COVID-19 guidance document for long-term care homes in Ontario

Learn more about requirements for long-term care homes with respect to COVID-19.

On this page

Highlight of changes

As of August 20, 2021, the following changes to this document were made and are in effect:

- Added a fall preparedness checklist to support proactive planning, organizing, and prioritization activities in homes
- Added information regarding COVID-19 vaccine third doses

- Updated the section on IPAC to provide additional information and guidance and to set out important reminders
- Revised the rules and requirements regarding resident cohorting including providing allowance for the mixing of resident cohorts
- Clarified the definitions of the different types of visitors and clarified masking rules for singers and musicians visiting a home for the purpose of performing

Purpose

The purpose of this document is to provide licensees of long-term care homes, as defined in the *Long-Term Care Homes Act, 2007* (the Act), with general information on requirements set out by the Province of Ontario with respect to the COVID-19 pandemic, including those set out in Directive #3, issued by the Chief Medical Officer of Health (CMOH), and to help homes in developing approaches for operating safely while providing the greatest possible opportunities for maximizing resident quality of life.

It also outlines Ministry of Long-Term Care ("MLTC") visitor policies and is provided to support homes in implementing the requirements to safely receive visitors while protecting residents, staff, and visitors from the risk of COVID-19.

This document is to be followed in conjunction with any applicable legislation, directives, and orders and is not intended as a substitute and does not constitute legal advice. This document should be followed unless there are reasonable health and safety reasons to exercise discretion or as ordered by the local public health unit. In the event of any conflict between this document and any legislation, directive, or order, the legislation, directive, or order prevails. Additionally, this document is not intended to take the place of medical advice, diagnosis, or treatment.

The definition of fully Immunized for the purposes of this document, are as defined in Directive #3, with respect to COVID-19 immunization.

As we collectively move forward on the path to recovery, all homes are asked to continuously review and update their policies and procedures to align with evolving direction from the government and public health experts and to do so in consultation with their residents, Residents' Councils, Family Councils, and team members while continuing to maintain a steady focus on residents' overall health and well-being and quality of life.

Fall 2021 Preparedness Planning

Planning for the upcoming change of season is critical for maintaining services and supports in long-term care homes and minimizing the introduction and spread of COVID-19. Building on the preparedness assessment framework implemented by homes in late summer 2020, MLTC has developed a checklist to help homes assess and update their preparedness plan for the upcoming 2021 fall season. When developing preparedness plans, homes should be as flexible and adaptable as possible to changing circumstances (e.g., a localized outbreak or a significant fourth wave of the Delta variant or a new variant against which vaccines are not as effective).

While homes have high COVID-19 vaccination rates, the upcoming fall season is expected to include a rise in positive cases as well as the return of the seasonal flu and other respiratory viruses. At the same time, there will be fewer opportunities to have visits outdoors and hold group activities outdoors.

Given the variation in homes' physical layout, staffing approaches, size/number of beds, and access to community-based services/supports, the checklist is meant to support homes in developing a fall preparedness plan that meets the unique needs and circumstances of each home.

When completing their fall preparedness checklist in the Appendix, licensees are encouraged to engage with residents and a wide range of staff and consult with their Family Councils and Residents' Councils.

Vaccination

The goal of the provincial COVID-19 immunization program is to protect Ontarians from COVID-19. Vaccines minimize the risk of severe outcomes, including hospitalizations and death, due to COVID-19, and may help reduce the number of new cases.

All vaccines provided as part of Ontario's vaccine rollout are **safe and effective**; vaccines provide high levels of protection against hospitalization and death from COVID-19.

Maximizing the number of persons who are vaccinated in homes is critically important. Homes should continue to actively encourage all residents, staff, caregivers, and persons attending or conducting activities in homes to be vaccinated as soon as possible.

Vaccine Maintenance Strategy

In an effort to decrease barriers and help increase vaccination rates closer to 100%, including the administration of third doses to residents, the Ministry of Health ("MOH") and MLTC have worked together with local public health units to facilitate and improve access to vaccines in homes, through the development of a Vaccine Maintenance Strategy that supports the readiness of LTC homes to administer vaccines directly to their residents, staff, and essential caregivers, wherever possible. The strategy aims to:

- Recognize and increase capacity within LTC to administer COVID-19 vaccines independently
- Decrease barriers to vaccine access
- Achieve and maintain a high coverage rate for residents, staff and essential caregivers in homes
- Improve confidence in the COVID-19 vaccination program, and
- Continue to build the foundation for the administration of vaccines, including COVID-19 vaccines, to be given routinely within homes.

Broadly speaking, the strategy requires:

- Public health units working with long-term care homes, as well as other community and health partners as needed, to develop and implement an approach for independent administration of vaccines by homes where the home indicates interest and capacity to do so.
- Public health units continuing to support homes who are not able to independently administer vaccine through alternative approaches to ensure continued access to vaccine doses (e.g., mobile/onsite clinics, hub model, etc.).

To support public health units and long-term care homes to implement this strategy, the ministries have developed an Onboarding and Readiness Toolkit that includes guidance on program planning and governance, communication protocols, logistics and oversight, vaccine storage, IT requirements, data reporting, and clinical guidance, among other topics. For more information, please refer directly to relevant source materials on the ltchomes.net website.

Note: Onsite vaccination clinics in homes, regardless of who is administering the vaccine, **must abide by provincial vaccine-eligibility requirements** as set out in Ontario's COVID-19 Vaccination Plan.

Local public health units are responsible for the COVID-19 vaccine rollout in their jurisdiction. Homes should work with their local public health units to:

- arrange for onsite vaccine administration wherever possible;
- support and arrange those who need to book appointments at offsite clinics where necessary
- communicate actively to staff to promote such opportunities.

Any questions from the home regarding vaccination should be directed to the local public health unit.

COVID-19 Vaccine Third Dose

As a result of increasing presence of the Delta variant in the province, along with weaker immune response in older populations, the Province announced that residents in long-term care homes will be eligible to receive third doses of a COVID-19 vaccine to ensure the safety of senior populations in high-risk congregate settings. The Province, including the Chief Medical Officer of Health, strongly encourages all residents in homes to take advantage of the third dose being offered to maximize protection from COVID-19.

As announced on August 17, 2021, eligibility for third doses will include, among others, residents in high-risk congregate settings (i.e., long-term care homes). Residents of homes will be eligible to receive their third dose five months after they received their second dose. If readily available, third doses should be the same product as second doses, but the mRNA vaccines (i.e. Pfizer-BioNTech and Moderna) can be interchanged if needed for operational reasons.

Consistent with the Vaccine Maintenance Strategy, public health units and homes should continue to work together to set up homes to independently administer COVID-19 vaccines and begin working on administering third doses to residents as soon as possible. Where homes do not have the ability to do so, public health units are expected to continue to work with homes to identify the appropriate approach for administering third doses in homes (for example, through the use of mobile teams).

Minister's directive – Long-term care COVID-19 immunization policy

As part of ongoing efforts to encourage vaccination uptake in long-term care homes, the Minister of Long-Term Care issued a Minister's Directive requiring homes to have a COVID-19 immunization policy. At a minimum, the home's policy must require staff, student placements, and volunteers to do one of three things:

1. provide proof of vaccination against COVID-19
2. provide a documented medical reason for not being vaccinated against COVID-19
3. participate in an educational program approved by the licensee about the benefits of vaccination and risks of not being vaccinated if not providing proof of vaccination or a medical reason for not being vaccinated

The Minister's Directive came into effect on July 1, 2021.

Further details are available in the Minister's Directive: Long-term care home COVID-19 immunization policy.

Long-term care COVID-19 vaccine promotion toolkit

The Ministry of Long-Term Care's Long-term care COVID-19 vaccine promotion toolkit is available in 12 languages. Licensees and home administrators are encouraged to use the toolkit to support vaccine education and raise awareness by distributing widely with their home community.

