Prince Edward Island
Health and Wellness
CANADA

Prince Edward Island Guidelines for Viral Respiratory Illnesses and Outbreak Management in Long-Term Care and Community Care Facilities

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How to Use This Guideline

This guideline supports long-term care facilities (LTCFs) and community care facilities (CCFs) in preparing for, identifying, reporting, and managing viral respiratory illness (VRI) and outbreaks.

For immediate actions when a resident develops symptoms of a VRI, see the Quick Action Box following Table 1. For detailed outbreak management, see Section 7.0. Facility-specific planning and respiratory season preparation requirements are outlined in Section 5.1 and Appendix B.

1.0 Introduction

In May 2023, the World Health Organization (WHO) determined that COVID-19 no longer constituted a public health emergency of international concern (PHEIC) and recommended transitioning from an emergency response to longer-term management. WHO also recommended integrating COVID-19 preparedness and response into broader infectious disease prevention and control programs while maintaining operational readiness for surges and emerging respiratory pathogens.

The COVID-19 pandemic strengthened infection prevention and control (IPAC) knowledge, practices, and tools for managing both known and emerging pathogens. As SARS-CoV-2 continues to circulate, these strategies remain important for preventing and managing illness caused by viral respiratory pathogens that share similar modes of transmission.

Aligned with current public health guidance and the need to balance IPAC measures with residents' physical, psychological, emotional, and spiritual well-being, this guideline provides guidance for preventing and managing viral respiratory illnesses and outbreaks in LTCFs and CCFs.

2.0 Background

Respiratory viruses such as SARS-CoV-2, influenza, and RSV continue to circulate and can spread readily in LTCFs and CCFs due to communal living arrangements, shared spaces, and close contact among residents, staff, visitors, and volunteers. Residents in these settings often have underlying risk factors, such as advanced age and chronic health conditions, that increase their risk of severe illness, hospitalization, and death.

While influenza and RSV typically occur seasonally from fall to early spring, other viral respiratory illnesses, including COVID-19, may circulate year-round. Facilities should routinely monitor residents and staff for early signs and symptoms of viral respiratory illness, particularly during respiratory season or when community transmission is elevated.

Prompt recognition, reporting, and implementation of IPAC measures can help limit transmission, reduce the duration of outbreak control measures, and support continuity of care.

3.0 Reporting Requirements

Test-confirmed cases of influenza, COVID-19, and RSV, and outbreaks of VRI in health facilities and institutions, are notifiable under the Prince Edward Island Public Health Act and the Notifiable Diseases and Conditions and Communicable Diseases Regulations. Timely reporting supports effective outbreak management and public health response.

3.1 Facility Operators and Staff

Health practitioners or facility administrators must report confirmed or probable cases and suspected outbreaks in accordance with the Public Health Act and applicable regulations. Reports should be made to the Chief Public Health Office (CPHO) or designate by telephone and/or electronic transfer, as directed.

3.2 Laboratory

The Provincial Laboratory must report positive laboratory results for notifiable diseases and conditions as soon as they are known. Reports should be made to CPHO or designate by telephone and by mail, fax, or electronic transfer, as required.

4.0 Summary of Viral Respiratory Infections

Viral respiratory infections in LTCFs and CCFs can be caused by multiple pathogens that often co-circulate. These infections share similar symptoms, making clinical diagnosis and management challenging.

Transmission

- Primarily through respiratory particles generated during breathing, talking, coughing, and sneezing.
- Transmission may also occur through direct contact with respiratory secretions or contaminated hands, surfaces, or objects.

Clinical Considerations

- Older residents may present atypically, such as with confusion or delirium instead of fever.
- Monitor for clusters of residents with symptoms in the same area over a short period.
- Testing should be considered when new symptoms or changes from baseline suggest possible VRI, based on clinical judgment and current testing guidance.

Prevention and Management

- Initiate Droplet and Contact Precautions immediately when a viral respiratory illness is suspected, even if the causative pathogen is unknown.
- Precautions should be reassessed based on test results, symptom progression, clinical judgment, and direction from IPAC or CPHO.
- Additional IPAC measures, such as masking and physical distancing, may be implemented in LTCFs and CCFs based on resident vulnerability, outbreak circumstances, and direction from IPAC or CPHO.
- Immunization against influenza, COVID-19, and RSV is an important measure for reducing the risk of severe illness and related complications, although outbreaks can still occur among vaccinated residents.

4.1 Influenza

Influenza is an acute viral respiratory illness caused by influenza A and B viruses. Seasonal influenza typically occurs each year, beginning in late fall and extending into spring.

Clinical Features

- Typical influenza illness commonly includes fever and cough.
- Other symptoms may include sore throat, arthralgia, myalgia, and marked fatigue or weakness.
- Atypical presentations in older residents may include cough, fatigue, or confusion without fever.
- Most people recover within 3–7 days; however, older adults are at increased risk of hospitalization and complications such as pneumonia or worsening of underlying conditions.

Prevention and Management

Antiviral treatment and prophylaxis may be recommended for LTCF residents with confirmed or suspected influenza, in consultation with CPHO and the attending physician or nurse practitioner. See Section 5.2.1 for influenza immunization and Appendix A for antiviral guidance.

4.2 COVID-19

COVID-19 is caused by the SARS-CoV-2 virus. Residents in LTCFs and CCFs are at increased risk of severe illness because of advanced age, chronic health conditions, and the potential for transmission in communal settings.

Clinical Features

- Symptoms may include runny nose, headache, sneezing, sore throat, cough, and fever.
- Symptoms may resemble influenza or other viral respiratory illnesses.
- Illness severity ranges from asymptomatic infection to severe disease.
- COVID-19 symptoms and transmission patterns may vary over time as SARS-CoV-2 continues to evolve.

Prevention and Management

Paxlovid™ (nirmatrelvir/ritonavir) may be available for eligible residents with mild to moderate COVID-19 to reduce the risk of progression to severe disease. Eligibility and prescribing requirements should be confirmed using current PEI guidance. See Section 5.2.2 for COVID-19 immunization.

4.3 Respiratory Syncytial Virus

RSV is a common seasonal respiratory illness that typically occurs from late fall to early spring. Reinfection can occur at any age because immunity is incomplete and temporary.

Clinical Features

- Symptoms are usually mild and cold-like and may include runny nose, cough, sneezing, fatigue, headache, and fever.
- Older adults may present atypically.
- Most healthy adults recover within 1–2 weeks; however, older adults and immunocompromised individuals are at increased risk of severe disease, including pneumonia and worsening of underlying cardiopulmonary conditions.
- RSV may cause severe illness and death in vulnerable populations.

Prevention and Management

Antiviral medications are not currently available to prevent or treat RSV infection in this population. See Section 5.2.3 for RSV immunization.

4.4 Other Respiratory Viruses

Other respiratory viruses, including human metapneumovirus (HMPV), human rhinovirus (HRV), and human parainfluenza virus (HPIV), can also affect older adults, particularly those living in LTCFs and CCFs.

Clinical Features

- These viruses often cause symptoms similar to other viral respiratory illnesses, such as cough, congestion, sore throat, and fever.
- Older adults may present atypically.
- Illness severity varies by virus and by individual and may be more significant in older adults or those with underlying health conditions.

Prevention and Management

Apply the general prevention and management measures outlined in Section 4.0. Measures may be adjusted based on the identified pathogen, clinical circumstances, and direction from IPAC or CPHO.

4.5 Incubation, Infectious, and Symptomatic Periods

Following exposure to a respiratory virus, individuals may experience incubation, infectious, and symptomatic periods. These periods may overlap, and their timing and duration can vary by virus and by individual. Understanding these periods supports early recognition, timely implementation of IPAC measures, and appropriate monitoring of close contacts.

Stage	What is Happening	Facility Considerations
1. Incubation Period	The virus is replicating within the individual. Infectiousness varies by virus and may begin before symptoms develop.	Continue routine monitoring. Be alert for new symptoms or changes from baseline, especially during respiratory season or following a known exposure.
2. Infectious Period	The individual can spread the virus to others. This may occur before symptoms develop.	Reinforce Routine Practices, hand hygiene, respiratory hygiene, and PCRA. Monitor close contacts according to pathogen-specific guidance when an exposure has occurred.
3. Symptomatic Period	Symptoms are present, and the individual may continue to shed virus. As recovery progresses, viral shedding and risk of transmission generally decrease.	Initiate Droplet and Contact Precautions immediately when VRI is suspected. Follow applicable testing, reporting, close-contact monitoring, and duration of precautions guidance.

Table 1 provides a comparison of key features of common respiratory viral pathogens that may cause illness or outbreaks in LTCFs and CCFs.

