Saskatchewan Health Authority

COVID-19

Saskatchewan Health Authority COVID-19 Outbreak Guidance For Acute Care Facilities

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Summary of Revisions:

Revision Date	Description of changes	Page
Oct-21	Added Section 2 Outbreak Preparedness and included link to Outbreak Preparedness Checklist	5
Oct-21	Updated link in Section 5.3 Identify Contacts/Contact Tracing	7
Oct-21	Updated recommendations on student placements in Section 5.8 Staff Cohorting and Return to Work and removed reference to the Public Health Order	12
Oct-21	Added Section 5.10 Safety Walk/Risk Assessment and included link to Outbreak Response Checklist	14
Oct-21	Revised Patient and Staff Line List	20,21

1 Table of Contents

Introduction

The purpose of this document is to provide guidance for the investigation and management of COVID-19 outbreaks in acute care facilities in an effort to control and prevent further spread to patients and staff within the facility.

This guidance document is based on the latest available scientific evidence about this emerging disease, which is subject to change as new information becomes available.

Key Sources of Provincial COVID-19 Guidance & Information

Provincial guidance and information specific to COVID-19 can be found at:

- Government of Saskatchewan: Ministry of Health (MoH) - Public Health Orders, Notices and Guidance: Control of Transmission of 2019 Novel Coronavirus: https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/treatment-procedures-and-guidelines/emerging-public-health-issues/2019-novel-coronavirus/public-health-measures/public-health-ordersPublic Health Orders
- Saskatchewan Health Authority (SHA) – COVID-19 General Information for Health Care Providers
- Saskatchewan Health Authority (SHA) – COVID-19 PPE/Infection Prevention and Control
- Saskatchewan Communicable Disease Control Manual – COVID-19

2 Outbreak Preparedness

To prepare in advance and assess their readiness to respond to a COVID-19 outbreak, a safety assessment will be conducted by IPAC and Safety* (*if available) once per year, preferably before the respiratory virus season (late summer/early fall). This must be done for each unit/facility using the following tools:

- IPAC Outbreak Preparedness Checklist
- Safety Review Guide for Preparedness
- Health Care Facility Outbreak Safety Walk – Risk Assessment

3 Outbreak Definitions

Confirmed COVID-19 Outbreak:
Two or more individuals* with laboratory confirmed COVID-19 for whom the Medical Health Officer has determined that transmission likely occurred[1] within a common non-household (i.e., unit/floor/facility) during a specified time period (Saskatchewan Communicable Disease Control Manual 2020).

Note: In some instances, outbreak control measures beyond enhanced surveillance may not be required, even if the facility/unit meets the outbreak definition above. Some examples include:

- The second case is a roommate of a known case and the second case has been appropriately placed on Droplet and Contact Plus precautions since identification of the first case. In this example, there should be no ongoing transmission risk from the second case;
- Two cases among staff members who are close contacts of each other and investigation suggests transmission is among the staff only and there has been no transmission risk to patients from the staff cases.

Table 1*Expanded definition for health care workers (HCWs):

Two or more confirmed[2] COVID-19 cases in HCWs linked to a unit/facility[3], AND:

- Where at least one of the HCWs was in the work place during the communicable phase of illness;[4] **OR**
- Work site transmission is suspected as cause for one or more of the infections.

Transmission could have been:

- Patient to HCW transmission; or
- HCW to HCW transmission; or
- Visitor to HCW transmission; or
- The transmission link may thus far be unknown but after detailed review it is clear there was no obvious community risk for infection acquisition.

[1] Reasonable evidence that transmission likely occurred within a common non-household setting include:

- Close contact is confirmed with COVID-19 from 2 to 14 days following exposure;
- Individual with exposure to a setting where confirmed case was present and onset of symptoms consistent with incubation period of COVID-19;
- The individual has been located within a closed setting (e.g. admitted to hospital, residing at a work camp, correctional facility) for ≥ 7 days before symptom onset or date of specimen collection if asymptomatic;
- No obvious source of exposure other than at the setting

[2] Laboratory confirmation of infection with COVID-19

[3] "Unit" may refer to a single acute care unit or area

[4] Communicable phase of illness includes the pre-symptomatic phase (48 hours before onset of symptoms) and the 14 days after symptom onset or until symptom resolution (whichever is longer)regardless of continuous masking

Suspect/Sentinel COVID-19 Outbreak:
One individual** with laboratory confirmed COVID-19 who may have acquired or transmitted COVID-19 in a non-household setting (i.e., unit/floor/facility) would trigger a public health investigation to determine whether an outbreak exists (Saskatchewan Communicable Disease Control Manual 2020).