All long-term care home licensees and home leadership are asked to continually amplify messages about the benefits of vaccination and to take all actions that might help with uptake, such as:

- having one-to-one conversations about vaccination with every team member
- tailoring messages regarding the benefits of vaccination so they resonate with the unique staff characteristics and needs within a home
- working with local public health units to find onsite vaccination opportunities wherever possible to vaccinate current and new staff, new residents who have not been vaccinated pre-admission and residents who need a second dose

- giving staff the opportunity to go to an offsite vaccination clinic during paid work time and covering the transportation costs (where onsite options are not feasible)
- assisting staff with booking vaccine appointments
- identifying vaccine champions including primary care physicians, seasoned staff, and faith or cultural leaders to talk to staff directly (for example, through a virtual event) and share their personal stories

Note: If workers in long-term care homes are seeking to be immunized against COVID-19, they may visit the Ontario vaccine booking site or their local public health unit website to identify opportunities for vaccination, including pop-up vaccine clinics. To facilitate accurate data collection in the provincial data base for the administration of the COVID-19 vaccine, workers should identify themselves as long-term care home workers employees and provide the name of the home they work in at the time of their vaccination (for each dose administered).

Homes should be aware that vaccines can cause mild side effects and reactions. These can last a few hours or a couple of days after vaccination.

Infection prevention and control

There is an ongoing need to protect long-term care home residents and staff from COVID-19 as well as other infections, particularly as residents are more susceptible to infection and are at an increased risk of severe illness and death from COVID-19 due to their age and underlying health conditions.

Section 86 of the *Long-Term Care Homes Act, 2007* requires that every home have an IPAC program. Section 229 of Ontario Regulation 79/10 under the Act contains additional requirements, including that homes follow an interdisciplinary team approach in the coordination and implementation of the IPAC program and that every long-term care home must have an IPAC coordinator in place. The importance of ongoing adherence to strong IPAC processes and practices cannot be overstated.

Specific requirements for long-term care homes in the context of the COVID-19 pandemic are also set out in the Required Infection and Prevention Control (IPAC) Practices section of Directive #3.

Long-term care homes are reminded that they must be in compliance with current requirements under the Act as well as COVID-19 related Directives.

Everyone in a long-term care home, whether it is a staff, student placement, volunteer, caregiver, support worker, general visitor, or resident has a responsibility to ensure the ongoing health and safety of all by practicing these measures at all times.

Licensees should ensure that they have adequate stock levels of all supplies/materials required on a day-to-day basis regardless of outbreak status, including but not limited to:

- personal protective equipment (PPE)
- hand hygiene products (for example, alcohol-based hand rub, liquid soap, paper towels)
- diagnostic materials (for example, swabs)
- bed linens, incontinence products, and towels
- cleaning supplies (including disinfectant products)

Note: it is important for homes to use supplies such as alcohol-base hand rub products and disinfectants that have not expired. Homes are strongly encouraged to monitor expiration dates and promptly discard expired products and replace these with new, unexpired stock.

It is critical that homes strive to prevent and limit the spread of COVID-19 by ensuring that strong IPAC practices are in place. Appropriate and effective IPAC practices should be carried out by all people attending or living in the home, at all times regardless of whether there are cases of COVID-19 in the home or not, and regardless of the vaccination status of an individual.

Funding has been provided to homes for the hiring of new staff and for the training and education of new and existing personnel. In addition, IPAC hubs continue to be a resource to all homes. The hubs in coordination with public health partners support the provision of IPAC knowledge, training, and expertise to congregate living settings, including long-term care homes.

For information and guidance regarding general IPAC measures (for example, hand hygiene, environmental cleaning), please refer to the following documents:

- Infection prevention and control (IPAC) program guidance (Ministry of Long-Term Care)

- Public Health Ontario

    - Infection Prevention and Control for Long-Term Care Homes: Summary of Key Principles and Best Practices
    - At a Glance: Prevention and Management of COVID-19 in Long-Term Care Homes and Retirement Homes
    - COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes
    - COVID-19 IPAC Fundamentals Training
    - Interim Guidance on Infection Prevention and Control for Health Care Providers and Patients Vaccinated Against COVID-19 in Hospital and Long-Term Care Settings
- Recommendations for Control of Respiratory Infection Outbreaks in Long-Term Care Homes
- Infection Prevention and Control in Long-Term Care (Ontario CLRI)

McMaster University offers a free online IPAC learning course for caregivers and families.

Homes must follow the direction of their local public health unit on any matters related to IPAC. If there is a conflict between anything set out in this document and the direction from the local public health unit, long-term care homes must follow the direction from their public health unit

Infection prevention and control guidance

For information about COVID-19 IPAC requirements and guidance in homes please refer to:

- Directive #3
- Public Health Ontario, Prevention and Management of COVID-19 in Long-Term Care Homes and Retirement Homes

Physical distancing

Homes should configure the physical space and the layout of the home (such as common areas and resident and staff-specific areas) to facilitate physical distancing of two metres per Directive #3. This may include:

- posting signage in common areas regarding maximum capacity;
- moving furniture around or removing unnecessary furniture or equipment, including beds in rooms, where appropriate and taking care not to block fire exits,

- placing visual markers on the floor to guide physical distancing

Consistent with 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 or when the following additional exceptions apply:

- for residents to have brief physical contact with their essential caregiver(s) and/or general visitor(s) (for example, hugs)
- between residents in the same cohort
- between fully immunized caregivers and/or fully immunized general visitors and residents
- for the purposes of a compassionate/palliative visit
- during the provision of personal care services (for example, haircutting)

Masking

Per Directive #3, homes must ensure that all staff comply with universal masking at all times, even when they are not delivering direct patient care, including in administrative areas. Masks must be worn appropriately – this mean a person's nose and mouth are covered. During their breaks, to prevent staff-to-staff transmission of COVID-19, staff must remain two metres away from others at all times and be physically distanced before removing their medical mask for eating and drinking. Masks must not be removed when staff are interacting with residents and/or in designated resident areas.

The purpose of universal masking is to prevent possible spread from the potentially infectious respiratory droplets of the person wearing the mask to others.

Homes must ensure that all **essential visitors** wear a medical mask for the entire duration of their visit, both indoors and outdoors, regardless of their immunization status.

General visitors must wear a medical mask or a non-medical mask during their visit. If the visit is indoors, general visitors must wear a medical mask.

For **residents**, homes are required to have policies regarding masking for residents. While **there is no requirement for residents to wear a mask**, a home's policy must set out that residents must be encouraged to wear/be assisted to wear a medical mask or non-medical mask when receiving direct care from staff, when in common areas with other residents (with the exception

of meal times), and when receiving a visitor as tolerated. Homes are also required to follow any additional directions provided by the province, the local public health unit, and/or municipal bylaws.

Exceptions to the masking requirements are:

- children who are younger than two years of age
- any individual (staff, visitor, or resident) who is being accommodated in accordance with the *Accessibility for Ontarians with Disabilities Act, 2005*
- any individual (staff, visitor, or resident) who is being reasonably accommodated in accordance with the Human Rights Code

See the visitor policy section of this document for information regarding masking of entertainers who must remove their mask to perform (e.g. singing, playing musical instruments, etc.).

Homes must have policies for individuals (staff, visitor, or resident) who:

- have a medical condition that inhibits their ability to wear a mask
- are unable to put on or remove their mask without assistance from another person

See:

- Directive #3
- Directive #1
- Directive #5 issued by the CMOH for further requirements related to masking.

Note that the physical distancing requirements set out in Directive #3 apply even when people are masked.

Personal protective equipment (PPE)

Long-term care homes must follow the precautions described in the following directives issued by the Chief Medical Officer of Health:

- Directive #1 for health care providers and health care entities
- Directive #3 for Long-Term Care Homes
- Directive #5 for hospitals within the meaning of the *Public Hospitals Act* and long-term care homes within the meaning of the *Long-Term Care Homes Act, 2007*

Per Directive #5, if a regulated health professional determines, based on their point-of-care risk assessment (PCRA), and based on their professional and clinical judgement and proximity to the patient or resident, that an N95 respirator may be required in the delivery of care or services (including interactions), then the long-term care home must provide that regulated health professional and other health care workers present for that patient or resident interaction with a fit-tested N95 respirator or approved equivalent or better protection. The long-term care home cannot deny access to a fit-tested N95 respirator or approved equivalent or better protection if it is determined necessary by the PCRA.

Homes must provide training on PPE to all people regularly attending a home, including temporary staff or service providers coming to the home from a third party (for example, an agency).