TABLE 1. Comparison of Common Respiratory Viral Pathogens

Feature	Influenza	COVID-19	RSV	Other Respiratory Viruses
Viral etiology	Influenza A and B	SARS-CoV-2	Respiratory syncytial virus	Adenovirus, HMPV, HPIV, HRV, and other respiratory viruses
Incubation period	1 to 4 days; median 2 days	2 to 14 days; median 2 to 4 days	2 to 8 days; median 5 days	Varies by pathogen; generally 2 to 10 days
Communicable period	From 1 day before symptom onset to approximately 5 days after symptom onset	Approximately 2 to 3 days before symptom onset to 7 to 10 days after symptom onset. For asymptomatic infection, timing is based on the date of the positive test.	1 to 21 days; median approximately 8 days	Varies by pathogen; transmission may occur before symptom onset and while symptomatic
Vaccine available	Yes, publicly funded	Yes, publicly funded	Yes, publicly funded for eligible residents	No
Antiviral treatment or prophylaxis	Treatment and prophylaxis may be recommended for LTCF residents in consultation with CPHO and the attending physician or nurse practitioner.	Treatment may be available for eligible residents.	No antiviral treatment or prophylaxis is available for this population.	No routine antiviral treatment or prophylaxis is available.

For testing order and facility-specific testing availability, see Section 7.2.1.

Quick Action Box: Resident with Symptoms of VRI

Step	Action
1. Initiate Precautions	• Immediately separate the symptomatic resident from others, where possible. • Initiate Droplet and Contact Precautions.
2. Test	• Collect the appropriate respiratory specimen. • If no pathogen has been identified, test for COVID-19 first, followed by influenza if negative. • If influenza testing is negative and RSV is clinically suspected, follow the facility-specific RSV testing pathway in Section 7.2.1. • If an outbreak pathogen has already been identified, test for that pathogen first when testing is indicated.
3. Report and Document	• Notify CPHO if a resident tests positive or an outbreak is suspected. • Begin resident and staff line lists when an outbreak is suspected or confirmed.
4. Follow Detailed Guidance	• See Sections 7.2 and 7.2.1 for management of symptomatic residents and the complete testing pathway. • See Section 7.3 for pathogen-specific treatment, precautions, and close-contact monitoring. • Use the line list in Appendix H.

5.0 Infection Prevention and Control (IPAC) for Viral Respiratory Illnesses

This section outlines the core IPAC measures for preventing and managing VRI in LTCFs and CCFs.

5.1 Facility Planning

Viral respiratory infections may occur at any time in LTCFs and CCFs. Outbreaks can cause serious illness and disrupt facility operations. Effective prevention and control require collaboration among facility leadership, staff, physicians or nurse practitioners, residents, families, visitors, volunteers, IPAC, CPHO, and other partners as required.

Facilities should use this guideline to support setting-specific policies, procedures, education, communication plans, and outbreak response planning before and during viral respiratory season. See Table 2 for preparation steps and Appendix B for the viral respiratory season preparation checklist.

TABLE 2. Steps in Preparing for Viral Respiratory Season

Area	Preparation Steps
Policies and Procedures	• Ensure facility-specific policies and procedures are in place, including: o IPAC measures o Staff education on influenza, COVID-19, RSV, and other viral respiratory illnesses o Environmental cleaning and disinfection protocols o A communication plan for staff, residents, families, visitors, volunteers, IPAC, and CPHO, as required.
Personal Protective Equipment (PPE)	• Confirm sufficient PPE supply for routine operations and initial outbreak response. • Establish a process for ordering additional PPE when needed. • Ensure a process for regular N95 respirator fit testing at required intervals.
Testing Supplies	• Ensure an adequate supply of testing supplies based on facility type and current respiratory season direction, including: o Nasopharyngeal (NP) swabs for PCR testing, as required o Abbott ID NOW testing supplies for COVID-19 and influenza POCT in LTCFs and standalone CCFs o RSV POCT supplies for LTCFs, where applicable during the current respiratory season • Verify expiry dates for all POCT supplies. • Provide staff education on proper specimen collection techniques and current testing pathways.
LTCF-Specific Preparations	• Calculate and record creatinine clearance for all residents annually in the fall. • Obtain a signed physician/nurse practitioner standing order by early fall for administration of influenza antiviral treatment and/or prophylaxis, as outlined in Appendix A.
COVID-19 Treatment Access	• Establish a process to support timely access to Paxlovid™ for eligible residents with COVID-19.
Consent for Vaccines and Treatments	• Obtain resident or substitute decision-maker consent for COVID-19, influenza, and RSV vaccines and treatments, as applicable.
Immunization Planning	• Plan for immunization of: o Residents: influenza, COVID-19, and RSV, as eligible o Staff: influenza and COVID-19
Goals of Care	• Review and update goals of care and advance directives for all residents.

5.2 Immunization of Staff and Residents

Immunization recommendations, product availability, and publicly funded eligibility may change by respiratory season. Facilities should confirm current eligibility, product availability, and timing through current PEI immunization program guidance and CPHO communications.

5.2.1 Influenza Immunization

Staff Influenza Immunization

The National Advisory Committee on Immunization (NACI) recommends annual influenza vaccination for health care providers and other care providers in facilities who, through their activities, may transmit influenza to individuals at elevated risk of complications. Staff should receive annual influenza vaccination for their own protection and to help protect residents.

Resident Influenza Immunization

For adults 65 years of age and older, the preferred influenza vaccine products should be selected according to current NACI and PEI immunization guidance. If a preferred product is unavailable, an age-appropriate influenza vaccine should be used.

5.2.2 COVID-19 Immunization

Staff COVID-19 Immunization

Facility operators of LTCFs and CCFs are responsible for policies regarding COVID-19 vaccination for employees, outside service providers, and volunteers. Vaccination remains an important measure for reducing the risk of severe COVID-19, hospitalization, and death.

Resident COVID-19 Immunization

COVID-19 immunization remains particularly important for residents of LTCFs and CCFs because of their increased risk of severe disease and complications. NACI strongly recommends COVID-19 immunization programs for individuals at increased risk of severe COVID-19 disease, including residents of LTCFs, CCFs, and other congregate living settings for seniors.

The number and timing of COVID-19 vaccine doses may vary by season and individual risk. Residents of congregate living settings for seniors may be recommended to receive additional doses based on current NACI and PEI guidance.

5.2.3 RSV Immunization

Resident RSV Immunization

RSV vaccination is publicly funded for eligible residents of LTCFs and CCFs and may reduce the risk of severe illness and complications. Immunization should follow current PEI program recommendations.

5.3 Routine Practices

Routine Practices must be used by staff for all residents, at all times, in all care settings. Residents and visitors should follow applicable hand hygiene, respiratory hygiene, PPE, and other IPAC instructions. These include, but are not limited to:

- Conducting a PCRA before every resident interaction
- Performing hand hygiene according to facility protocols
- Using PPE based on the PCRA and anticipated exposure risk
- Practicing respiratory hygiene, including:
    - Turning away from others when coughing or sneezing
    - Covering coughs and sneezes with a tissue or the upper sleeve
    - Disposing of tissues immediately
    - Performing hand hygiene after coughing or sneezing

5.4 Point-of-Care Risk Assessment (PCRA) (Appendix C)

Before each resident interaction, staff must assess the risk of exposure to infectious agents associated with the resident, situation, or procedure.

Purpose of PCRA

- Helps staff identify known and potential infectious risks before an interaction
- Guides the selection of appropriate IPAC measures and PPE to minimize exposure

Resident Factors to Consider During PCRA

- Signs, symptoms, or clinical syndromes requiring Additional Precautions
- Volume of respiratory secretions and the resident's ability to control coughing and manage secretions
- Ability to comply with IPAC practices, such as hand hygiene, medical mask use, and respiratory hygiene
- Need for extensive, prolonged, or close-contact care

5.5 Hand Hygiene (Appendix D)

5.5.1 Staff Hand Hygiene Requirements

Staff are required to perform hand hygiene:

- On entry to and exit from the LTCF or CCF
- Before and after contact with a resident, regardless of whether gloves are worn
- Before preparing or administering medications or food
- Before performing aseptic procedures
- Before putting on PPE and during removal of PPE, according to facility procedures
- Before putting on gloves and after removing gloves
- Before and after contact with the resident's environment, such as medical equipment, bed, table, or door handle, regardless of glove use
- Any other time hands are potentially contaminated, such as after handling blood, body fluids, bedpans, urinals, or wound dressings
- After personal hygiene practices, such as blowing nose, touching face, or using toilet facilities

5.5.2 Hand Hygiene Recommendations for Residents

Residents should perform hand hygiene:

- When entering or leaving their room
- Before eating, oral care, or managing oral medications
- After using toileting facilities
- Any time hands are potentially contaminated

NOTE: For staff and residents, use soap and water when hands are visibly soiled, after using toilet facilities, before preparing or handling food, and when indicated for certain gastrointestinal illnesses. Otherwise, ABHR may be used when hands are not visibly soiled.