Table 2 Expanded definition**

May include one of the following scenarios: • One confirmed COVID-19 case in a patient who was admitted to an acute care unit during the communicable phase of their illness and recommended infection prevention and control (IPAC) measures were not in place for any period of time (e.g., inadequate personal protective equipment (PPE) use; and/or breaches in PPE use; and/or inappropriate patient placement/cohorting) resulting in exposure (i.e., close contacts) to HCWs and/or other patients • One confirmed COVID-19 case in a patient seen during the communicable phase of their illness in an outpatient setting within an acute care facility without the recommended IPAC measures (e.g., inadequate PPE use; and/or breaches in PPE use and/or inappropriate patient placement/cohorting) resulting in exposure (i.e., close contacts) to HCWs and/or other patients • One confirmed COVID-19 case in a HCW on an acute care unit who has been at work during the communicable phase of their illness without the use of appropriate PPE • One confirmed COVID-19 case in a HCW on an acute care unit who after investigation is deemed to have acquired their infection at work on the unit through transmission from a confirmed COVID-19 patient or other HCW • One confirmed COVID-19 case in a support person/family member who has visited a patient on an acute care unit or accompanied them into an outpatient setting while infectious • Any other situation the Medical Health Officer/designate[5]/Infection Control has deemed a significant COVID-19 exposure to patients or staff

4 Declaration of an Outbreak

- The Medical Health Officer (MHO)/designate is responsible for declaring a COVID-19 outbreak and assigning an outbreak number.
- Public Health (PH) and/or Infection Prevention and Control (IPAC) will submit an Outbreak Notification Form and Summary Report. Refer to:
  - Instructions for Outbreak Notification and Summary Form
  - WS0052 COVID-19 Outbreak Notification and Reporting Process for Suspect/Confirmed Outbreaks in Health Care Facilities

5 Outbreak Response - Confirmed Case/Outbreak - First 24 Hours

IMPORTANT: All outbreak prevention and control measures indicated in this document apply to both suspect and confirmed outbreaks. Exceptions: 5.6 Laboratory Testing, 5.8 Staff Cohorting and Return to Work and 5.9 Patient Movement (Admissions, Transfers)

[5] Designate may be Infection Control Officer (i.e., Medical Microbiologist, Infectious Disease Physician) in the acute care setting

REMEMBER: Early detection and immediate implementation of infection prevention and control measures are two important factors in reducing the impact of an outbreak.

5.1 Isolate Index Case(s)/Lab Confirmed

Staff Case

- Lab confirmed staff member is excluded from work until released by PH.

Patient Case

- Place lab confirmed patient on Droplet/Contact Plus precautions.

5.2 Identify Additional Symptomatic Patients & Staff

- Initially assess all patients and staff for signs and symptoms of COVID-19 using:
  - Inpatient, Outpatient and Continuing Care Screening Form
  - Health Care Workforce Screening Questionnaire
- Immediately place all symptomatic patients on Droplet/Contact Plus precautions

QUICK TIP: Consider using Signs and Symptoms Daily Monitoring Form – Acute Care daily for quick identification of symptomatic patients.

5.3 Identify Contacts/Contact Tracing

- IPAC, PH and Occupational Health & Safety (OHS) will collaboratively trace and advise all named contacts to the confirmed cases(s) during the outbreak investigation (Refer to Exposure to COVID-19 Package and IPAC Contact Tracing Documents for more information).

Isolate Close Contacts

- Exposed roommate(s) should not be transferred to any other shared room for 14 days from last exposure.
- Place patient(s) identified as close contacts on Droplet/Contact Plus precautions.

Communication of Discharged Contacts

- Notify facilities (Acute or Long Term Care) where patient close contacts had been transferred or discharged to in the last 14 days.

Visitors of Case

- A log of visitors should be kept and retained for contact tracing purposes (refer to SHA 0072 COVID-19 Screen Form Log - Repeat Visits). In the event contact tracing is required, the unit will provide a list of all visitors that had contact with the case to PH.

5.4 Line Lists

- Unit manager/charge nurse/designate will initiate Patient and Staff line lists (Appendix A and Appendix B) and provide this to IPAC/PH and/or OH&S (staff line lists only). Line lists will continue to be updated (e.g., date recovered, new symptoms, etc.) and new cases added to the original list as they are identified.