For any questions regarding PPE supply and stock, speak with your local Ontario Health Team.

Eye protection

Appropriate eye protection requirements (for example, face shields or eye googles) are part of an individual's PPE to protect themselves against other people's potentially infectious respiratory droplets. As per Directive #3, appropriate eye protection (goggles or face shield) is required for all staff and essential visitors when providing care to residents with suspect/confirmed COVID-19 and in the provision of direct care within 2 metres of residents in an outbreak area. In all other circumstances, the use of eye protection is based on the point-of-care risk assessment when within 2 metres of a resident(s).

Cohorting

Cohorting is an important IPAC measure. Cohorting helps limit the potential transmission of infection throughout the home in the event of an introduction of the virus that causes COVID-19.

Cohorting residents is done based on their COVID-19 status or risk of COVID-19 (for example, due to close contact exposure), especially during an outbreak.

Mixing cohorts outdoors

Residents can freely socialize and interact with each other outdoors **within and across cohorts**, including during planned/organized group activities. Physical distancing amongst

residents in the same cohort is not required but physical distancing should be maintained between residents from different cohorts as much as possible.

Mixing cohorts indoors

Residents can also socialize indoors and interact with each other **within and across cohorts**; for example, this means a resident from one cohort can visit a resident from another cohort or two cohorts of residents can come together to watch a movie. If residents from different cohorts are mixing indoors then they should:

1. wear a mask (as tolerated); and
2. residents from different cohorts should maintain physical distancing from one another as much as possible.

Some residents may only wish to have an in-room visit or otherwise interact with a resident from a different cohort who is fully immunized against COVID-19; homes are expected to help to communicate such wishes amongst residents. Homes are encouraged to find alternatives to assist residents in connecting with other residents when in-person interaction is not possible/appropriate (for example, schedule and set up a videoconference between the two residents).

Exceptions to mixing cohorts (either indoors or outdoors)

Exceptions to mixing of resident cohorts are as follows:

- When activities involve eating and/or drinking (e.g. during regular dining and when celebrations involve eating and/or drinking), **residents from different cohorts are not to be mixed**.
- In the event of a COVID-19 outbreak, residents should be cohorted for all organized activities taking place indoors, different cohorts are not to be mixed, and residents from different cohorts should not visit one another.
- Residents who are isolating under droplet and contact precautions must not interact with any other residents unless by virtual means (e.g. video conferencing).
- The local public health unit directs the home not to mix resident cohorts.

Cohorting staff

Staff cohorting means having each staff member provide service to only one cohort (group) of residents. Residents may or may not be physically in the same part of the facility.

Staffing assignments should ideally be organized for consistent cohorting in specific resident areas to limit staff interactions with different areas of the home.

- To the extent possible, staff should be cohorted to work on consistent floors or 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 or units.
- Where full cohorting is not possible, partner specific floors or units to share change rooms and break rooms and cross-cover consistently when necessary, rather than staff mixing across the entire home.
- Consideration can be given to assigning fully immunized staff to cover multiple units where required; however, assignments should remain as consistent as possible.
- With respect to employees who meet the exception for fully immunized employees in Ontario Regulation 146/20 made under the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020*, it is recommended that such fully immunized employees work in a single, consistent cohort in each of the homes where they work. Long-term care homes should have policies regarding staff cohorting and maintain a current list of staff who are:
    - fully immunized (as described in *Ontario Regulation 146/20*)
    - working in multiple homes

Environmental cleaning and disinfection

All common areas (including shared bathrooms) and surfaces that are frequently touched and used should be cleaned and disinfected regularly and when visibly soiled. These include:

- door handles
- light switches
- elevator buttons
- corridor handrails
- arm rests on shared furniture
- carts/trolleys used to transport food, linen, etc.
- mechanical floor lifts and other common equipment/devices in the home
- other common equipment in the home

Contact surfaces (such as areas within two metres) of a person who has screened positive should be disinfected as soon as possible.

For more information on environmental cleaning, refer to the Public Health Ontario resources:

- 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
- PIDAC Routine Practices and Additional Precautions in All Health Care Settings

Activities

Communal dining

Communal dining is an important part of many homes' social environment.

All long-term care homes may provide communal dining with the following precautions:

- when not eating or drinking, residents should be encouraged to wear a mask where possible or tolerated
- residents are to be within their cohort and seating arrangements be kept consistent,
- fully immunized staff and fully immunized visitors may accompany a resident for meals including for the purposes of either having a meal themselves or for caregivers to assist a resident with feeding. (Note: staff assisting residents with feeding is considered part of resident care and is not dependent on staff immunization status).
- limiting room capacity to allow physical distancing between tables; note that residents do not need to be physically distance at the table
- buffet and family style dining are permitted both indoors and outdoors
- frequent hand hygiene of residents and staff or caregivers or volunteers assisting with feeding should be undertaken

What happens in an outbreak

If an area of long-term care home has a confirmed outbreak, as declared by the local public health unit, all communal dining must be suspended or modified based on direction from the local public health unit.

What happens when a resident is isolating or fails screening

Residents in isolation are not to join communal dining. However, homes should attempt to have isolated residents join-in virtually where possible to provide the isolated resident with an alternative to in-person social interaction. No resident who fails symptom screening is to join in communal dining.

Organized events and social gatherings

Homes need to provide safe opportunities for residents to gather for group activities.

All long-term care homes can have organized events and social gathering with the following precautions:

- masking, including for residents where possible or tolerated
- activities such as those involving singing, dancing, etc. are permitted both indoors and outdoors
- limiting room capacity to allow physical distancing between residents from different cohorts as appropriate
- cleaning and disinfection of high touch surfaces between activities and room use
- natural ventilation wherever possible (for example, open windows) as long as thermal comfort can be maintained

Fully immunized caregivers who are in a home per the home's visitor policy and who have passed screening may join residents during activities in all homes, both indoors and outdoors, unless otherwise directed by the local public health unit.

What happens in an outbreak

If a long-term care home has a confirmed outbreak, as declared by the local public health unit, all non-essential group activities must be suspended or modified based on direction from the local public health unit.

What happens when a resident is isolating or fails screening

Residents in isolation are not to join in group organized events/activities or social gatherings. However, homes should attempt to have isolated residents join-in virtually where possible to

provide the isolated resident with an alternative to in-person social interaction. No resident who fails symptom screening is to join in organized events/activities or social gatherings.

Note: the indoor and outdoor “gathering limits” set out under regulations governing the province’s Roadmap to Reopen made under the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020* do not apply with respect to activities taking place on the premises of a long-term care home including activities such as social gatherings, religious services/ceremonies, communal dining, entertainment and physical activity or exercise.

While homes no longer need to calculate or monitor immunization coverage rates at the level of the home, they are required to provide statistical information on immunization as per the Minister’s Directive – Long-term Care Home COVID-19 Immunization Policy.

Personal care services

Personal care services such as hairdressing and barber services are permitted in long-term care homes in accordance with all applicable laws including regulations under the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020*.

Residents should be encouraged to wear masks where possible or tolerated.

Rules in respect of masking, eye protection, physical distancing, screening, etc. that apply to staff, caregivers, or general visitors set out in Directive #3 and this document apply to persons providing personal care services. Which rules apply depend on whether an individual personal care service provider is staff of the licensee or a caregiver. If the individual providing the personal care service is not staff or a caregiver, the person is a general visitor.

Additionally, service providers of personal care services are subject to industry-specific occupational health and safety standards and laws, as applicable.

Residents who are symptomatic or isolating must not take part in personal care services.

Personal care services must be discontinued in areas of the home where an outbreak has been declared by the local public health unit or when otherwise directed by the local public health unit.

Screening

Passive symptom screening

Signage must be visible and posted throughout the home to remind everyone in the home to self-monitor for COVID-19 symptoms. A list of COVID-19 symptoms, including atypical symptoms, can be found in the COVID-19 Reference Document for Symptoms.

Active symptom screening

Homes are required to have an active screening program for entry. Anyone who enters the home, with the exception of emergency first responders, are to be actively screened by a screener for signs and symptoms of COVID-19 as they enter the building. Homes may establish their own screening process based on needs and the characteristics of the home which is compliant with Directive #3 and must include, at a minimum, the questions set out in the current version of the Ministry of Health's COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes.