5.6 Droplet and Contact Precautions (Appendix E)

Droplet and Contact Precautions must be implemented for residents with suspected or confirmed VRI.

Required PPE

- Gloves and a long-sleeved, cuffed gown covering the front of the body from neck to mid-thigh, worn upon entering the resident's room
- A well-fitting medical mask
- Eye protection, including:
    - a full-face shield that covers the front and sides of the face; or
    - well-fitting goggles.
- Regular eyeglasses or safety glasses with gaps between the glasses and face are not sufficient protection.

Additional Requirements

- Whenever possible, don PPE outside the resident care area and remove and discard PPE inside the resident care area.
- Hand hygiene must be performed before putting on PPE and after removing PPE.

NOTE: For residents with suspected or confirmed VRI, PPE must be worn in accordance with Droplet and Contact Precautions. An N95 or equivalent respirator should replace a medical mask when performing or being present during an aerosol-generating medical procedure (AGMP). Use of an N95 or equivalent respirator may also be considered based on PCRA, facility policy, or direction from IPAC or CPHO when there is a risk of exposure to aerosolized virus.

6.0 Case Definitions of Respiratory Viral Infections

Residents should be routinely monitored for new symptoms or changes from baseline that may indicate a respiratory infection. During a suspected or confirmed outbreak, active daily screening and documentation must be implemented for all residents in the affected area.

Purpose of Active Screening

- Detect viral respiratory illness early, including symptoms that may present atypically in older adults, such as confusion or delirium.
- Support timely implementation of IPAC measures to prevent spread.

Testing Guidance

- Widespread asymptomatic testing is not recommended.
- Testing may be considered when a resident has new symptoms or a change from baseline that raises concern for VRI, even in the absence of classic respiratory symptoms.

6.1 Viral Respiratory Illness (VRI)

VRI Case Definition	VRI Outbreak Definition
New or acute onset of viral respiratory illness with TWO or more symptoms listed below, at least **ONE** of which MUST be respiratory: **Respiratory:** • Cough • Shortness of breath, difficulty breathing, or dyspnea • Decreased oxygen saturation or increased oxygen requirement • Sore throat, painful swallowing, or hoarse voice • Runny nose, nasal congestion, or sneezing • Loss of or change in sense of taste or smell **Other:** • Fever* • Headache • Myalgia or arthralgia • Significant or unusual fatigue • Nausea, vomiting, or diarrhea	Two or more cases of VRI within a seven-day period with a common epidemiological link **AND** testing is not available or all negative.

***Fever is defined as:**

• a single oral temperature >37.8°C; **OR**
• repeated oral temperatures >37.2°C or rectal temperatures >37.5°C; **OR**
• a single oral or rectal temperature >1.1°C above the individual's baseline.

6.2 Influenza Illness

Influenza Case Definition	Influenza Outbreak Definition
A person with VRI symptoms as outlined above and test-confirmed infection with influenza.	Two or more cases of VRI within a seven-day period with an epidemiological link, including at least one test-confirmed case of influenza within the surveillance setting; **OR** Two or more test-confirmed cases of influenza that are epidemiologically linked to a specific setting or location.

Test-confirmed influenza case: A case with a positive result on laboratory-based PCR or Abbott ID NOW NAAT.

6.3 COVID-19 Illness

COVID-19 Case Definition	COVID-19 Outbreak Definition
A person with test-confirmed infection with SARS-CoV-2.	Two or more test-confirmed cases of COVID-19 that are epidemiologically linked to a specific setting or location.
Test-confirmed COVID-19 case: A case with a positive result on laboratory-based PCR or Abbott ID NOW NAAT. A positive rapid antigen test may also be considered test-confirmed upon review by CPHO or designate.	

6.4 RSV Illness

RSV Case Definition	RSV Outbreak Definition
A person with VRI symptoms as outlined above and test-confirmed infection with RSV.	Two or more cases of VRI within a seven-day period with an epidemiological link, including at least one test-confirmed case of RSV within the surveillance setting; **OR** Two or more test-confirmed cases of RSV that are epidemiologically linked to a specific setting or location.
Test-confirmed RSV case: A case with a positive result on laboratory-based PCR or Abbott ID NOW NAAT.	

7.0 Outbreak Management for Viral Respiratory Illnesses

Staff must initiate IPAC measures promptly when VRI is suspected and should not wait for laboratory confirmation. See the Quick Action Box following Table 1 for immediate actions.

This section provides detailed guidance for facility-wide outbreak management, management of symptomatic residents, testing, pathogen-specific requirements, and other outbreak control measures.

7.1 Facility-Wide Outbreak Management

When an outbreak is suspected or declared, facilities should implement the following measures in affected units or areas.

Notification and Reporting

- Notify CPHO immediately if an outbreak is suspected.
- CPHO will declare the start and end of the outbreak.
- Once an outbreak is confirmed, report subsequent cases using the line list in Appendix H, or as directed by CPHO.

Resident Monitoring

- Conduct daily active monitoring of all residents in the affected unit or area for symptoms or changes from baseline.
- Monitor close contacts according to the pathogen-specific guidance in Section 7.3.

Staff Screening and Work Exclusion

- Use passive screening before every shift and require staff to self-monitor during shifts.
- Exclude symptomatic staff from work in accordance with Section 7.5 or as directed by IPAC or CPHO.

Environmental Cleaning and Disinfection

- Increase cleaning and disinfection in affected resident and staff areas.
- Clean and disinfect high-touch surfaces at least every 4 hours during outbreaks.
- Use a Health Canada-authorized disinfectant and follow the manufacturer's instructions, including the required contact time.

PPE and Signage

- Ensure staff follow required PPE practices in affected units or areas.
- Staff should wear a well-fitting medical mask in resident care areas during an outbreak.
- Post outbreak signage in affected areas. See Appendix I.

Communication

- Notify residents, families, staff, visitors, and volunteers of the outbreak status and required precautions.

End-of-Outbreak Criteria

- Continue outbreak measures until the outbreak is officially declared over by CPHO. See Section 8.0 and Table 3.

7.2 Management of a Symptomatic Resident

Active Screening

- Conduct daily active screening of residents in the affected unit or area.
- Pay particular attention to changes from baseline, including new confusion or delirium.
- Refer to Section 6.0 for case and outbreak definitions.

Isolation and Precautions

- Immediately separate the symptomatic resident from others, where possible, and initiate Droplet and Contact Precautions.
- Use a single room with a dedicated toilet and sink, if possible.
- Do not move an asymptomatic roommate to another shared room, as this could expose additional residents.
- Where possible, provide the roommate with a single room and monitor closely for symptoms.

Testing

- Collect the appropriate respiratory specimen as soon as possible, ideally within 24 hours of symptom onset.
- Follow the testing pathway in Section 7.2.1.

Reporting and Documentation

- Notify CPHO if any resident tests positive or an outbreak is suspected.
- Initiate the resident and staff line list in Appendix H when an outbreak is suspected or confirmed.
- During business hours, contact CPHO at 902-368-4996.
- **After hours, report confirmed cases and suspected outbreaks to the Nursing on Call service at 902-231-5824.**
- **For urgent questions related to treatment, antiviral use, or clinical management, contact the Physician On Call through QEH Locating.**
- Submit line list updates to CPHO by fax at 902-620-3354, or as otherwise directed.

7.2.1 Testing Order and Facility-Specific RSV Pathway

Testing depends on whether a respiratory pathogen has already been identified in the facility. Follow the testing pathway below. Once an outbreak pathogen has been established, additional testing of subsequent symptomatic residents is generally not required unless needed for treatment, clinically indicated, or directed by IPAC or CPHO.

Testing Situation	Required Action
No respiratory pathogen has been identified in the facility	1. Test for COVID-19 first using Abbott ID NOW NAAT POCT. 2. If negative, test for influenza using Abbott ID NOW NAAT POCT. 3. If influenza testing is negative and RSV is clinically suspected, follow the facility-specific RSV testing pathway below.
RSV testing in an LTCF	Test for RSV using POCT, where available, during the current respiratory season or when directed by IPAC or CPHO.
RSV testing in a standalone CCF	RSV POCT is not available. FLUVID/RSV PCR may be arranged through the resident's primary care provider when clinically indicated or directed by IPAC or CPHO.
A pathogen has already been identified in the facility	When testing is indicated, test for the identified outbreak pathogen first. If the result is negative and the clinical or epidemiological picture is inconsistent with the outbreak, additional testing may be considered based on symptoms, current pathogen circulation, and direction from IPAC or CPHO.
POCT is unavailable, or results are negative but clinical suspicion remains	Consider laboratory-based PCR when POCT is unavailable, another pathogen is suspected, results do not fit the clinical or epidemiological picture, or testing is clinically indicated or directed by IPAC or CPHO.