- All sick calls from staff should be screened for symptoms of COVID-19 and added to line list, if symptoms compatible.
- Retain line list forms on the unit for IPAC/PH to review daily or fax to a central location as per local process.

5.5 Patient Placement and Additional Precautions

REMEMBER: For suspect and confirmed outbreaks, only the lab-confirmed patient case(s), patient(s) deemed close contacts and those with symptoms are placed on Droplet/Contact Plus precautions.

Cohort Patients

- Place confirmed COVID-19 patients in single rooms and cohort in a section/wing of the unit to facilitate care and limit contact between COVID-19 patients and other patients.
    - If single rooms are not available, cohort confirmed COVID-19 patients in shared rooms ensuring 2 metres of separation between bed spaces. Attempts should be made to not cohort patients with other conditions warranting precautions (Influenza, MRSA, etc.).
- Refer to IPAC Recommendations for Cohorting Patients on Additional Precautions in Acute Care for details.

Personal Protective Equipment (PPE)

- Continuous mask and eye protection[6] is required for all staff providing direct care or anticipating contact with any patients on the outbreak unit (regardless of whether the patient is on precautions).
- Follow Personal Protective Equipment (PPE) Guidelines when caring for patients confirmed to have COVID-19 in Designated Units/Cohorted Spaces.
- If unable to cohort patients in a section/wing of unit, follow PPE Guidelines for Staff in All Health Care Settings during COVID-19
- Re-emphasize donning and doffing sequences with staff. Refer to:
    - Putting on (Donning) PPE
    - Taking off (Doffing) PPE
- PPE removal posters are placed inside the room, ideally above the garbage and/or linen hamper.
- Appropriately stocked PPE carts/tables have been placed (e.g., masks, goggles (non-vented or indirectly vented) or face shields, gowns and gloves) outside room. Ensure there are sufficient quantities to last a minimum of 72 hours.
    - All PPE should be kept off the floor;
    - Refrain from folding gowns (i.e., keep in bag); refolding may result in potential contamination of clean linen.

[6] Eye protection refers to face shield or goggles (indirectly or non-vented)

PPE QUICK TIPS: CONTINUOUS MASK & EYE PROTECTION

- Mask and eye protection may be worn for repeated interactions with multiple patients for a maximum of one shift.
- Change mask when wet, soiled or damaged. Discard when taking a scheduled break and at end of shift.
- Disinfect eye protection when soiled. Remove and disinfect before a scheduled break and at the end of the shift. Discard face shield at the end of shift.

PPE QUICK TIPS: GOWN & GLOVES

- Always change gloves between each patient encounter. Perform hand hygiene after removing gloves.
- COVID-19 Designated Units/Cohorted Spaces: The same gown may be worn for repeated interactions with multiple COVID-19 positive patients until the gown becomes wet, soiled or damaged. Gowns MUST be removed prior to entering common clinical spaces (e.g., nursing desk or unit work station, medication room, sterile or clean supply room and utility rooms. This does not include a corridor or space between designated COVID positive private rooms or multi-bed rooms).
- Gowns must be changed between each patient encounter when moving from lab-confirmed COVID-19 positive patient rooms to suspect patient rooms.

Outbreak Signage

- Post outbreak signage at entrances to unit or facility as appropriate (refer to Outbreak Posters).

Hand Hygiene

Strict hand hygiene is the single most important measure in preventing spread of infections for both staff and patients. Hand hygiene is everyone's responsibility.

- Staff have reviewed and know when and how to perform hand hygiene according to SHA Hand Hygiene policy (specifically how to perform hand hygiene and the 4 Moment for Hand Hygiene).
- When possible, instruct patients how to perform hand hygiene and respiratory hygiene.
- Ensure alcohol-based hand rub (ABHR) is readily available and accessible to patients and HCWs at all facility and unit entry and exit points, common areas, and at point-of-care in the patient's room.
- Soap, paper towel and ABHR dispensers should be checked daily and replaced as needed.
- Glove use is not a substitute for hand hygiene. Hand hygiene is required after glove removal.

REMEMBER – 4 Moments for Hand Hygiene

1. BEFORE initial patient/patient environment contact
2. BEFORE aseptic procedure
3. AFTER body fluid exposure risk
4. AFTER patient/patient environment contact

5.6 Laboratory Testing

- For suspect outbreak, at a minimum test staff and patients who are symptomatic, close and non-close contacts. Additional testing may be at the discretion of the MHO/designate.
- For confirmed outbreak, perform initial unit wide testing (staff and patients) to help identify source and/or case(s) where transmission may have occurred.