See Directive #3 for more information.

Admissions and transfers

Isolation and testing requirements upon admission or transfer

All long-term care homes must have policies and procedures to accept new admissions, as well as transfers of residents from other health care facilities back to the home, in a way that balances the dignity of the resident against the overall health and safety of the home's staff and residents.

Long-term care homes must follow the current version (as amended from time to time) of the Ministry of Health's COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, which provides information on testing and isolation of new admissions and transfers into the home.

Admissions and transfers may take place during an outbreak where approved by the local public health unit and there is concurrence between the long-term care home, local public health unit, and hospital.

Identifying beds for use for isolation

Each long-term care home has unique characteristics that need to be considered when identifying the necessary number of beds that should be set aside for the purpose of isolating residents where required. Long-term care homes should consider the following when identifying the number of beds that are to be set aside for isolating residents:

- the total bed capacity of the home
- the layout of the home, layout and size of rooms, and whether there is a dedicated area of the long-term care home used for isolation purposes
- number of residents per washroom or showering facility
- the frequency of beds in rooms shared by two residents becoming available for admission
- the frequency of temporary and medical absences of residents who are partially immunized or unimmunized
- need to have beds for those who are going to be admitted/transferred after recently recovering from COVID-19 and who are beyond 90 days from a laboratory-confirmed infection or who are not fully immunized
- need to have beds to isolate new admissions and residents who have returned from hospital stay
- need to have beds including single rooms if possible, to isolate symptomatic residents

Homes are encouraged to work with their local public health unit when determining the appropriate number of beds for isolation. Public health units may provide advice or direction about the appropriate number of beds.

Absences

Per Directive #3, all long-term care homes must establish and implement policies and procedures in respect of resident absences, which, at a minimum set out the definitions and requirements/conditions described below.

There are four types of absences:

1. **medical absences** are absences to seek medical and/or health care and include:
    - outpatient medical visits and a single visit (less than or equal to 24 hours in duration) to the Emergency Department
    - all other medical visits (for example, admissions or transfers to other health care facilities, multi-night stays in the Emergency Department)
2. **compassionate and palliative absences** include, but are not limited to, absences for the purposes of visiting a dying loved one
3. **short term (day) absences** are absences that are less than or equal to 24 hours in duration. There are two types of short term (day) absences:
    - **essential absences** include absences for reasons of groceries, pharmacies, and outdoor physical activity
    - **social absences** include absences for all reasons not listed under medical, compassionate/palliative, and/or essential absences that do not include an overnight stay
4. **temporary absences** include absences involving two or more days **and** one or more nights for non-medical reasons

Short term and temporary absences

All residents, regardless of immunization status, may go on short term (essential and social) and temporary absences unless the resident:

- is in isolation on droplet and contact precautions
- resides in an area of the home that is in an outbreak
- is otherwise directed by the local public health unit

Residents do not need to seek approval to go on short-term absences however prior approval is required from the home for a temporary absence. Request for approval **does not** need to be in writing.

For all absences, residents must be:

- provided with a medical mask when they are leaving the home
- reminded to practice public health measures such as physical distancing and hand hygiene when outside of the home
- actively screened upon their return to the home

As per Directive #3, homes cannot restrict or deny absences for medical or palliative or compassionate reasons at any time. This includes when a resident is in isolation or when a home is in an outbreak. In these situations, homes must contact their local public health to obtain further direction.

Residents who leave the home for an overnight absence (including temporary absences) are required to follow the isolation and testing requirements as set out in the Admissions and Transfers section of the COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units).

Off-site excursions

Off-site group excursions (for example, to an attraction) are considered social absences and are permitted to reflect the reopening of attractions, music/theatre venues, etc.

Where an off-site excursion involves transporting residents in a vehicle, cohorting of residents and physical distancing should be maintained to the maximum extent possible during travel in the vehicle including during the use of public transportation.

Homes should also encourage consistent seating in vehicles and maintain seating records.

For all off-site group excursions, residents must be:

- provided with a medical mask when they are leaving the home
- reminded to practice public health measures such as physical distancing and hand hygiene when outside of the home
- actively screened per Directive #3 upon their return to the home

Visitors

Required visitor policy

All homes are required to establish and implement a visitor policy that complies with this document and Directive #3 (as amended from time to time).

Guiding principles

Rules for long-term care home visits continue to be in place to protect the health and safety of residents, staff, and visitors and are being updated as appropriate to support residents in receiving the care they need and maintaining their mental and emotional well-being.

These rules are in addition to the requirements established in the Act and *Ontario Regulation 79/10*.

The visiting policy is guided by long-term care homes responsibility for supporting residents in receiving visitors while mitigating the risk of exposure to COVID-19.

Homes' visitor policies are to be developed in accordance with the following principles:

- **safety** – any approach to visiting must balance the health and safety needs of residents, staff, and visitors, and ensure risks are mitigated
- **emotional well-being** – allowing visitors is intended to support the mental and emotional well-being of residents by reducing any potential negative impacts related to social isolation
- **equitable access** – all residents must be given equitable access to receive visitors, consistent with their preferences and within reasonable restrictions that safeguard residents
- **flexibility** – the physical/infrastructure characteristics of the home, its staffing availability, whether the home is in an outbreak and the current status of the home with respect to personal protective equipment (PPE are all variables to consider when setting home-specific policies

- **equality** – residents have the right to choose their visitors. In addition, residents and/or their substitute decision-makers have the right to designate caregivers

Minimum requirements for a home's visitor policy

Every home must have a visitor policy that includes, at a minimum, the parameters and requirements set out in this document with respect to visitors, including the definitions of the different types of visitors.

The home's visitor policy should include guidance from the following Public Health Ontario resources to support IPAC and PPE education and training for caregivers:

- guidance document: recommended steps: putting on personal protective equipment
- video: putting on full personal protective equipment
- video: taking off full personal protective equipment
- videos: how to hand wash and how to hand rub

Homes must ensure that all visitors have access to the home's visitor policy and understand the rules regarding physical distancing and masking at the outset of their visit.

Homes' visitor policy must include provisions around the home's ability to support and implement all required public health measures as well as infection prevention and control practices. All visitors must follow all applicable public health measures that are in place at the home (for example, active screening, physical distancing, hand hygiene and masking) for the duration of their visit.

Homes' visitor policies must also reflect the requirements related to the screening and testing of visitors, consistent with Directive #3, the current Minister of Long-Term Care's Directive COVID-19: Long-term care home surveillance testing and access to homes, and this Guidance Document, as applicable.

There are no sector-specific limitations on the number of visitors who can visit a resident indoors or outdoors at a long-term care home. Homes' policies should ensure there is the ability for

adequate physical distancing between groups and persons (as required) and that public health measures are being followed.

Homes are reminded that residents have a right under the *Long-Term Care Homes Act, 2007*, to receive visitors and homes should not develop policies that unreasonably restrict this right. It is expected that, at a minimum, residents would be permitted two general visitors and two caregivers at a time (unless the resident is isolating or in an area of a home with an outbreak).

The indoor and outdoor "gathering limits" set out under regulations governing the province's *Roadmap to Reopen* made under the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020* do not apply with respect to visitors coming to a long-term care home.

Visitor logs

Per Directive #3, homes must maintain visitor logs of all visits to the home. The visitor log must include, at minimum:

- the name and contact information of the visitor
- time and date of the visit
- the purpose of the visit (for example, name of resident visited)

These visitor logs or records must be kept for a period of at least 30 days and be readily available to the local public health unit for contact tracing purposes upon request.

Further detailed information with respect of minimum requirements for homes' visitor policies are outlined below:

Types of visitors

Not considered visitors

Long-term care home staff (as defined under the Act), volunteers, and student placements are not considered visitors as their access to the home is determined by the licensee.
Children under the age of two years are not considered visitors.

Essential visitors

A home's visitor policy must specify that essential visitors are persons visiting a home to meet an essential need related to the operations of the home or residents that could not be adequately met if the person does not visit the home.

There are no limits on the number of essential visitors allowed to come into a home at any given time.

Essential visitors are the only type of visitors allowed when there is an outbreak or when a resident is in isolation.

