagnosed with a laboratory-confirmed COVID-19 infection may not be permitted to return to the home until after they are cleared by local public health.

- Clearance of cases and release from isolation is at the direction of the local PHU, guided by the [COVID-19 Quick Reference Public Health Guidance on Testing and Clearance](#).
 - Negative clearance tests (e.g., requiring a proof of negative test result in order to return to work) is neither recommended nor required from a public health perspective.

Contact Management

- Contact management decisions are made by the local PHU. Accordingly, all individuals who are identified as a close contact of a known COVID-19 case or an outbreak are required to follow the direction of the local PHU.
- At any time, regardless of their immunization status, if an asymptomatic contact develops COVID-19 symptoms, they must promptly self-isolate and be tested for COVID-19, using a laboratory-based PCR test or a rapid PCR test, in accordance with [Public Health Management of Cases and Contacts of COVID-19 in Ontario](#).
- Contact management should be done as per:
 - [COVID-19 Fully Vaccinated Individuals: Case, Contact, and Outbreak Management Interim Guidance](#);
 - [Public Health Management of Cases and Contacts of COVID-19 in Ontario](#); and
 - [COVID-19 Provincial Testing Guidance Update](#).
- **When the resident is a contact:** Residents who have had a high risk exposure to a known case of COVID-19, as determined by the local PHU, should be isolated on Droplet and Contact Precautions and tested for COVID-19 using a laboratory-based PCR test or rapid PCR test as per the [COVID-19 Provincial Testing Guidance Update](#).

Outbreak Management

The local PHU is responsible for investigating (e.g., determining when cases are epidemiologically-linked), declaring, and managing outbreaks under the HPPA. As such, the local PHU directs and coordinates the outbreak response. LTCHs and RHs must adhere to any guidance provided by the local PHU with respect to implementation of any additional measures to reduce the risk of COVID-19 transmission in the setting.

Additional information can be found in the following resources:

- [Public Health Management of Cases and Contacts of COVID-19 in Ontario](#);
- [COVID-19 Provincial Testing Guidance Update](#); and
- [COVID-19 Fully Vaccinated Individuals: Case, Contact, and Outbreak Management Interim Guidance](#).

Declaring an Outbreak

- Surveillance definitions of COVID-19 outbreaks in LTCH/RH are as follows:
 - **A suspect outbreak** in a home is defined as one lab-confirmed COVID-19 case in a resident.
 - **A confirmed outbreak** in a home is defined as two or more lab-confirmed COVID-19 cases in residents and/or staff (or other visitors) in a home with an epidemiological link, within a 14-day period, where at least one case could have reasonably acquired their infection in the home. Examples of reasonably having acquired infection in a home include:
 - No obvious source of infection outside of the LTCH setting; OR
 - Known exposure in the LTCH setting.
 - **Note:** the definitions above are for surveillance purposes only. PHUs have the discretion to declare a suspect or a confirmed outbreak based on the results of their investigation, including when the above definitions are not completely met.
- Declaring an outbreak may not be necessary in certain scenarios such as:
 - When a resident has tested positive during their self-isolation period following their admission or transfer and has been under Droplet and Contact Precautions for the entirety of this period, OR
 - When only asymptomatic staff or essential caregiver with positive results are found as part of routine surveillance testing with no known high-risk exposure.
 - If the staff or the essential caregiver is fully immunized, re-test immediately and follow the protocol for managing asymptomatic individuals with an initial positive result and a low pre-test probability as per the [Management of Cases and Contacts of COVID-19 in Ontario](#) document.

Suspect Outbreak Management

- Suspect outbreak management should include the following steps at minimum:
 - Case(s) and their high-risk of exposure contacts (e.g., roommates, dining/activity cohort, staff who cared for the case without appropriate and consistent PPE) should be tested immediately and managed appropriately;
 - Staff and residents should be [cohorted](#) to limit the potential spread of COVID-19;
 - Enhanced cleaning and disinfection of the affected area;
 - Additional testing at discretion of PHU; and
 - Additional control measures at discretion of PHU.