    - Ancillary staff (e.g., therapies, environmental services, lab, etc.) is usually not included unless it is felt that transmission/source may have occurred.
    - Patients and staff who are considered COVID-19 recovered[7] do not need to be tested or isolated.
    - Testing may be decreased if the source of transmission is known and has been identified in a timely manner where secondary transmission is unlikely to have occurred.
    - While awaiting test results, staff are expected to continue working provided they pass the Health Care Workforce Screening Questionnaire.
- The initial testing should be performed as soon as possible (within 24hr of the declaration) on patients and staff.
    - Unit/facility should organize peer-to-peer testing of staff.
    - Staff may choose to seek testing in the community if they are not scheduled to work for the next 2-3 days. In this instance, the Manager should provide the staff member with the outbreak number for use on the requisition.
    - Staff/patients that have tested positive within the last 90 days are not to be re-tested as they are considered immune/non-infectious.
    - Patients who have been tested within 48 hours do not need to be re-tested unless they have developed symptoms compatible with COVID-19 since their last negative test.
    - Staff that have been tested within 48 hours do not need to be re-tested unless they have developed symptoms compatible with COVID-19 since their last negative test. Refer to Return to Work Guide for staff testing and isolation.
- For confirmed outbreaks: at minimum, all staff and patients should be tested every 7 days using POC-PCR (if available). Depending on transmission dynamics and availability of test kits/human resources, increased frequency may be recommended (e.g., every 2-3 days). Refer to Acute Care Test Selection Guide.
- For more information on testing, specimen collection and lab requisitions, refer to COVID-19 Testing.

5.7 Communication and Cancellations

Assemble C-ORT

- The local COVID Outbreak Response Team (C-ORT) will oversee control of the outbreak and should include (as applicable), but is not limited to:
    - Medical Health Officer (MHO) or designate
    - Infection Prevention and Control (IPAC)
    - CD Coordinator
    - Occupational Health and Safety/Employee Health Nurse
    - SHA Site Leader
    - Unit/Facility Manager
    - Environmental Services
    - Lab Services
    - Additional membership based on the extent of the outbreak and anticipated support requirements (i.e., security, supply chain, etc.).

[7] Considered COVID-19 recovered if confirmed infection has been within 90 days of symptom onset or date of specimen collection, if asymptomatic AND criteria for discontinuation of precautions has been met

- Initially, the C-ORT should meet daily (should occur in the morning) to discuss and review the situation until the outbreak is declared over (refer to Sample Outbreak Response Daily Huddle Agenda). Ensure any issues/barriers that were identified during the daily huddle are escalated appropriately. The frequency of meetings may be reduced once the outbreak preventative measures are in place and no further transmission has been reported.

Communication

- Communication plan/notification strategy initiated for staff
  - Notify staff through usual process (i.e., phone calls, e-mail, text)
- Ensure all departments are notified of outbreak status, including laundry, food & nutrition, therapies, environmental services etc.

REMINDER FOR STAFF:
- Be diligent with hand hygiene
- Change uniforms at work
- Leave shoes at work

Cancellations

- Cancel/reschedule outside contractors scheduled to perform work on the outbreak unit unless the job is urgent or related to resolving the outbreak (i.e., oxygen, respiratory equipment).

5.8 Staff Cohorting and Return to Work

Cohorting Principles for Suspect Outbreak

1. Staff should be cohorted to the unit for the duration of their shift and should not move to other units or facilities within the same day. Emphasis should be on the daily "fit to work" self-assessment

Cohorting Principles for Confirmed Outbreak

1. All staff on the outbreak unit should be cohorted to that unit starting on the date the outbreak was declared.
   - If support services staff cannot be dedicated to the outbreak unit, then staff should organize workflow whereby tasks are performed on non-outbreak units first and the outbreak unit last.
   - Staff who has worked on the outbreak unit cannot work on another unit until 14 days after their last shift or until the outbreak is declared over (whichever is earlier), unless directed otherwise.
2. For integrated facilities (where one or both areas are in outbreak), there may be consideration for staff to work in both the acute care and long term care areas after consultation with the MHO and/or designate.
3. Staff should not move from an outbreak unit to long term care homes and private care homes. If for operational reasons it is not feasible for all staff in all settings and/or geographies to work at only one site, exceptions may be made by an MHO.
4. Where necessary, staff from the outbreak unit may work concurrently on another outbreak unit/facility provided the outbreaks are due to the same causative organism (e.g., both units are experiencing an outbreak due to lab-confirmed COVID-19).
5. In the event of severe staff shortages, staff working in the outbreak unit may work in a non-

outbreak unit (excluding Oncology, Hemodialysis, Transplant units) provided they have had no personal protective equipment (PPE) breaches and do not screen positive on the daily "fit to work" self-assessment and only after consultation with IPAC. Before starting a shift on another unit, staff must shower and put on a clean uniform.