There are four types of essential visitors:

1. Persons visiting very ill or palliative residents for compassionate reasons, hospice services, end-of-life care, etc.
2. Government inspectors with a statutory right of entry,
    - Government inspectors who have a statutory right to enter long-term care homes to carry out their duties must be granted access to a home at all times. Examples of government inspectors include inspectors under the *Long-Term Care Homes Act, 2007*, the *Health Protection and Promotion Act*, the *Electricity Act, 1998,* the *Technical Standards and Safety Act, 2000,* and the *Occupational Health and Safety Act*.

3. **Support workers**: Support workers are persons who visit a home to provide support to the critical operations of the home or to provide essential services to residents. Essential services provided by support workers include but are not limited to:

    - assessment, diagnostic, intervention/rehabilitation, and counselling services for residents by regulated health professionals such as physicians and nurse practitioners
    - moving a resident in or out of a home
    - social work services
    - legal services
    - post-mortem services
    - emergency services (for example, such as those provided by first responders)

- maintenance services such as those required to ensure the structural integrity of the home and the functionality of the home's HVAC mechanical, electrical, plumbing systems, and services related to exterior grounds and winter property maintenance
- food delivery
- Canada Post mail services and other courier services

4. **Caregivers**: A caregiver is a type of essential visitor who is visiting the home to provide *direct care* to meet the essential needs of a particular resident. Caregivers must be at least 18 years of age and must be designated by the resident or his/her substitute decision-maker.

   Direct care includes providing support/assistance to a resident that includes providing direct physical support (eating, bathing and dressing) **and/or** providing social and emotional support.

   Examples of direct care provided by caregivers include but are not limited to the following:

   - Supporting activities of daily living such as bathing, dressing, and feeding
   - Assisting with mobility
   - Assisting with personal hygiene
   - Providing cognitive stimulation
   - Fostering successful communication
   - Providing meaningful connection and emotional support
   - Offering relational continuity assistance in decision-making

   Examples of caregivers include:

   - family members who provide meaningful connection
   - a privately hired caregiver
   - paid companions
   - translator

Whether a caregiver is paid for services is **not** a condition in meeting the criteria of the definition of caregiver as set out above. An important role of the caregiver is that of providing meaningful connection and emotional support. A person should not be excluded from being designated as a caregiver if they are unable to provide direct physical support.

Designating a caregiver

Caregivers must be designated. **The decision to designate an individual as a caregiver is entirely the remit of the resident and/or their substitute decision-maker and not the home**. While there is currently no limit to the number of persons who can be designated as a caregiver for a resident, only one caregiver may visit a resident who is isolating or in situations where a home/area of a home is in outbreak.
The designation of a caregiver should be made in writing to the home. Homes should have a procedure for documenting caregiver designations.
A resident or their substitute decision-maker may change a designation in response to a change in the:

- resident's care needs that is reflected in the plan of care
- availability of a designated caregiver, either temporary (for example, illness) or permanent

Residents or their substitute decision-makers should inform the home when they want to add or remove a designation of a person as a caregiver. The home is to document such changes in designation.

Caregivers – verbal attestation

Prior to allowing a caregiver to enter the home, the caregiver shall verbally that, in the last 14 days, they have not visited another:

- resident who is self-isolating or symptomatic
- home in an outbreak where the caregiver was in a portion of the home affected by the outbreak

Caregivers – education and training

Prior to visiting any resident for the first time, the home must provide training to caregivers that addresses how to safely provide direct care, including putting on and taking off required PPE, and hand hygiene, and confirm the caregiver has read the home's visitor policy. The home must also provide retraining to caregivers, with the frequency of retraining indicated in the home's visitor policy.

Caregivers – scheduling and length and frequency of visits

Homes may not require scheduling or restrict the length or frequency, of visits by caregivers.

Essential visitors – masking

Essential visitors must wear a medical mask for the entire duration of their shift or visit, both indoors and outdoors, regardless of their immunization status, per Directive #3 unless exceptions in the directive or this document apply.

General visitors

A general visitor is a person who is not an essential visitor and is visiting to provide non-essential services related to either the operations of the home or a particular resident or group of residents.

There are two broad categories of general visitors:

1. Visitors providing non-essential services which include but are not limited to:

    - personal care service providers (for example, hairdressers, barbers, manicurists, etc.)
    - entertainers (singers, musicians, etc.)
    - recreational service providers
    - animal handlers (for example, as part of therapy animal program)
    - individuals who are touring the home to inform decisions regarding application for admission

2. Persons visiting for social reasons that the resident or their substitute decision-maker assess as different from “direct care” as described in the section on caregivers.

General visitors are not permitted:

- when a home/area of a home is in outbreak
- to visit an isolating resident
- when the local public health unit so directs

General visitors younger than 14 years of age must be accompanied by an adult (someone who is 18 years of age or older).) and must follow all applicable public health measures that are in place at the home (for example, active screening, physical distancing, hand hygiene, masking for source control).

General visitors – masking

The home's visitor policy must specify that general visitors must wear a mask or face covering that covers their **mouth**, nose, and chin for the duration of their visit. If the visit takes place indoors, the general visitor must wear a medical mask.

If the entertainment provided by a live performer (i.e. general visitor) requires the removal of their mask to perform their talent, such as for a singing performance or to play a musical instrument, this is permitted, provided that all applicable the requirements for live entertainment are met:

- In line with the provincial rules for areas at Step 3 under Ontario Regulation 364/20, where live entertainment is performed, licensees must ensure that performers must maintain a physical distance of at least two metres from spectators or be separated from any spectators by plexiglass or other impermeable barrier. The same requirements apply in homes.

Screening of all visitors

Per Directive #3, any visitor who fails active screening (for example, having symptoms of COVID-19 or having had contact with someone who has COVID-19) must not be allowed to enter the home, be advised to go home immediately to self-isolate, and encouraged to be tested. There are two exceptions where visitors who fail screening may be permitted entry to a long-term care home:

- fully immunized staff and essential visitors as per the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes, effective July 14, 2021 or as current, and
- visitors of imminently palliative residents. Visitors for imminently palliative residents must be screened prior to entry. If they fail screening, they must be permitted entry but homes must ensure that they wear a medical (surgical or procedural) mask and maintain physical distance from other residents and staff.

General visitors' access to the visitor policy

In addition to screening, homes should ensure general visitors have access to the home's visitor policy and understand the rules regarding physical distancing and masking at the outset of their visit.

Personal protective equipment

The home's visitor policy must specify that visitors must wear personal protective equipment (PPE) as required in Directive #3.
General visitors must maintain physical distancing of two metres from residents. However, brief hugs are permitted. Fully immunized general visitors may have close contact (for example, holding hands) with residents. Homes must advise general visitors during screening that if they are not fully immunized, then they should maintain physical distance from the resident, except for brief hugs.

General visitors – scheduling and length and frequency of visits

Homes have the discretion to require general visitors to:

- schedule their visits in advance
- limit the length of the visit; however, each visit should be at least 60 minutes long
- limit the frequency of visits; however, homes should allow at least two visits per resident per week

Homes should prioritize the mental and emotional well-being of residents and strive to be as accommodating as possible when scheduling visits with general visitors. When scheduling outdoor visits, consideration should be given to maximizing physical space and human resources to assist residents (where needed) to entry points to meet general visitors. In addition,

where homes do not have sufficient outdoor space to accommodate visits, outdoor visits can also take place in the general vicinity.

Physical contact

Homes should not restrict physical touch (for example, holding hands) between residents who are fully immunized and caregivers/ general visitors who are fully immunized, provided appropriate IPAC measures, like masking and hand hygiene, are in place. Brief hugs are permitted regardless of immunization status.

Access to home areas

All homes need to create safe opportunities for caregivers to spend time with residents in areas outside the resident's room including lounges, walks in hallways (without going outdoors), and outdoor gardens and patios(if available).

Supervising visits

Homes are not required to supervise visits. However, homes should have a reasonable approach to support health and safety during visits (for example, monitoring the flow of visitors to ensure sufficient physical distancing can be maintained, supporting residents during the visit, providing suggestions of nearby outdoor spaces or common areas that can be used, etc.). Where a home needs to supervise visits, the supervision should be implemented in a manner that respects the resident's right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference under paragraph 14 of subsection 3(1) of theAct.