Confirmed Outbreak Management

- Once an outbreak is declared, the local PHU will direct testing and public health management of all those impacted (staff, residents, and visitors).
- A confirmed outbreak management should include the following steps at minimum:
 - Defining the outbreak area of the home (e.g., floor or unit or whole facility) and cohorting based on COVID-19 status (i.e., infected or exposed and potentially incubating);
 - Assessing risk of exposure to residents/staff based on cases' interactions, and in consideration of factors such as exposed resident/staff immunization status and whether cases are infected with a variant of concern with known immune/vaccine escape potential;
 - Enhanced monitoring for new symptoms in all residents and staff in the outbreak area;
 - Facilitate assessment of IPAC and outbreak control measures (as needed).
 - Enhanced cleaning and disinfection practices;
 - The need for staff to follow Droplet and Contact Precautions for all resident interactions in the outbreak area;
 - Modification of dining and indoor social activities (as required);
 - Limiting or restricting new admissions and transfers; and

- Limiting or restricting visitors, depending on the nature of the outbreak.

Testing for Outbreak Management

- Local PHUs are responsible for making recommendations on and facilitating outbreak testing using a risk-based approach based on exposures (e.g., affected unit/outbreak area) and following the most recent [COVID-19 Provincial Testing Guidance Update](#).
- Those who had exposure to the case(s) in the 14 days prior to illness onset should be assessed to identify potential source cases as well as those who had exposure to the case(s) while the case(s) were infectious and not in isolation with [Droplet and Contact Precautions](#) in place.
- All fully immunized individuals should continue to be tested at the direction of the local public health unit as part of outbreak investigations in alignment with the [COVID-19 Fully Vaccinated Individuals: Case, Contact and Outbreak Management Interim Guidance](#).
- Re-testing of asymptomatic individuals who initially test negative is recommended if they develop symptoms.
- In the event of ongoing transmission in an outbreak, following the initial testing of the home at the time of outbreak declaration, repeat testing of all residents and staff who initially tested negative should be conducted within 3-7 days from when the initial testing was conducted. If additional cases are identified, continue repeat testing of residents and staff who tested negative every 3-7 days until no new cases are identified.
- PHUs are responsible for following usual outbreak notification steps to the PHO Laboratory to coordinate/facilitate outbreak testing.

Declaring the Outbreak Over

- The outbreak may be declared over by the PHU when there are no new cases in residents or staff after 14 days (maximum incubation period) from the latest of:
 - Date of isolation of the last resident case; OR
 - Date of illness onset of the last resident case; OR
 - Date of last shift at work for last staff case.
- Following the end of an outbreak, please see PHO's guidance document on [De-escalation of COVID-19 Outbreak Control Measures in Long-Term Care Homes and Retirement Homes](#).

Occupational Health & Safety

Staff Exposure/Staff Illness

- All staff who fail active screening questions must report to their supervisor/manager or occupational health and safety representative and discuss any work restrictions.
- Staff who test positive for COVID-19 should report their illness to their manager/supervisor or to Employee Health/Occupational Health and Safety as per usual practice. Homes must report all suspect and confirmed cases of COVID-19 to local public health.
 - The manager/supervisor or Employee Health/Occupational Health designate must promptly inform the Infection Control Practitioner or designate of any cases or clusters of staff including contract staff who are absent from work.
 - Employers should support workers with symptoms and/or illness to self-isolate.
- If COVID-19 is suspected or diagnosed in a staff, return to work should be determined in consultation with their health care provider and as per the [Quick Reference Guidance on Testing and Clearance](#).
 - Staff must report to Occupational Health and Safety prior to return to work. Detailed general occupational health and safety guidelines for COVID-19 are available on the MOH [COVID-19 website](#).
- Symptomatic staff who decline testing should not be at work and should not be returning to work at minimum until 10 days after symptom onset and 24 hours post improvement of symptoms with resolution of fever. Staff should also follow directions provided by their employer/Occupational Health and Safety representative.

Reporting staff illness

- Workers who are unwell should not attend at a workplace. They should report their illness-related absence to their supervisor or employer.

- In accordance with the *OHSA* and its regulations, if an employer is advised that a worker has an occupational illness or that a claim has been filed with the Workplace Safety and Insurance Board (WSIB) by or on behalf of the worker with respect to an occupational illness, the employer must provide written notice within four days to:
 - A Director appointed under the *OHSA* of the MLTSD.
 - The workplace's joint health and safety committee (or a health and safety representative).
 - The worker's trade union, if any.
- This may include providing notice for an infection that is acquired in the workplace.
- In accordance with the *WSIA*, the employer must also report any instance of an occupationally acquired disease to the WSIB within 72 hours of receiving notification of said illness.
- For more information, please contact the MLTSD:
 - Employment Standards Information Centre: Toll-free: 1-800-531-5551
 - Health and Safety Contact Centre: Toll-free: 1-877-202-0008
- For more information from the WSIB, please refer to the following:
 - Telephone: 416-344-1000 or Toll-free: 1-800-387-0750.