6. Oncology, hemodialysis and transplant units are considered high-risk, and as such, staff who has worked on the outbreak unit cannot work on these units until:
   - The outbreak has been declared over OR 14 days after their last shift (whichever is earlier); and
   - They screen negative on the Health Care Workforce Screening Questionnaire
7. In rare instances when staffing shortages will significantly impact daily operations and only after all other means of obtaining staff are exhausted, staff from the outbreak unit may be permitted to work on high-risk units (identified above)/Long Term Care Homes/Private Care Homes prior to the timelines indicated in #6 provided all criteria below has been met:
   - Consultation with the Medical Health Officer/designate and operational leadership has occurred and they are in support of this staffing plan;
   - There is confirmation of no PPE breaches;
   - Staff member must test negative on the last day of exposure (i.e. last day worked on the outbreak unit). In addition,
     - Where point of care testing is available, the staff member must subsequently test negative every two days (or next scheduled shift worked) until 14 days has elapsed since last exposure
     - Where point of care testing is not available, the staff member must test negative on day 7 (or as close to) and day 14 post exposure
   - Staff must continue to self-monitor daily for symptoms
8. Any health science students (e.g., Medicine, Nursing, Pharmacy & Nutrition, Rehabilitation Science, Dentistry, Lab, etc.) in preceptored or group clinical placements will be allowed to complete their placements on a unit where an outbreak has been declared, regardless if the placement has started. Students will follow the same cohorting principles for confirmed outbreaks that apply to their discipline provided health science programs commit to ongoing PPE training, comply with the SHA vaccine policy and minimize time on outbreak units for those learners that cannot be cohorted.

Return to Work

- Staff/Physicians/Students with symptoms of COVID-19 are to remain off work as per the Return to Work Guide.
- As part of contact tracing, staff will be deemed a close contact, non-close contact or not a contact as per the Health Care Worker Risk Matrix Tool and recommended actions will be based upon their exposure.
- Staff who have tested positive for COVID-19 must remain off work until released by Public Health.

5.9 Patient Movement

Admissions

- For suspect outbreaks, there are no restrictions to admissions.
- For confirmed outbreaks, admissions to the outbreak unit should be discouraged. Exceptions: Lab-confirmed patients may be admitted if the outbreak is occurring on the COVID-19

designated unit (Refer to IPAC Recommendation for Cohorting Patients on Additional Precautions in Acute Care)

- The decision to admit to the outbreak unit must be made in consultation with the MHO/designate prior to admission. This decision should be based on the following factors to mitigate/decrease risk to the patient:
  - Current status of the outbreak and its management – is the outbreak considered under control (i.e., attack rate, severity of illness, length of time since the last case and where transmission chains are understood)
  - Patient factors – consider not admitting patients who are at an increased risk of complications due to COVID-19 (e.g., over 60 years of age, immunocompromised); unable/unwilling to comply with IPAC measures or have conditions requiring extensive care where staffing ratio may be jeopardized
  - Unit factors – multi-bed rooms; wards that are overcapacity, unit that provides specialized care (e.g., critical care)

    Note: overcapacity spaces should never be utilized during an outbreak
  - HCW capacity – sufficient staffing available to manage
- Admissions can still continue to other units not on outbreak at a facility. If there is a facility-wide outbreak, decisions must weigh the risk of admitting patients versus the risk of not having a service available.

Transfers

If transfer to other units/facilities or if leaving the unit for medically necessary tests is required:

- Advise EMS and/or receiving unit that patient is COVID-19 positive (case), symptomatic or deemed a close contact.
- Maintain ***Droplet/Contact Plus precautions*** during transport.
- If the patient will tolerate a mask, have them wear one.
- For confirmed outbreak, precautions must be continued for 14 days post transfer or until the outbreak is declared over, whichever is sooner. These measures apply to all patients leaving the outbreak unit, including those patients not currently on precautions. Note: Patients who are considered COVID-19 recovered[8] do not need to be placed on precautions.
- For suspect outbreak, if deemed a close contact, continue precautions for 14 days after date of last exposure. If there are lab confirmed or symptomatic patients, refer to the ***Patient Placement and Precautions Table – Acute Care*** for duration of precautions.