Non-compliance with homes' visitor policy by visitors

Non-compliance with the home's policies could result in a discontinuation of visits for the non-compliant visitor. The home's policy should align with the guidance below with respect to non-adherence. When a person's ability to visit has been discontinued, the home should provide the reason for the discontinuation in writing.

Responding to non-compliance by visitors

The home's visitor policy should include procedures for responding to non-compliance by visitors in the home that:

- provide strategies for supporting visitors in understanding and adhering to the home's visitor policy
- recognize visits are critical to supporting a resident's care needs and emotional well-being
- consider the impact of discontinuing visits on the resident's clinical and emotional well-being
- reflect and are proportionate to the severity of the non-adherence.
- where the home has previously ended a visit by, or temporarily prohibited, a visitor, specify any education or training the visitor may need to complete before visiting the home again
- protect residents, staff and visitors in the home from the risk of COVID-19

Homes are encouraged to consult the Residents' Council and the Family Council in the home on procedures for addressing non-adherence by visitors.

Ending a visit

Homes have the discretion to end a visit by any visitor who repeatedly fails to adhere to the home's visitor policy, provided:

- the home has explained the applicable requirement(s) to the visitor
- the visitor has the resources to adhere to the requirement(s) (for example, there is sufficient space to physically distance, the home has supplied the PPE and demonstrated how to correctly put on PPE, etc.)
- the visitor has been given sufficient time to adhere to the requirement(s)

Homes should document where they have ended a visit due to non-compliance.

Temporarily prohibiting a visitor

Homes have the discretion to temporarily prohibit a visitor in response to repeated and flagrant non-compliance with the home's visitor policy. In exercising this discretion, homes should consider whether the non-compliance:

- can be resolved successfully by explaining and demonstrating how the visitor can adhere to the requirements
- is with requirements that align with instruction in Directive #3 and guidance in this policy
- negatively impacts the health and safety of residents, staff and other visitors in the home
- is demonstrated continuously by the visitor over multiple visits
- is by a visitor whose previous visits have been ended by the home.

Any decision to temporarily prohibit a visitor must:

- be made only after all other reasonable efforts to maintain safety during visits have been exhausted
- stipulate a reasonable length of the prohibition
- clearly identify what requirements the visitor should meet before visits may be resumed (for example, reviewing the home's visitor policy, reviewing specific Public Health Ontario resources, etc.)
- be documented by the home

Where the home has temporarily prohibited a caregiver, the resident or their substitute decision-maker may need to designate an alternate individual as caregiver to help meet the resident's care needs.

Restrictions during outbreaks or when resident is isolating

- In the case where a resident is symptomatic or isolating under droplet and contact precautions, only one caregiver may visit at a time and no general visitors are permitted.
- In the case where a resident resides in an area of a home that is in an outbreak, as declared by the local public health unit, no general visitors are permitted.
- In the case where a local public health unit directs a home in respect of the number of visitors allowed, the home is to follow the direction of the local public health unit.

Essential visitors are the only type of visitors allowed when a resident is isolating or resides in an outbreak area of the home. A caregiver may not visit any other resident or home for 14 days after visiting another:

- resident who is self-isolating, including those experiencing symptoms of COVID-19 and are being assessed

- home or area of a home affected by an outbreak

The local public health unit may provide direction or restrictions on visitors to the home, depending on the specific situation.

Recognizing that not all homes have suitable outdoor space, outdoor visits may also take place in the general vicinity of the home.

Homes should ensure physical distancing (a minimum of two metres or six feet) is maintained between a resident and his/her visitors and another resident and his/her visitors.

Accessibility considerations

Homes are required to meet all applicable laws such as the *Accessibility for Ontarians with Disabilities Act, 2005*.

Surveillance testing

Surveillance testing refers to routine COVID-19 testing of asymptomatic persons entering a long-term care home. This includes asymptomatic staff, caregivers, student placements, volunteers, and visitors over age 2 years who have not been exposed to COVID-19. This is different from COVID-19 testing of individuals who are symptomatic, have had a high-risk exposure or in an outbreak setting as directed by the local public health unit.

Per the current Minister of Long-Term Care's Directive COVID-19: Long-term care home surveillance testing and access to homes, all staff, caregivers, student placements, volunteers, and visitors at a long-term care home must be tested in accordance with the Minister's Directive, unless the person shows proof of being fully immunized against COVID-19 in accordance with the Minister's Directive or another exception in the Minister's Directive applies. For detailed information on requirements, refer to the Minster's Directive.

General visitors who are coming to the home for an outdoor visit only are not subject to surveillance testing.

Signage

All homes should have signage posted throughout the home to remind everyone in the home to:

- physically distance
- wear masks
- perform hand hygiene
- follow respiratory etiquette as per routine measures for respiratory illness (flu) season

Homes should post signage in obvious places on the premises, including at entrances and in common areas regarding:

- symptom screening for visitors and residents
- how to physically distance in long-term care
- universal mask use in health care
- how to handwash and how to hand rub
- additional precautions

Local public health units may have additional signage on their websites that may be helpful or useful to homes.

Signage such as posters etc. are available here:

- Resources to prevent COVID-19 in the workplace (Ministry of Labour, Training and Skills Development)
- Public Health Ontario

Air conditioning and air flow

Below is a list of Public Health Ontario knowledge products that can help with information on the use of portable fans, air conditioning units and portable air cleaners. These summarize a number of considerations such as placement, cleaning and maintenance, and room size.

- At a glance: the use of portable fans and portable air conditioning units during COVID-19 in long-term care and retirement homes

- FAQ: use of portable air cleaners and transmission of COVID-19 (question three outlines performance standards and question six talks about placement in general)
- Focus on: heating, ventilation and air conditioning (HVAC) systems in buildings and COVID-19

Staff education

Homes must familiarize themselves with all applicable pandemic-related policies, including directives and orders, and stay up to date on new and revised requirements.

Homes should develop and implement educational opportunities for staff, including through virtual means, regarding pandemic-specific policies issued by the province, as well as local public health units. Emphasis should be placed on newly-hired and retained staff but opportunities and learning should also be provided on a continuous basis to all staff (as refreshers and when new or different advice is being set out). In addition to keeping staff informed about policies, educational opportunities should focus on IPAC measures, environmental cleaning, masking, and how to put on and take off (don and doff) PPE.

All staff should also know the signs and symptoms of COVID-19 in order to identify and respond to and report these quickly. For signs and symptoms of COVID-19 please refer to the COVID-19 Reference Document for Symptoms.

Homes must also provide education about physical distancing, respiratory etiquette, hand hygiene, infection prevention and control practices and proper use of PPE for all visitors.

Infectious Disease Emergency Days

On April 29, 2021, the government introduced and passed *Bill 284, COVID-19 Putting Workers First Act, 2021*, which amends the *Employment Standards Act, 2000* to require employers to provide employees with up to three days of paid leave, at their regular wage, up to $200 per day, for reasons related to COVID-19. The three paid infectious disease emergency days are retroactive to April 19, 2021 and available until September 25, 2021. The three days of paid leave would only be available to employees who:

- are covered by the *Employment Standards Act, 2000* (ESA) (independent contractors or federally regulated employees would not qualify for these days) Learn more about who is an employee under the Employment Standards Act guide.
- do not already receive paid sick time through their employer

Employers are reimbursed up to $200 per day for each employee.

Paid leave is available for certain reasons related to COVID-19, including going to get vaccinated and experiencing a side effect from a COVID-19 vaccination.

Employers and their workers can call a dedicated COVID-19 Sick Days Information Centre hotline at 1-888-999-2248 or visit Ontario.ca/COVIDworkerbenefit to get more information.

For more information about COVID-19 vaccine safety, homes can also refer to the province's COVID-19 Vaccine Safety website. It is important to note that all individuals must continue to practice recommended public health measures for the prevention and control of COVID-19 infection and transmission, regardless of whether they have been vaccinated.

Communications

Long-term care homes must keep staff, residents and families informed about COVID-19, including frequent and ongoing communication during outbreaks. Homes must remind staff to:

- monitor themselves for COVID-19 symptoms at all times
- immediately self-isolate if they develop symptoms

Signage in the home must be clear about COVID-19, including signs and symptoms of COVID-19 and steps that must be taken if COVID-19 is suspected or confirmed in staff or a resident as per Directive #3.