When Sending Specimens for PCR

- Notify the laboratory when specimens are being submitted as part of a suspected outbreak, where applicable.
- Follow current specimen collection and submission requirements.
- See Appendix G for mid-turbinate and NP swab collection procedures.

7.3 Pathogen-Specific Management

The table below outlines pathogen-specific treatment, duration of precautions, close-contact monitoring, and additional considerations. Follow the testing pathway in Section 7.2.1.

Unless otherwise directed by IPAC or CPHO, asymptomatic close contacts do not require routine testing or activity restriction. If a close contact develops symptoms, initiate Droplet and Contact Precautions and manage the resident according to Sections 7.2 and 7.2.1.

Moderately or severely immunocompromised residents may require an extended duration of precautions. Consult IPAC or CPHO.

Pathogen-Specific Resident Management

Management Element	COVID-19	Influenza	RSV	Unidentified VRI
Treatment or prophylaxis	Residents who test positive may be eligible for Paxlovid™. Confirm current eligibility and prescribing requirements using current PEI guidance.	Influenza treatment and prophylaxis may be recommended for LTCF residents. See Appendix A.	No antiviral treatment is available for this population.	Treatment is supportive unless a pathogen is identified and pathogen-specific treatment is indicated.
Duration of precautions	At least 5 days following symptom onset or positive test date, AND fever resolved for 24 hours without fever-reducing medication, AND symptoms improved.	At least 5 days following symptom onset, AND clinically improving, AND fever resolved for 24 hours without fever-reducing medication.	At least 8 days following symptom onset, AND fever resolved for 24 hours without fever-reducing medication, AND symptoms improved.	Continue Droplet and Contact Precautions while symptomatic and until the resident is clinically improving AND fever has resolved for at least 24 hours without fever-reducing medication. Duration may be adjusted based on direction from IPAC or CPHO.
Close-contact monitoring	At least twice daily for 4 days after the last exposure. Day 0 is the day of the last exposure.	At least twice daily for 2 days after the last exposure. Day 0 is the day of the last exposure.	At least twice daily for 5 days after the last exposure. Day 0 is the day of the last exposure.	Follow the monitoring period established by IPAC or CPHO based on the clinical and epidemiological picture.
Additional considerations	Do not repeat COVID-19 testing for a newly symptomatic resident who tested positive for COVID-19 within the previous 60 days. Arrange FLUVID/RSV PCR if clinically indicated.	Once antiviral prophylaxis is started in an LTCF, a daily line list is no longer required by CPHO but may remain useful for facility management.	Not applicable.	If a pathogen is identified, transition to the applicable pathogen-specific guidance in this table.

7.4 New Admissions, Readmissions, and Transfers During Outbreaks

General Principles

- Admissions, readmissions, and transfers to affected areas may be permitted during an outbreak.
- **The facility is responsible for these decisions**, based on a risk-benefit assessment and its ability to maintain safe care and required IPAC measures.

Key Considerations

- **Scope of outbreak:** Is the outbreak limited to one household, unit, or section, or does it involve the entire facility?
- **Outbreak status and management:** Consider the length of time since last case, attack rate, severity of illness, and whether transmission is ongoing.
- **Staffing**: Is adequate staffing available to provide care safely?
- **Resident-specific factors**:
    - Is the area to which the resident is being admitted or returning affected by the outbreak?
    - Has the resident had previous exposure to the circulating pathogen?
    - Consider comorbidities and overall health status.
    - Consider immunization status and antiviral prophylaxis, where applicable.
- **Consent and communication:** Have the resident or substitute decision-maker and the most responsible provider been informed of the outbreak and the potential risks associated with the move?
- **Risk vs. benefit:** What are the risks and benefits of immediate versus delayed placement or transfer?

Transfers for Medical Necessity

For hospital admissions or urgent appointments, such as dialysis:

- Notify the receiving facility or unit and transport personnel of the outbreak status and any Additional Precautions required for the resident.
- Ensure the receiving facility is able to provide care safely.

Post-Transfer Notification

- Notify any facility that received a resident from the outbreak-affected facility during the 10 days before the outbreak was declared, or as directed by CPHO.

Testing and Precautions for Admissions

- Test only if symptoms are present at admission.
- Follow the facility-specific testing pathway in Section 7.2.1.
- Initiate Droplet and Contact Precautions for symptomatic residents.
- If initial POCT is negative but clinical suspicion remains, continue Droplet and Contact Precautions and consider further testing when clinically indicated or directed by IPAC or CPHO.

7.5 Screening and Management of Symptomatic Staff

Testing

- Staff are not routinely tested for respiratory viruses as part of facility outbreak management. Resident POCT is not used for staff testing; any testing must be clinically ordered through usual healthcare pathways.

Self-Monitoring and Reporting

- Staff must self-monitor daily for signs and symptoms of viral respiratory illness.
- Immediately report any new symptoms to facility management.

Work Restrictions

- Staff must refrain from working when experiencing symptoms of any viral respiratory illness.
- If staff become symptomatic while at work:
    - Perform hand hygiene immediately.
    - Put on a well-fitting medical mask, if not already wearing one.
    - Inform their supervisor.
    - Avoid further contact with residents and staff.
    - Leave the workplace promptly.

Return-to-Work Criteria

- Symptomatic staff should not return to work until:
    - Fever-free for at least 24 hours without fever-reducing medication, **AND**
    - Other symptoms have resolved or significantly improved.

7.6 Screening and Management of Symptomatic Visitors and Volunteers

Self-Monitoring

- Visitors and volunteers must self-monitor for signs and symptoms of viral respiratory illness before entering the LTCF or CCF.

Exclusion from the Facility

- **Visitors and volunteers must not enter the facility if they have any of the following:**
    - Fever (temperature ≥38°C / 100.4°F)
    - New or worsening cough, sore throat, runny nose, or congestion
    - Vomiting or diarrhea
    - Any other symptoms of an infectious illness

Return Criteria

- Visitors and volunteers may return only when **both** of the following are met:
    - fever-free for at least 24 hours without fever-reducing medication, **AND**
    - other symptoms have resolved or significantly improved.

7.7 Aerosol-Generating Medical Procedures (AGMPs)

Definition

An AGMP is a procedure that may generate aerosols of various sizes, including droplet nuclei.

General Guidance

During an outbreak, continued use of CPAP/BiPAP should be assessed in consultation with the physician or nurse practitioner, considering the resident's clinical need and the facility's ability to implement appropriate precautions.

Performing AGMPs on Residents Suspected or Confirmed to Have a Viral Respiratory Illness

AGMPs should be avoided where possible and performed only when clinically necessary. When an AGMP is required:

- The procedure should be performed by the most experienced available person.
- Only the minimum number of persons required to safely perform the procedure should be present.
- All persons in the room must wear:
    - a fit-tested N95 respirator or equivalent respirator, with a successful fit check before use (see Appendix F);
    - gloves;
    - a gown; and
    - eye protection.
- Keep the room door closed during the procedure.
- After the AGMP is completed, keep the door closed for at least 1 hour, or according to facility-specific ventilation requirements, before allowing entry without airborne precautions.

7.8 Specimen Collection

Specimen Type

- **POCT:** Mid-turbinate swab (RSV POCT requires an NP swab).
- **Laboratory PCR:** NP swab.

Personnel

- Swabs must be collected by qualified staff trained in proper collection techniques to support test accuracy and resident safety. See Appendix G.

During Sample Collection

- Limit the number of staff in the room to those required for the procedure and resident care.
- All staff present must wear PPE in accordance with Droplet and Contact Precautions.

Handling Laboratory Specimens

- Treat all specimens as potentially infectious.
- Place specimens in an appropriate biohazard specimen bag.
- Handle and transport specimens according to Routine Practices and current specimen transport requirements.

7.9 Environmental Cleaning and Disinfection

Cleaning and Disinfection Principles

Regular cleaning and disinfection of high-touch surfaces help reduce environmental contamination and transmission risk.

Use a disinfectant authorized for use in Canadian health care settings, identifiable by a Drug Identification Number (DIN) or Medical Device License (MDL), as applicable. Follow the manufacturer's instructions, including the required contact time.

Alternative Disinfectant: Bleach Solution

If a Health Canada-authorized disinfectant is unavailable:

- Use a bleach solution at the concentration specified by facility procedures for the intended purpose.
- Clean surfaces before applying the bleach solution.