Discharges

To home in community:

- A positive COVID-19 test result should not delay discharge home if the patient is medically stable (this includes patients who are considered still infectious).
- Patients who are discharged into the community will be followed up and advised by PH whether they need to need to self-isolate or self-monitor. Patient information sheets for self-monitoring and self-isolation can be provided prior to discharge.

[8] Considered COVID-19 recovered if confirmed infection has been within 90 days of symptom onset or date of specimen collection, if asymptomatic AND criteria for discontinuation of precautions has been met

Discharges to the sites below may still be permitted as per MHO or designate:

To Shelters, First Nations Communities, Metis Settlements and Correctional Facilities:

- Generally, discharge of patients from acute care outbreak units/facilities to these locations should be avoided except when patient is known to be COVID-19 recovered (e.g., tested positive and no longer on isolation).
- Consider discharge only when communications with the receiving site/community has been established and the discharge is accepted.

To Long Term Care and Personal Care Homes:

- Refer to Move-In to Long Term Care or Personal Care Home from Acute Care or Other Long Term Care document for details.

5.10 Safety Walk/Risk Assessment

A safety walk/risk assessment will be conducted after and in response to a suspect or confirmed COVID-19 outbreak having been declared on a unit/facility (Note: this does not apply to outbreaks declared in non-patient care areas). It must be completed by IPAC, Safety* (*if available) and the unit manager/designate using the following tools:

- IPAC Outbreak Response Checklist
- Health Care Facility Outbreak Safety Walk – Risk Assessment

Process for conducting a safety walk/risk assessment

A safety walk/risk assessment is to be conducted by IPAC and Safety within 72 hours of the declaration of an outbreak. Arrangements for the initial assessment must be made in advance with the unit manager/designate. Important: Subsequent/follow-up visits may not always be announced or planned and may occur without prior arrangements made.

1. Suspect outbreak:
   - May conduct a safety walk/risk assessment at the discretion of the ICP and IPAC Manager (consider factors such as any deficiencies identified from the preparedness checklist and safety review, issues/concerns arising from the C-ORT daily huddle, etc.).
   - If a risk assessment is needed, consider conducting virtually (e.g., phone, WebEx, FaceTime).
2. Confirmed outbreak:
   - Must conduct a safety walk/risk assessment on-site.
3. Recurring outbreak less than 3 months:
   - IPAC will review the previous health care facility outbreak safety walk risk assessment tool and work with the unit/facility manager to determine if there are any outstanding deficiencies. At the discretion of the ICP and IPAC manager, another safety walk/risk assessment may be conducted (consider factors such as staff capacity and resources, outstanding risk assessment deficiencies and the level of support requested by the unit/facility manager).
   - If a risk assessment is needed, consider conducted virtually (e.g., phone, WebEx, FaceTime).
4. Recurring outbreak greater than 3 months:
   - Must conduct an additional safety walk/risk assessment on-site, as capacity and resources allow.

5. Additional site visits/audits (e.g., hand hygiene audits, tub room audits, etc.) may be done more frequently and on additional units/areas (e.g., clean and dirty service rooms) as part of routine IPAC work at the discretion of local ICPs and the IPAC manager.

6 Ongoing Outbreak Management

NOTE: The unit manager/charge nurse/designate is responsible for ensuring the implementation of the following control measures.

Depending on the layout of the facility, the location of cases and the degree of unavoidable movement of HCWs between units, outbreak measures may be applied to specific units, or to the entire facility, at the discretion of the MHO.

6.1 Monitoring of Symptoms

- Perform ongoing monitoring and assessment of all patients on the unit/facility for new symptom onset, including temperature checks at least once per shift (twice daily). Any patient who develops symptoms consistent with COVID-19 during the incubation period must be added to the Line List and placed on Droplet/Contact Plus precautions.
- Continue to actively monitor all patients and staff for symptoms for the duration of the outbreak.

QUICK TIP: Consider using Signs and Symptoms Daily Monitoring Form – Acute Care for quick identification of symptomatic patients

6.2 Risk Reduction Strategies

Risk reduction strategies may be implemented for ill patients who can't/unable to remain in their room.

THINK MR. CLEAN:
Mask (as tolerated),
Redirect back to their room,
Clean their hands,
Lead others away (keep sick away from the well),
Environmental cleaning of areas they are in,
All staff can help,
No go (visual barriers).