Issuing a media release to the public is the responsibility of the institution but should be done in collaboration with the public health unit.

Outbreak definition and management

Please refer to:

- Directive #3
- COVID-19 Guidance: Long-Term Care Home Outbreak Management
- Management of Cases and Contacts of COVID-19 in Ontario
- COVID-19 Provincial Testing Guidance

Homes must follow direction from their local public health unit in the event of a suspect or confirmed outbreak.

Outbreak definition

A COVID-19 outbreak is defined as:

- a **suspect outbreak** in a long-term care home is defined as one single lab-confirmed COVID-19 case in a resident
- a **confirmed outbreak** in a long-term care home is defined as two or more lab-confirmed COVID-19 cases in residents 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

Only the local public health unit can declare an outbreak and declare when it is over.

It is not the long-term care home's responsibility to determine whether cases have an epidemiological link. Local public health units will determine whether cases have a link as part of their investigation, which will inform their decision as to whether they will declare an outbreak.

Reporting outbreaks and cases

COVID-19 is a designated disease of public health significance (Ontario Regulation 135/18) and thus confirmed and suspected cases of COVID-19 are reportable to the local public health unit under the *Health Protection and Promotion Act* (HPPA).

Homes must follow the critical incident reporting requirements set out in section 107 of *Ontario Regulation 79/10* made under the *Long-Term Care Homes Act, 2007*. Homes are required to immediately report any COVID-19 outbreak (suspect or confirmed) to the Ministry of Long-Term Care 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.

Post-mortem

Contact your local public health unit immediately following the death of any person from confirmed or suspected COVID-19 that occurred on the premises of the home.

Contact information

- Questions regarding COVID-19 related policies and guidance can be emailed to the Ministry of Long-Term Care at MLTCpandemicresponse@ontario.ca
- Contact your local public health unit
- Questions regarding surveillance testing can be sent to:
    - MLTCpandemicresponse@ontario.ca
    - covid19testing@ontariohealth.ca
    - your Ontario Health primary contact

Resources

- https://www.health.gov.on.ca/en/pro/programs/ltc/covid19.aspxCOVID-19 Long-Term Care Communications
- LTCHomes.net for long-term care home licensees and administrators
- Ministry of Health, COVID-19 Vaccine-Relevant Information and Planning Resources
- Public Health Ontario, COVID-19 long-term care resources for the sector:
    - 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

Appendix: LTC Fall 2021 Preparedness Checklist

The Ministry of Long-Term Care has developed this self-assessment tool (non-exhaustive) to help long-term care homes assess pandemic preparedness, inform outbreak response planning, and prepare for potential future waves of COVID-19 as well as flu season.

The checklist contains specific measures recommended/required by the Ministry of Long-Term Care, the Ministry of Health, Ontario Chief Medical Officer of Health, and Public Health Ontario as set out through multiple sources:

- Ontario Chief Medical Officer directives including:
    - Directive #1
    - Directive #3
    - Directive #5
- COVID-19 Guidance Document for Long-Term Care Homes in Ontario
- Minister's Directive: Long-term care home COVID-19 immunization policy
- Minister's Directive COVID-19: Long-term care home surveillance testing and access to homes
- *Long-Term Care Homes Act, 2007* and Ontario Regulation 79/10 (General)

Leaders, managers, direct health care workers, and resident/family partners are encouraged to familiarize themselves with all guidance and directives and refer to them for clarification as appropriate.

This tool can help to identify strengths and areas for improvement to inform pandemic planning efforts ahead of future waves of COVID-19 and flu season. It can be complementary to COVID-19-specific checklists that may be regionally or provincially available. Homes are strongly encouraged to use the readiness checklist to surface any gaps that need to be filled and identify key risks and related mitigation strategies.

OVERALL RESPONSE PLANNING	**Complete**	**In Progress**	**Not Started**
A pandemic plan is established that is tailored to the needs of the home while following Ontario guidelines and is broadly shared with staff, student placements, volunteers, and visitors as appropriate	☐	☐	☐
Leadership roles have been identified that are specific to a pandemic response plan. Persons involved may include a Director of Care/Manager, Medical Director, Infection Control Practitioner, Public Health liaison, Occupational Health and Safety experts, and any other home-specific leadership roles	☐	☐	☐

Roles and responsibilities of health care workers and staff are clearly stated and understood including any shifts/transitions in roles and responsibilities during an outbreak	☐	☐	☐
“Tabletop” or drill exercises completed to practice implementing plans/protocols, especially those related to outbreaks	☐	☐	☐
Rooms/areas for isolating residents, including for new admissions and transfers, are identified and taken into consideration when scheduling staff, cleaning, meal delivery, etc.	☐	☐	☐
SUPPORTING RESIDENTS	**Complete**	**In Progress**	**Not Started**
Plans and protocols for resident symptom monitoring including active screening requirements as set out in Directive #3 are in place	☐	☐	☐
All residents have an up-to-date Plan of Care, including the goals the care is intended to achieve and up-to-date advance directives (i.e. written direction for future care in the event a resident will not be able to communicate)	☐	☐	☐
All residents have access to high quality primary health care that does not require them to leave the home including during an outbreak	☐	☐	☐
All designated caregiver information for each resident is up-to-date	☐	☐	☐
HUMAN RESOURCES/STAFFING	**Complete**	**In Progress**	**Not Started**
Confirm appropriate level and capacity of leadership and management in place, develop contingency plans in the event a person is not able to work, identify those responsible for staffing/scheduling and address leadership recruitment, development, retention, and support as relevant	☐	☐	☐
Review and update home’s incident commander/incident management system (IMS) structure should there be a need to implement			
Staff schedules prepared to ensure appropriate coverage of shifts, in accordance with all applicable laws/policies and any prescribed restrictions related to working in multiple locations, including for screeners	☐	☐	☐
Review and update staff cohorting plans and workstation use, including assignments during outbreak situations and for providing care for residents who are isolating	☐	☐	☐
Contingency staffing plan has been developed that identifies the minimum staffing needs for the home and prioritizes critical and non-essential services based on residents’ health status, functional limitations, disabilities, and	☐	☐	☐

essential home/building operations. This plan should address surge capacity Note: Home should include in their plan a proposed approach in the case of a shortage of registered health professions taking into consideration scope of practice parameters for potential backfill personnel and planning to support the delegation of the provision of controlled acts pursuant to the *Regulated Health Professions Act, 1991* where/if appropriate Contingency plans could include: • having a contract in place with pre-trained agency staff • proactive preparation to call on caregivers and family members as volunteers in extreme staffing shortages			
Home is prepared to refer staff to resources to support mental health and well-being including to assistance programs, local and provincial resources, etc. Partnerships with local agencies that can assist with counselling are in place	☐	☐	☐
Staff, student placements, volunteers, and visitors are regularly reminded (e.g., email alerts, signage, newsletters, etc.) of their obligation to stay home if ill, to advise if they have had close contact with someone with COVID-19, and to report any signs/symptoms of illness to their supervisor/manager	☐	☐	☐
COVID-19 OUTBREAK PREDPAREDNESS PLAN	**Complete**	**In Progress**	**Not Started**
Outbreak lead and backup for home is identified	☐	☐	☐
In consultation with their joint health and safety committees or health and safety representatives if any, ensure measures are taken to prepare for and respond to a COVID-19 outbreak, including developing and implementing a COVID-19 Outbreak Preparedness Plan (per Directive #3)	☐	☐	☐
The outbreak preparedness plan includes: • identification of members of the Outbreak Management Team	☐	☐	☐
• an IPAC program, in accordance with the LTCHA both for non-outbreak and outbreak situations, in collaboration with IPAC hubs, public health units, local hospitals, Home and Community Care Support Services, and/or regional Ontario Health	☐	☐	☐
• a clear agreement/understanding with the IPAC Hub lead about how the home and Hub will work together, particularly if extra support is needed	☐	☐	☐