Frequency and Scope

High-touch surfaces, such as call bells, bedrails, door handles, light switches, tables, sinks, toilets, and grab bars:

- **Routine:** Clean and disinfect at least twice daily and when visibly soiled.
- **During an outbreak:** Clean and disinfect at least every four hours and when visibly soiled, particularly in affected resident and common areas.

Low-touch surfaces, such as shelves, chairs, and windowsills:

- Clean and disinfect at least once daily.

Floors and walls

- Keep visibly clean and free of spills, dust, and debris.

Shared staff equipment, such as computer carts, medication carts, and charting desks:

- Clean and disinfect at least daily and when soiled.
- Staff should perform hand hygiene before and after using shared equipment, as indicated.

Environmental Services Staff

Environmental Services staff must wear PPE consistent with the precautions in place for the resident or area being cleaned.

Special Considerations

Carpeted Areas

- Avoid vacuuming during an outbreak unless performed according to facility procedures that minimize aerosolization (e.g., using a HEPA-filtered vacuum).
- If contaminated:
    - Remove visible soil using absorbent material.
    - Clean using a product suitable for carpeted surfaces and follow facility cleaning procedures.

Post-discharge/transfer cleaning

- Follow facility procedures for discharge/transfer cleaning, including management of disposable supplies and privacy curtains, as applicable.

Resident Care Equipment

Dedicate reusable equipment and supplies to a resident with suspected or confirmed VRI whenever possible.

If equipment must be shared:

- Clean and disinfect it between residents using a Health Canada-authorized disinfectant, ensuring the manufacturer's required contact time is met before reuse.
- Discard items that cannot be properly cleaned and disinfected.

Linen, Dishes, and Cutlery

No special precautions are required. Follow Routine Practices**.**

Waste Management

No special precautions are required. Follow Routine Practices.

7.10 Communal Dining, Recreational Activities, and Group Entertainment During Outbreaks

General Principles

- Modify communal dining and group activities in affected units or areas as needed to reduce transmission risk while maintaining resident well-being and social engagement where possible.
- Prioritize lower-risk activities that allow for smaller groups and greater spacing, such as:
    - arts and crafts
    - bingo
    - card games
    - other small-group activities

Dining and Food Service

- Remove shared food and beverage containers from dining areas, such as water or juice pitchers, salt and pepper shakers, and butter dishes.
- Serve food and snacks directly to residents.
- If single-serve condiment packets are used, provide them directly to each resident.
- Suspend resident participation in food preparation during an outbreak.
- Disposable plates and cutlery are not required for symptomatic residents.
- Restrict access to kitchen or nourishment areas used by residents or visitors, as appropriate.

7.11 Resident Off-Site Outings

Minimize non-essential off-site outings for residents from affected units or areas during an outbreak. Residents who are symptomatic or on Additional Precautions should not leave the facility except for essential medical or emergency care.

7.12 Outbreak Visitation

General Principles

Facility decisions regarding visitation during an outbreak should be based on operational capacity and the ability to maintain required IPAC measures. Visitation should balance resident physical, psychological, emotional, and spiritual well-being with the need to reduce transmission risk and maintain safe care.

Visitor Guidelines

- Limit movement within the facility to the resident being visited and exit promptly after the visit.
- Follow all required IPAC measures, including hand hygiene and use of appropriate PPE.
- Maintain appropriate spacing from other residents and staff, where possible.
- Visits may continue when they can be supported safely and do not interfere with care or required outbreak-control measures.

8.0 Declaring the Outbreak Over

General Principles

The facility Outbreak Management Team should have a plan for discontinuing Additional Precautions at the resident, room, unit, and facility level. IPAC measures must remain in place until resident-specific criteria are met or until the outbreak is officially declared over by CPHO.

Criteria for Declaring an Outbreak Over

- No new cases of VRI epidemiologically linked to the outbreak have been identified among residents or staff for the required period outlined in Table 3.
- The required period has elapsed since the last known exposure to an infectious person in the affected unit or area.
- The outbreak is declared over in consultation with CPHO.

Factors to Assess

- Whether symptomatic residents remain in the affected room, unit, area, or facility
- Whether new epidemiologically linked cases are continuing to occur
- Whether IPAC measures have been effective in controlling transmission
- The length of time since the most recent epidemiologically linked case or exposure
- Whether staffing is sufficient to maintain safe care and required IPAC measures

TABLE 3. Criteria for Declaring a Viral Respiratory Outbreak Over

Respiratory Virus	Required Period Without a New Epi-Linked Case*
Confirmed influenza	4 days
Confirmed COVID-19	10 days
Confirmed RSV	10 days
Unidentified or other respiratory pathogen	5 days

*The required period is based on the expected incubation period and operational outbreak-management guidance for the identified pathogen. Final determination that the outbreak is over is made by CPHO.

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Appendix A – Influenza Antiviral Guidelines and Post-Exposure Prophylaxis (PEP): LTCFs Only

ANTIVIRAL TREATMENT AND PEP - KEY POINTS

Treatment and PEP

Antiviral treatment is recommended for residents with influenza, particularly when started within 48 hours of symptom onset. Treatment may still be appropriate after 48 hours for residents at high risk of influenza-related complications. PEP is recommended for exposed LTCF residents who have not developed symptoms to help reduce transmission and outbreak impact.

Oseltamivir Supply and Decision-Making

CPHO provides pre-positioned oseltamivir 75 mg and 30 mg doses for LTCFs. Use of treatment or PEP during an outbreak is guided by CPHO in consultation with the attending physician or nurse practitioner, as appropriate.

Dosing and Follow-Up

Use Table A1 for dosing and Table A2 to determine whether additional medication is required. If a resident develops VRI while receiving PEP and influenza treatment is indicated, change to the treatment dose and begin as Day 1.

Table A1. Oseltamivir Treatment and Post-Exposure Prophylaxis Dosing - LTCFs Only

Renal Function / Dialysis Status	Treatment	Post-Exposure Prophylaxis (PEP)
Greater than 60 mL/min	75 mg twice daily for 5 days	75 mg once daily until outbreak is over
30-60 mL/min	75 mg once daily OR 30 mg twice daily for 5 days	30 mg once daily until outbreak is over
10-30 mL/min	30 mg once daily for 5 days	30 mg on alternate days until outbreak is over
Less than 10 mL/min (renal failure)	One single 75 mg dose for the duration of illness	No data available. Consult primary physician or specialist.
Low-flux hemodialysis (HD)	30 mg at onset of influenza symptoms, then 30 mg after each dialysis session	30 mg before dialysis, then 30 mg after alternate dialysis sessions
High-flux hemodialysis (HD)	75 mg after each dialysis session	No data available. Consult primary physician or specialist.
Continuous ambulatory peritoneal dialysis (CAPD)	30 mg once before the start of dialysis	30 mg before dialysis, then 30 mg once weekly
Continuous renal replacement therapy (CRRT), high-flux dialysis	30 mg daily OR 75 mg every second day	No data available. Consult primary physician or specialist.

Table A2. Facility-Specific Information for Influenza Antiviral Medication Replacement - LTCFs Only

Instructions: Please complete all of the information in Table A2 below and return to the following CPHO fax number: **(902)-620-3354**. Refer to Table A1 for calculation guidance on Influenza Treatment and Post-Exposure Prophylaxis Dosages.

Name of Facility:	**Completed By:**	**Phone Number:**
Number of current doses in the facility	**75 mg: _____**	**30 mg: _____**
Total number of residents at the facility: _____		

Creatinine Clearance (CC)	Number Of Residents
Greater than 60 mL/min	_____
30-60 mL/min	_____
10-30 mL/min	_____
Less than 10 mL/min (renal failure)	_____
On dialysis	_____
Total	_____

MEDICATION REQUIREMENT SUMMARY

	75 mg	30 mg
Total doses required	_____	_____
Doses currently on hand	_____	_____
Additional doses required	_____	_____

Use Table A1 to calculate medication requirements. CPHO will arrange additional doses as required.

Creatinine Clearance and Standing Order Template - LTCFs Only

Use this form to calculate creatinine clearance and document standing orders for oseltamivir.

NOTES

- A creatinine result obtained within the past 12 months is adequate.
- If a resident cannot be weighed, an estimated weight may be used.