Appendix A: Summary for Active Screening Practices for Homes

	Staff and Visitors	Current Residents
Who does this include?	<p>Staff and all visitors, including caregivers, students, and volunteers.</p> <p>Exception is provided to first responders, who should, in emergency situations, be permitted entry to the home without screening.</p>	Residents currently living in the home.
What are the screening practices?	<ul style="list-style-type: none"> • Conduct active screening before they are allowed to enter the home, including for outdoor visits. At a minimum, homes should ask the questions listed in the COVID-19 Screening Tool for Long-Term Care Home and Retirement Homes. • Temperature checks are not required. • All visitors entering the home must adhere to the home's visitor policies. 	<ul style="list-style-type: none"> • Conduct symptom assessment of all residents at least once daily to identify if any resident has symptoms of COVID-19, including any atypical symptoms as listed in the COVID-19 Reference Document for Symptoms. • All residents returning from any type of absence must be screened at entry upon their return.
What if someone does not pass screening (i.e., screens positive)?	<p>Staff and visitors who are showing symptoms of COVID-19 or had a potential exposure to COVID-19, and have screened positive must:</p> <ul style="list-style-type: none"> • Not enter the home, • Instructed to immediately self-isolate, and • Be encouraged to be tested for COVID-19 at an assessment centre. • See Directive # 3 for possible exceptions. 	Residents with symptoms of COVID-19 (including mild respiratory and/or atypical symptoms) must be isolated under Droplet and Contact Precautions and tested. For a list of typical and atypical symptoms, refer to the COVID-19 Reference Document for Symptoms .

Appendix B: Required PPE Precautions

- Where it is not possible to use other control measures to sufficiently reduce a worker’s risk of exposure, personal protective equipment (PPE) will be needed. As much as possible, PPE should be used in combination with other controls.
- It is important that any PPE that workers use is appropriate for the purpose. While caring for a suspected or confirmed patient with COVID-19 appropriate PPE consists of a medical mask, eye protection (e.g., face shield, goggles), gloves and a gown. Under the [appropriate circumstances](#) a fit-tested N95 respirator or equivalent protection should be used in place of a medical mask.

Activity	Precautions
Before every resident interaction	Staff must conduct a point-of-care risk assessment to determine the health and safety measures required.
All interactions with and within 2 metres of residents who screen negative	<ul style="list-style-type: none"> • Medical mask required • Eye protection (e.g. goggles, face shield) is required for all staff and essential visitors when providing care to a resident with suspect/confirmed COVID-19 and in the provision of direct care within 2 metres in an outbreak area. In all other circumstances, the use of eye protection is based on the point-of-care risk assessment (PCRA) when within 2 metres of a resident. • Perform hand hygiene before and after contact with the resident and the resident's environment and after the removal of PPE.
All interactions with and within 2 metres of residents who screen positive, symptomatic, identified as a high risk contact of a known COVID-19 case, have a confirmed COVID-19 infection, or in an outbreak area	Droplet and Contact Precautions: <ul style="list-style-type: none"> • Medical mask • Isolation gown • Gloves • Eye protection (e.g., goggles, face shield) • Perform hand hygiene before and after contact with the resident and the resident’s environment and after the removal of PPE

Appendix C: PPE Escalations to the Region and Ministry

The escalation process for acquiring PPE for your organization is as follows:

1. Implement conservation and stewardship strategies: [Ontario Health Recommendations to Optimize PPE Supply](#).
2. Use existing supply chain processes and collaboration with local partners to obtain supplies.
3. Expand alternate inventories to obtain supplies: [Ontario Workplace PPE Supplier Directory](#).
4. Continue with the [Critical PPE Requests-Intake Form](#) to escalate to your Regional Lead.

Health service providers are reminded to follow the hierarchy of controls to eliminate or reduce the risks of transmission, and to minimize their need for PPE. Health service providers and employers should be sourcing PPE through their regular supply chain, and they remain responsible for sourcing and providing PPE to their frontline workers. PPE allocation from the provincial pandemic stockpile will continue and PPE can be accessed, within available supply, on an emergency basis for those who have exhausted all efforts to procure their own stock through the established escalation process.