6.3 Equipment Cleaning

- Use disposable equipment when possible.
- All reusable equipment and supplies, along with toys, electronic games, personal belongings, etc., should be dedicated to the patient until discharge.
- If reusable equipment cannot be dedicated to a single patient, clean and disinfect thoroughly before use on another patient. Remember to clean the entire piece of equipment and not just the area that comes into contact with the patient.
- Items that cannot be appropriately cleaned and disinfected should be discarded upon patient discharge or transfer.

- Process is in place to clearly identify clean and dirty patient equipment (e.g., tags marked “I am clean”). A clear separation between clean and dirty carts and equipment should exist.
- Review and identify which surfaces/items unit staff is responsible for cleaning.
- Increased cleaning of high touch surfaces, at minimum twice per day
  - Patient wheel chairs – hand contact areas
  - Telephone/keyboard/desk and chair arms/backs at nursing stations
  - Medication carts – hand contact areas

6.4 Enhanced Cleaning

- A minimum of twice daily cleaning should be completed by environmental services staff in ill patient rooms and all common areas of the affected unit.
  - If staff cannot be cohorted and must move between areas, they are to avoid contact with the ill patients and visit the outbreak unit last.
- Cleaning is always performed from clean areas to dirty areas. Clean additional precautions rooms last.
- Consider paying particular attention to high touch surfaces including:
  - Staff and public washrooms (sinks/taps/toilets)
  - Hand rails/stair rails
  - Call lights/bed rails/overbed tables
  - Light switches/elevator buttons
  - Door knobs, push plates
  - Common area TV remotes/public phones
- Terminal clean of the room should be completed when additional precautions are discontinued.
  - In multi-bed rooms, all beds and bed spaces require a terminal clean.
- Rooms and surfaces are free of clutter to enable easy cleaning and disinfection of surfaces (e.g., hallways, nursing stations, patient rooms etc.).
- Clean linen is to be covered and kept away from contaminated items (e.g., dirty linen hampers, garbage bins).
- Indoor garbage cans should be hands-free (e.g., has foot release or the lid removed).
- When unit staff and environmental services staff both participate in the cleaning on the unit; ensure documentation exists of cleaning responsibilities.

6.5 Food Service Delivery

- Food services staff should not enter outbreak units or at minimum Droplet/Contact Plus precautions rooms.
  - Whenever feasible, it is advised that food carts be dropped off and then picked up by food services staff at the entry onto the outbreak unit, and the unit staff deliver the trays to the patients.
  - If staff are unable to be appropriately cohorted, well patients are served first followed by the ill patients.
- Cart handles should be cleaned and disinfected before entering and after leaving the outbreak unit
- Staff must perform hand hygiene:
  - Prior to delivering food trays
  - Between assisting patients during meals as per the 4 Moments for Hand Hygiene
  - After leaving patient rooms, units or floors when delivering and picking up food trays

- Staff should ensure hand hygiene is performed or assist (when necessary) all patients with hand hygiene prior to eating.
- Regular dishes and cutlery should be used (i.e., disposable not required). No special precautions are required for handling of dishes (i.e., bagging of the dishes is not required; regular dishwashing processes are adequate to clean dishware etc.).
- Automatic ice dispensing machines should be used by staff only (i.e., bulk ice machines with a scoop are not allowed).
- Holding carts and dish trolleys (including the wheels) are cleaned and sanitized as per local processes.
- Kitchenettes on units should be restricted to staff use only during the outbreak. Only single-serve items should be made available.

6.6 Family Member/Support Person Restrictions

- Confirmed outbreak – Family presence will be moved to Level 3 unless communicated by the local MHO/designate (refer to SHA Family Presence during a Pandemic policy).
- Suspect outbreak – Consult with local MHO/designate before moving to Level 3.
- Those permitted to enter the facility must be screened using General Family and Supports Pre-Screening Tool.

6.7 Discontinuation of Precautions

- Refer to Patient Placement and Precautions - Acute Care

Note: A dry cough may persist for several weeks, so a dry cough alone as a symptom does not indicate transmissibility or warrant continuation of isolation.

6.8 End of Life COVID-19 Related Care

- It is recommended that all deaths that occur during the outbreak regardless of symptoms are swabbed and tested for COVID-19.
- Refer to Death, Care of the Body During COVID-19 Pandemic document for information concerning handling of the deceased body, patient belongings and swabbing.