Calculating Creatinine Clearance (mL/min)

Male	(140 - age in years) x weight (kg) ---------- = _____ mL/min Serum creatinine (µmol/L) x 0.81
Female	[(140 - age in years) x weight (kg) ----------] x 0.85 = _____ mL/min Serum creatinine (µmol/L) x 0.81

RESIDENT INFORMATION

Name: _____	Health Number: _____
Age in years: _____	Weight (kg): _____
Serum creatinine (µmol/L): _____	Date: _____
Creatinine clearance (mL/min): _____	

STANDING ORDERS

Standing order for oseltamivir post-exposure prophylaxis during an influenza outbreak	☐ **Yes** ☐ **No**
Standing order for oseltamivir treatment during an influenza outbreak	☐ **Yes** ☐ **No**

Attending Physician / Nurse Practitioner Signature: _____ Date: _____

Appendix B – Viral Respiratory Season Preparation Checklist

Health and Wellness

PO Box 2000, Charlottetown
Prince Edward Island
Canada C1A 7N8

Santé et Mieux-être

C.P. 2000, Charlottetown
Île-du-Prince-Édouard
Canada C1A 7N8

Viral Respiratory Season Preparation Checklist

Guidelines, Policies and Procedures:

- ☐ The facility has a copy of, and staff have reviewed the most current *Prince Edward Island Guidelines for Viral Respiratory Infections and Outbreak Management in Long-Term Care and Community Care Facilities*
- ☐ Internal masking policy

Education:

- ☐ Staff understand/have been provided essential education on:
  - ☐ How to conduct a Point of Care Risk Assessment (PCRA)
  - ☐ Routine Practices, including hand hygiene and respiratory etiquette
  - ☐ Additional Precautions: Droplet/Contact and Enhanced Droplet/Contact Precautions
  - ☐ Donning and Doffing of PPE
  - ☐ Proper specimen collection technique for obtaining nasopharyngeal (NP) and/or nasal swabs
  - ☐ Abbott ID now testing process

Personal Protective Equipment:

- ☐ PPE sourcing, use, and preparation procedures (e.g. staff responsible for stocking PPE carts, PPE sources, staff responsible for preparing PPE carts during outbreaks)
- ☐ The facility has an adequate stock of PPE for Routine Practices and outbreak requirements
  - ☐ Gloves
  - ☐ Gowns
  - ☐ Medical grade masks
  - ☐ Full face shields/well-fitting goggles
  - ☐ N95 Respirator- see guidelines for staff fit checking and testing requirements
- ☐ PPE expiry dates checked
- ☐ Medical grade masks and alcohol-based hand rub (ABHR) are available for visitors at the facility entrance

Testing:

- ☐ Lab requisitions are readily available, and staff know how to complete them (for PCR testing)
- ☐ The facility has an adequate stock of testing supplies (expiry dates checked)
  - ☐ Abbott ID Now Testing Kits
  - ☐ Nasal Swabs
  - ☐ Nasopharyngeal (NP) swabs for PCR testing – **LTC Only** (obtained from the Micro Lab)
- ☐ Abbott ID Now machine is ready to use
  - ☐ Negative and Positive QC tests have been completed and passed for all required testing (and retested with each new box of testing supplies)
  - ☐ Abbott technical support contact posted directly onto Abbott ID Now Machine

Created: October 23 2024, Updated Dec 3 2025 *princeedwardisland.ca* *DHW IPAC Team* MB Campbell Roach, C O'Hearn, R Johnston, A Doherty, JD Baird

Health and Wellness

Santé et Mieux-être

Signage:

- ☐ IPAC Approved Contact/Droplet Precautions signage (donning/doffing)
- ☐ Outbreak signage for entrance to Unit/Facility

Reporting:

- ☐ The facility is aware to report confirmed COVID-19, Influenza, RSV cases OR 2 or more connected symptomatic residents, with respiratory symptoms to CPHO
  - ☐ CPHO contact info: Business hours: (902) 368-4996, After hours: (902) 213-5824
  - ☐ Line lists prepared for documenting cases for faxing to CPHO (902) 620-3354
- ☐ Facility is aware to contact their designated Infection Control Professional with suspect respiratory illnesses

Staff/Resident/Visitor Communication:

- ☐ The facility has a plan for communicating outbreaks **AND** Infection Prevention and Control (IPAC) practices that staff, residents, and visitors should implement during outbreaks, including:
  - ☐ Frequent/appropriate handwashing and use of ABHR
  - ☐ Proper respiratory etiquette (e.g. cough/sneeze into sleeve or tissue, wash hands after sneezing, coughing or blowing nose, etc.)
  - ☐ Utilizing *Cover your Cough* and *4 Moments of Hand Hygiene* signage
  - ☐ Appropriate use of PPE including additional masking requirements
  - ☐ Physical distancing when appropriate and feasible
  - ☐ Staying home when unwell

Cleaning and Disinfection:

- ☐ The facility has an adequate stock of cleaning/disinfection supplies and a process for sourcing more when required
- ☐ Disinfectants have a DIN (Drug Identification Number) or MDL (Medical Device License) and meet current Environmental Health guidelines
- ☐ Disinfectants are labelled as effective against both enveloped and non-enveloped viruses
- ☐ Cleaning/Disinfection product expiry dates checked
- ☐ Cleaning/Disinfection schedules available for: frequently touched areas, soap/ABHR replacement, paper towel etc.
- ☐ Written guidance is available to staff for both routine and outbreak environmental cleaning and disinfection practices

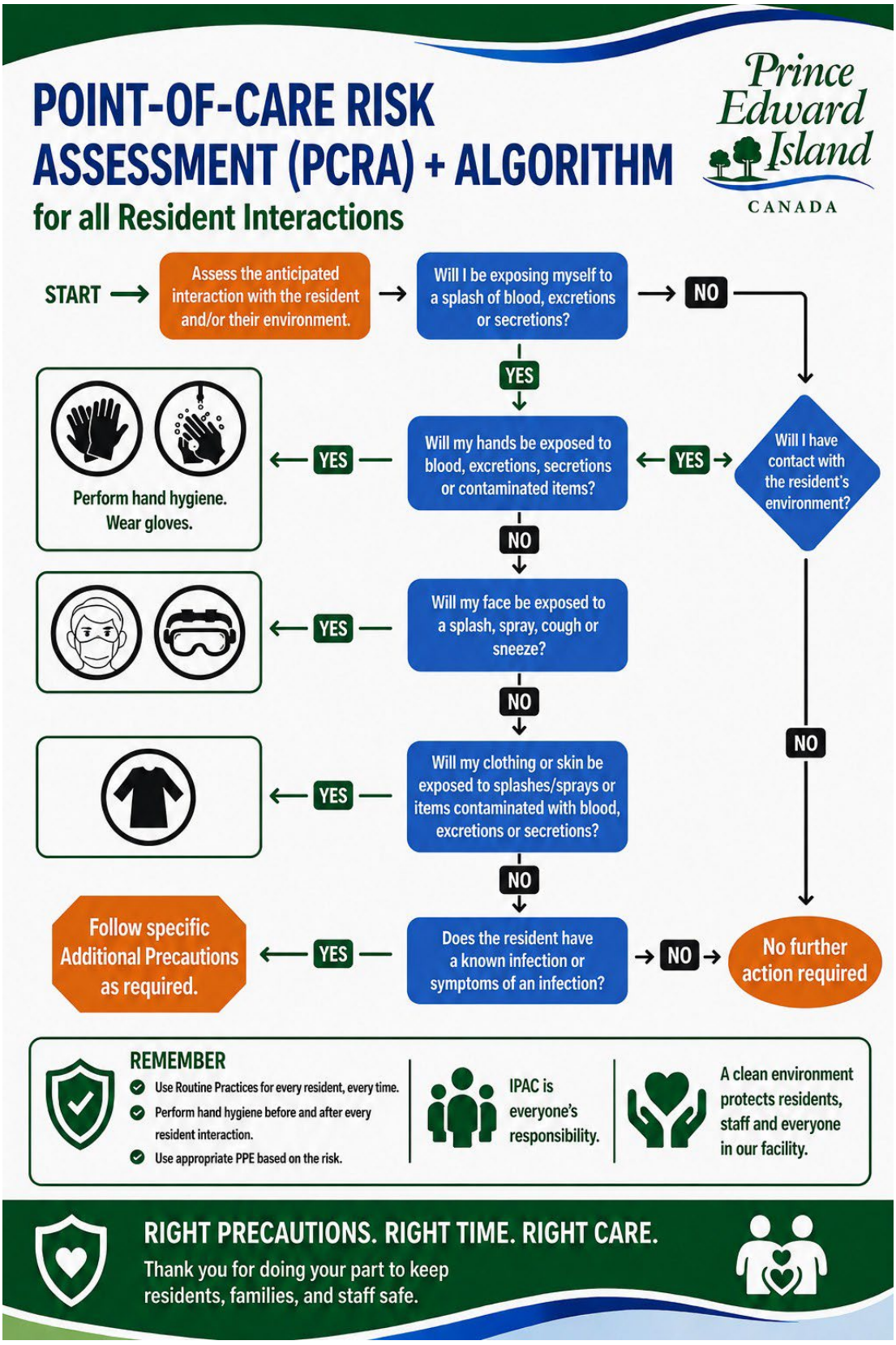
Immunization:

- ☐ Immunization of residents and staff for COVID-19, Influenza and RSV have been planned for/completed (e.g. consents signed, expired supply returned)

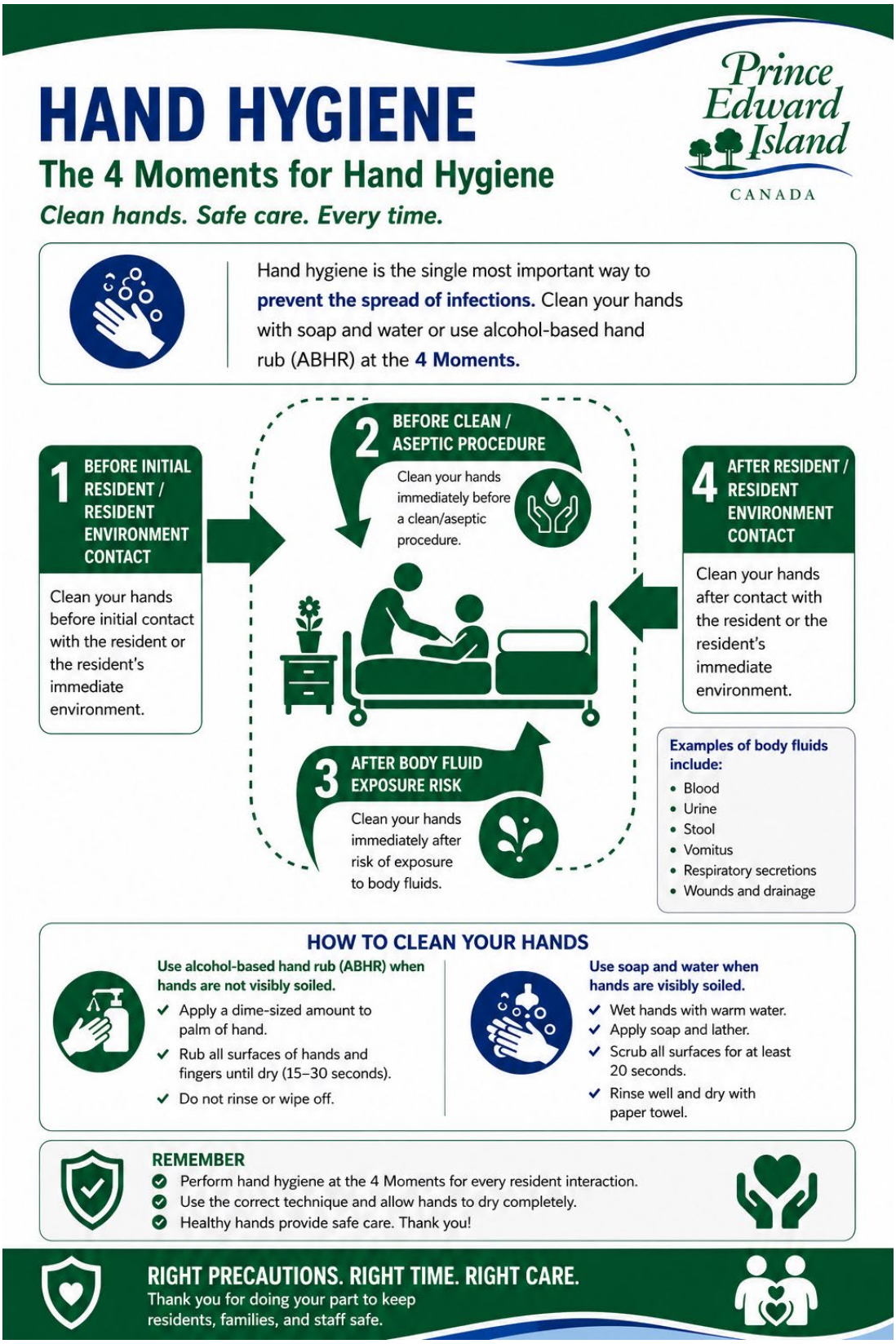
Treatment:

- ☐ Processes prepared for accessing and administering antiviral treatments (Tamiflu/Paxlovid)

Appendix C – Point-of-Care Risk Assessment (PCRA)



Appendix D – Hand Hygiene



Appendix E – Droplet and Contact Precautions

DROPLET AND CONTACT PRECAUTIONS

Prince Edward Island CANADA

Before entering the resident's room

Put on PPE in the correct order.

For residents with suspected or confirmed viral respiratory illness (VRI), wear the following PPE **before entering the room.**

1.

Perform hand hygiene

Clean your hands before putting on PPE.
Use soap and water when hands are visibly soiled; otherwise use alcohol-based hand rub (ABHR).

2.

Put on a long-sleeved, cuffed gown

Cover the front of the body from neck to mid-thigh and fasten securely.

3.

Put on a well-fitting medical mask

Ensure it fits over the nose and under the chin.

4.

Put on eye protection

Use a full-face shield that covers the front and sides of the face, or well-fitting goggles. Regular eyeglasses are not sufficient.

5.

Put on gloves

Extend gloves over the gown cuffs.

REMEMBER

- PPE must be worn upon entering the room of a resident on Droplet and Contact Precautions.
- Use Routine Practices and PCRA for every resident interaction.
- Perform hand hygiene before putting on PPE and after removing PPE.

AGMP NOTE

For an aerosol-generating medical procedure (AGMP), replace the medical mask with a fit-tested N95 or equivalent respirator. An N95 or equivalent respirator may also be used based on PCRA, facility policy, or direction from IPAC or CPHO.

RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.

Thank you for doing your part to keep residents, families, and staff safe.

DROPLET AND CONTACT PRECAUTIONS

Prince Edward Island
CANADA

When leaving the resident's room

Remove PPE carefully to avoid contamination.

Remove PPE in the correct order to prevent contamination of your hands, clothing, and environment.

1.

Remove gloves
Avoid touching the outside of the gloves.

2.

Perform hand hygiene
Clean your hands immediately after removing gloves.

3.

Remove gown
Unfasten ties and pull the gown away from the body.
Avoid touching the contaminated outside of the gown.

4.

Perform hand hygiene
Clean your hands immediately after removing the gown.

5.

Remove eye protection
Handle goggles or face shield by the arms, strap, or other clean areas only.

6.

Remove medical mask or N95 respirator
Handle by the ear loops, ties, or straps.
Do not touch the front.

7.

Perform hand hygiene
Clean your hands again after all PPE has been removed.

REMEMBER

- Discard single-use PPE in the appropriate waste container.
- Perform hand hygiene immediately if your hands become contaminated at any point during PPE removal.
- Follow facility procedures for reusable eye protection, if applicable.

NOTE
Remove PPE in a way that prevents contamination of your hands, clothing, and surrounding environment.

RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.
Thank you for doing your part to keep residents, families, and staff safe.

Appendix F – How to Fit Check and Wear an N95 Respirator

HOW TO FIT CHECK AND WEAR AN N95 RESPIRATOR

Prince Edward Island
CANADA

Fit check every time before providing care.

Fit checking is a quick check performed each time the respirator is put on to ensure a proper seal over the nose and mouth and no gaps between the respirator and face.

Do not enter the care area or provide care requiring an N95 respirator until a satisfactory seal has been achieved.

1 Cup the respirator in your hand with the nosepiece at your fingertips. Allow the straps to hang freely below your hand.

2 Place the respirator over your nose and mouth. Pull the top strap to the crown of your head.

3 Pull the bottom strap over your head and position it at the base of your neck, below the ears.

4 Using both hands, shape the nosepiece firmly over the bridge of your nose.

5 **Positive pressure check:** Gently exhale. If air escapes around the nose or edges, readjust the respirator.

6 **Negative pressure check:** Gently inhale. The respirator should draw in slightly. If the seal is not satisfactory, readjust or replace the respirator and repeat the fit check.

REMEMBER

- A fit check must be performed every time the respirator is put on.
- Use only the respirator make, model, and size for which you have been fit tested.
- Follow the manufacturer's fit-check instructions for the respirator being used.
- Follow facility procedures and report equipment concerns as required.

RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.
Thank you for helping protect residents, families, and staff.

Appendix G – Procedure for Obtaining a Mid-Turbinate and Nasopharyngeal Swab

MID-TURBINATE AND NASOPHARYNGEAL SWAB COLLECTION

Prince Edward Island CANADA

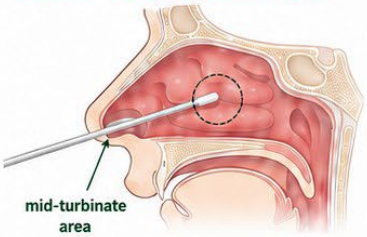
Procedure for viral respiratory testing

Collect specimens safely, correctly, and using the appropriate technique.