• a plan to ensure testing kits are available and plans are in place for taking specimens	☐	☐	☐
• a plan to ensure sufficient PPE is available, and that appropriate stewardship of PPE is followed	☐	☐	☐
• a plan to ensure that all staff, students, and volunteers, including temporary staff, are trained on IPAC protocols including the use of PPE	☐	☐	☐
• a written and clearly communicated policy to manage staff who may have been exposed to COVID-19	☐	☐	☐
• a process to permit an organization completing an IPAC assessment to do so and to share any report or findings produced by the organization with any or all of the following: public health units, local public hospitals, Ontario Health, Home and Community Care Support Services, MLTC, as may be required to respond to COVID-19 at the home	☐	☐	☐
• a plan to increase IPAC audits (beyond regular schedule) with results acted upon quickly	☐	☐	☐
• a plan to keep staff, residents, and families informed about the status of COVID-19 in the homes, including frequent and ongoing communication during outbreaks	☐	☐	☐
CASE MANAGEMENT	**Complete**	**In Progress**	**Not Started**
Review and update as necessary the home's case management procedures (as required by Directive #3)	☐	☐	☐
ADMISSIONS/TRANSFERS	**Complete**	**In Progress**	**Not Started**
Review and update as necessary the home's COVID-19 admissions and transfers operational policy and procedures (as required by Directive #3)	☐	☐	☐
Review and update as necessary the home's plan to ensure all new residents are placed in a single or semi-private room (as required by Directive #3)	☐	☐	☐
ABSENCES	**Complete**	**In Progress**	**Not Started**
Review and update as necessary the home's COVID-19 absences operational policy and procedures (as required by Directive #3)	☐	☐	☐
TESTING POLICY AND PROCEDURES	**Complete**	**In Progress**	**Not Started**
Review and update as necessary the home's asymptomatic testing operational policy and procedures (as required by Directive #3)	☐	☐	☐

VACCINATION	Complete	In Progress	Not Started
Vaccination lead and backup for home is identified	☐	☐	☐
Review home's COVID-19 immunization policy to ensure it is compliant with the current Minister's Directive, including plans/protocols related to collecting and reporting required statistical information	☐	☐	☐
Review and update as necessary the home's vaccine maintenance strategy including addressing how/when third dosages of COVID-19 vaccines and flu vaccines to residents will be administered, and onboarding so the home can administer COVID-19 vaccinations itself	☐	☐	☐
A plan is in place to continue promoting the benefits of being vaccinated against COVID-19	☐	☐	☐
IPAC PROTOCOLS & PLANS	**Complete**	**In Progress**	**Not Started**
IPAC lead and backup are identified	☐	☐	☐
Ensure there is a plan regarding dedicated capacity, planning, partnerships, and clear internal accountability for oversight, reinforcement, and support of proper IPAC responsibilities, protocols, and practices for all staff in the home	☐	☐	☐
Complete the Public Health Ontario COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes	☐	☐	☐
Per Directive #5, the home's Organizational Risk Assessment must be continuously updated to ensure that it assesses the appropriate health and safety control measures to mitigate the transmission of infections, including engineering, administrative and PPE measures. This must be communicated to the Joint Health and Safety Committee, including the review of the hospital or long-term care environment when a material change occurs	☐	☐	☐
There is a schedule for regular and frequent IPAC audits	☐	☐	☐
Review and update as necessary plans and protocols related to isolating residents. Where possible, residents needing to self-isolate should be placed in a single room and have access to a private washroom	☐	☐	☐
Review and update as necessary cohort plans for residents	☐	☐	☐
HOME VISITOR POLICY (Please see Communications section regarding communications of the visitor's policy)	**Complete**	**In Progress**	**Not Started**
Review home's visitor policy to ensure it is consistent with the current LTC Guidance Document, the current Directive #3, and direction from the local public health unit (if applicable)	☐	☐	☐

Protocol in place to fill out visitor logs and maintain records of logs, ensuring they are readily available to ministry inspectors and public health units (e.g. if an electronic log is being used and is password protected, ensure at all times that someone on-site has access to the password)	☐	☐	☐
Plan in place to adjust visiting in case of outbreak, for situations when a resident is isolating, and when local circumstances and/or direction from the local public health unit changes (e.g. plans/protocols for scheduling and holding virtual visits for residents)	☐	☐	☐
SUPPLIES	**Complete**	**In Progress**	**Not Started**
Ensure supply chain is secure and contact information for vendors is up-to-date	☐	☐	☐
Hand hygiene and respiratory etiquette supplies • alcohol-based hand sanitizer (60-90% alcohol) • soap and paper towels for all sinks • facial tissue	☐	☐	☐
PPE • medical masks and N95 respirators • gowns • gloves • face shields/goggles	☐	☐	☐
Trash disposal bins and bags	☐	☐	☐
Disinfectants for cleaning and disinfection of high-touch surfaces and equipment	☐	☐	☐
Diagnostic materials (for example, swabs)	☐	☐	☐
Bed linens, incontinence products, and towels	☐	☐	☐
Signage/posters for workers and others about: • physical distance (including decals, arrows etc.) • capacity limits • screening and self-assessment • wearing masks • breaks • hand hygiene	☐	☐	☐
EDUCATION/TRAINING	**Complete**	**In Progress**	**Not Started**
Home staff/administrators/licensee has signed up for the MLTC August 23 webinar regarding fall 2021 preparedness planning	☐	☐	☐
Education/training lead and backup has been identified to retain responsibility for coordinating education and training on COVID-19, sourcing education/training materials, and maintaining records related to persons accessing and completing education/training	☐	☐	☐

Licensees, leadership/management (existing, new, and incoming) have reviewed applicable COVID-19 guidance/policies/requirements including the LTC Guidance Document and Directives #1, #3, and #5	☐	☐	☐
Remind all existing staff and inform new staff about the reporting requirements related to communicable diseases, including COVID-19, and critical incident reporting	☐	☐	☐
Training provided to all health care workers, other staff, and any essential visitors who are required to wear PPE with information on the safe utilization of all PPE, including training on proper donning and doffing	☐	☐	☐
Provide training for new staff and refresher training for existing staff including regarding: • government/ministry and home policies regarding COVID-19 including the home's visitor policy, COVID-19 immunization policy, etc. • the home's sick leave policy • outbreak management	☐	☐	☐
Ensure screeners are appropriately trained and aware of current rules/requirements regarding active screening			
Ensure all staff, students, and volunteers – existing, new, and returning – in the home have core IPAC training and access to on-demand training on IPAC and PPE	☐	☐	☐
VENTILATION	**Complete**	**In Progress**	**Not Started**
Review the ministry's 10-Point Heating, Ventilation, and Air Conditioning Plan	☐	☐	☐
Schedule ventilation systems maintenance as appropriate	☐	☐	☐
Adjust systems to maximize the amount of fresh air and reduce recirculation while ensuring temperature and humidity levels are comfortable for residents, staff, and others who attend/visit the home	☐	☐	☐
COMMUNICATIONS	**Complete**	**In Progress**	**Not Started**
Internal communications protocols in place for residents, substitute decision-makers, families, staff on/offsite, caregivers, volunteers, student placements, visitors, Family Councils, and Resident Councils Internal communication protocol should be activated when there is a change in: • outbreak status • home, provincial, or ministry policies • home's schedule of activities including dining Where possible, communications should include information on the updates as well as including clarity about who is	☐	☐	☐

making the decisions (public health unit vs home vs Province)			
Staff assigned as lead for internal communications. Back up staff also assigned	☐	☐	☐
Ensure regular communications to residents including (but not limited too): • sharing with residents' changes in the home that directly impacts residents, particularly related to outbreaks, cohorting, isolation requirements, visitors, absences, activities, and staffing • reminding residents of importance of public health measures including hand hygiene, physical distancing, and masking (if tolerated)	☐	☐	☐
External communications protocols in place including to contact public health unit and the ministry and others as appropriate (e.g. supply vendors, building and ground maintenance, etc.) and a media relations plan	☐	☐	☐
Staff assigned as lead for external communications. Back up staff also assigned	☐	☐	☐
Review and update as necessary **contact information lists**: • for all staff, student placements, volunteers, and residents • for key individuals within the home, local public health unit, regulated health professionals serving the home, local COVID-19 assessment centre	☐ ☐	☐ ☐	☐ ☐