7 Declaration of End of Outbreak

- All outbreak measures must remain in place until the MHO/designate declares the outbreak over, at which time all excluded staff, students, volunteers and others may return to work/placement, provided they pass the Health Care Workforce Screening Questionnaire.
- An outbreak may be declared over when two incubation periods have passed (i.e., 28 days) after the last date of exposure, without any new cases; however, in acute care this may be shortened to one incubation period (i.e., 14 days) when outbreak preventative measures have proven effective and no further transmission has taken place. This would may be at the discretion of the MHO/designate.
- In integrated facilities, the shortened incubation does not apply because staff may be working in both areas.

Suspect Outbreak Measures can be lifted if 14 days have elapsed since:

- The patient case was placed on Droplet/Contact Plus precautions or their date of discharge, **OR**
- A staff case in the communicable phase of illness was on the unit, **OR**
- A visitor case in the communicable phase of illness was on the unit, **AND**

- There are no new cases in patients and/or HCWS on the unit in the 14-day follow-up period, **AND**
- The results of the day 14 unit wide test are negative.

Confirmed Outbreak Measures may be lifted if 14 days have elapsed since:

- The last patient case was placed on Droplet/Contact Plus precautions or their date of discharge, **AND**
- There is no evidence of ongoing transmission after the date when outbreak measures were implemented, **AND**
- No unprotected exposures to patients/staff from patient or staff cases (e.g., date of isolation of last case in a patient; or, date of last shift in a staff member who worked during the period of communicability with possible unprotected exposure(s) to patients/staff), **AND**
- The results of the end of outbreak unit wide test are negative.

Once the outbreak is declared over:

- An outbreak report will be completed and submitted by PH and/or IPAC. Refer to:
  - Outbreak Notification Form and Summary Report
  - WS0052 COVID-19 Outbreak Notification and Reporting Process for Suspect/Confirmed Outbreaks in Health Care Facilities
- Provide notification of the end of the outbreak to all staff and units who were notified of the start of the outbreak.
- Remove all outbreak signage.
- Re-stock any supplies depleted during the outbreak, including swabs for viral testing.
- Consider debriefing with C-ORT and facility staff to evaluate the management of the outbreak.
- Remain alert for possible new cases in staff and patients.
- Report any newly identified cases in a timely fashion.

8 Outbreak Debrief

It is strongly recommended that the C-ORT and staff from the outbreak facility schedule a debriefing session as soon as feasible following the end of an outbreak. The purpose of the debriefing session is to evaluate the management of the outbreak, identify interventions that worked well and discuss processes that can be improved (i.e., lessons learned), for instance:

- Communication
- Timeliness in recognizing and reporting outbreak
- Timeliness in implementing control measures
- Effectiveness of control measures in limiting the outbreak

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Appendix A – Patient Line List

Outbreak #: **Date Declared:**

Unit/Facility:

Contact Name: **Phone Number:**

Case ID	Daily Update (past 24 hours)											Complications		Specimens			Vaccination Status	Precautions	
Case # Room #	Baseline Temp & SpO_2	Date	Date of illness (Day 0 is onset of symptoms)	Fever	Cough (dry (D)/wet (W)	Runny nose (R) Nasal congestion (C)	Sore throat (S) Hoarse voice(H)	Headache	Myalgia (muscle pain)	Chest congestion	Malaise (M) Chills (C)	Others	Bronchitis/ Pneumonia	Death (d/m/y)	NP Swab Taken Date (d/m/y)	Results/VOC	Other	Fully Vaccinated (y/n)	Start Date	Removal Date
			Day 0																	
			Day 1																	
			Day 2																	
			Day 3																	
			Day 4																	
			Day 5																	
			Day 6																	
			Day 7																	
			Day 8																	
			Day 9																	
			Day 10																	
			Day 11																	
			Day 12																	
			Day 13																	
			Day 14																	
			Day 15																	

Comments/Diagnosis/Pertinent Respiratory History:

☐ Wanderer/non-compliant with precautions

Appendix B – Staff Member Line List

Outbreak #: **Date Declared:**

Unit/Facility:

Contact Name: **Phone Number:**

Case ID		Daily Update (past 24 hours)									Complications		Specimens			Investigation		
Name & HSN	Role	Onset date	Temperature	Cough (dry (D)/wet (W)	Runny nose	Hoarse voice	Sore throat	Headache	Myalgia	Others i.e. malaise	Bronchitis/ Pneumonia	Hospitalization (d/m/y)	NP Swab Taken Date (d/m/y)	Results/VOC	Other	Dates & floors/areas worked while infectious	Return to work date	Fully vaccinated (y/n)
Case#: Name: HSN:																		
Comments:																		
Case#: Name: HSN:																		
Comments:																		

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