BEFORE YOU BEGIN

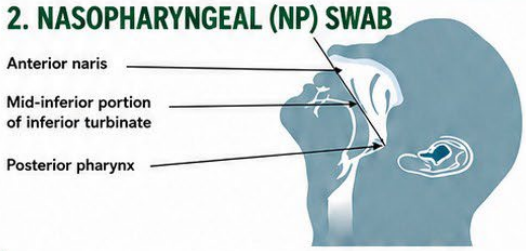
- Use the swab supplied with the appropriate testing kit or viral transport medium.
- Explain the procedure to the resident to reduce anxiety and improve cooperation.
- Don PPE in accordance with Droplet and Contact Precautions. See Appendix E.
- Perform hand hygiene and change gloves between residents.
- Follow facility procedures for putting on and removing PPE.
- If the resident has excess nasal mucus, ask them to gently clear their nose with a tissue before collection.

1. MID-TURBINATE SWAB



1. Insert the swab into the nostril until resistance is met, approximately 2 cm (1 inch).
2. Rotate the swab several times against the mid-turbinate area for 5–10 seconds.
3. Repeat in the other nostril using the same swab.
4. Follow the applicable Abbott ID NOW point-of-care testing (POCT) procedure.

2. NASOPHARYNGEAL (NP) SWAB



1. Estimate insertion depth by measuring from the tip of the nose to the front of the ear. Insert the swab approximately two-thirds of this distance.
2. Seat the resident comfortably and tilt the head back approximately 70 degrees, where tolerated.
3. Insert the swab gently parallel to the palate, along the floor of the nasal passage, toward the posterior nasopharynx.
4. If resistance is encountered, do not force the swab. Remove it and try the other nostril.
5. Once the posterior nasopharynx is reached, hold the swab in place for 5–10 seconds.
6. Rotate the swab several times to collect the specimen.
7. Withdraw the swab and place it immediately into the collection tube containing viral transport medium.

Note: Nasopharyngeal swab collection may induce coughing or sneezing.

AFTER COLLECTION — NP SPECIMEN FOR LABORATORY TESTING

- Label the specimen with at least two unique resident identifiers, such as resident name, date of birth, and PEI Health Number/MRN.
- Include the date and time of collection.
- Place the specimen tube in the zippered portion of the biohazard specimen bag and seal securely.
- Complete the laboratory requisition and place it in the outer pocket of the specimen bag.
- Remove PPE according to facility procedures and perform hand hygiene.
- Refrigerate the specimen until transport to the laboratory, according to current specimen storage and transport requirements.

REMEMBER

- Swabs must be collected by qualified staff trained in proper collection techniques.
- Limit staff in the room to those necessary for resident care during the procedure.
- All staff present must wear PPE in accordance with Droplet and Contact Precautions.

RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.

Thank you for doing your part to keep residents, families, and staff safe.

Appendix H – Line List

VIRAL RESPIRATORY ILLNESS – SURVEILLANCE LINE LIST

Prince Edward Island CANADA

Facility Name: _____ Unit/Wing/Neighbourhood: _____ Date: _____

RESIDENTS Total Number of Residents: _____ Number of Residents Ill: _____

No.	Name (Last, First)	PEI Health Number	Date of Birth (yyyy-mm-dd)	Room / Bed	Onset Date (yyyy-mm-dd)	Symptoms (use codes below)	Fever Y / N	Vaccinated Current Season			Specimen Collection / Testing				Notes / Comments
								Flu Y / N	COVID-19 Y / N	RSV Y / N	Date (yyyy-mm-dd)	COVID-19 Result	Influenza Result	RSV Result	
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															

STAFF Total Number of Staff: _____

No.	Name (Last, First)	Role / Department	Date of Onset (yyyy-mm-dd)	Date Last Worked (yyyy-mm-dd)	Symptoms (use codes below)	Notes / Comments
1						
2						
3						
4						
5						
6						

SYMPTOM CODES (use all that apply)

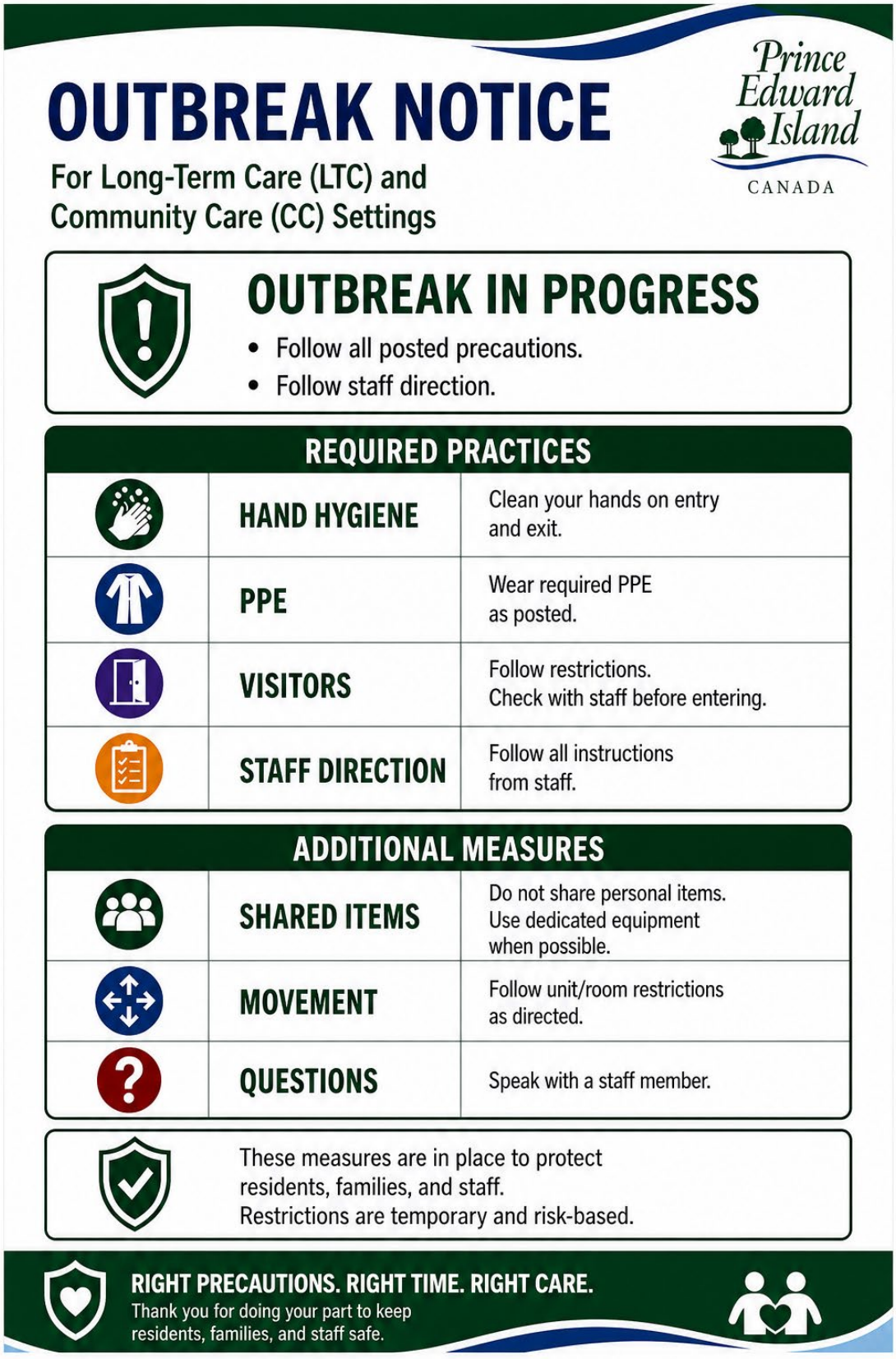
- **C** Cough
- **S** Shortness of breath / difficulty breathing
- **O** Decreased O_2 saturation / increased O_2 requirement
- **T** Sore throat / painful swallowing / hoarse voice
- **N** Runny nose / nasal congestion / sneezing
- **L** Loss or change of taste or smell
- **F** Fever (≥37.8°C oral or ≥37.2°C rectal)
- **H** Headache
- **M** Muscle aches or joint pains
- **X** Significant or unusual fatigue
- **G** Nausea / vomiting / diarrhea
- **A** Other / change from baseline (specify in Notes)

REMINDERS

- Report according to facility and provincial requirements.
- Update the line list daily during an increased respiratory illness event or outbreak.
- Use one line per resident or staff member.

NOTES

- Retain as per facility policy.
- Add any additional facility-specific instructions in the Notes / Comments columns.

RIGHT PRECAUTIONS. RIGHT TIME. RIGHT CARE.

Appendix I – Outbreak Signage