Prince Edward Island
Health and Wellness
CANADA

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

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Department of Health and Wellness
Chief Public Health Office

Contents

1.0 Introduction

In May 2023, the World Health Organization (WHO) determined that COVID-19 was no longer a public health emergency of international concern (PHEIC) and is now considered an established and ongoing health issue. WHO recommended integrating the COVID-19 response into broader infectious disease prevention and control programs that maintain operational readiness for surges of COVID-19 cases and other emerging respiratory pathogens. [1]

The COVID-19 pandemic has provided many lessons, particularly in infection prevention and control (IPAC). These lessons have strengthened our knowledge and tools for managing both known and emerging pathogens. As we continue to live with SARS-CoV-2 and its variants, it is essential to apply these IPAC strategies to all viral respiratory pathogens, given the similarities in transmission and prevention. [1 2]

Aligned with updated guidance across many jurisdictions, and with a focus on balancing IPAC practices with the physical, psychological, emotional, and spiritual needs of residents, this document outlines current best practices and evidence-based recommendations for managing respiratory outbreaks in long-term care facilities (LTCFs) and community care facilities (CCFs).

2.0 Background

Respiratory viruses such as SARS-CoV-2, influenza, and respiratory syncytial virus (RSV) will continue to circulate and are easily transmitted in long-term care facilities (LTCFs) and community care facilities (CCFs) due to communal living arrangements and close contact among residents. Individuals in these settings often have underlying risk factors—such as advanced age and chronic health conditions—that increase their vulnerability to severe illness, which can lead to hospitalization and death.

While influenza typically occurs seasonally, from fall to early spring, other viral respiratory infections, including COVID-19, may circulate year-round. Facilities should routinely monitor residents and staff for early signs and symptoms of respiratory infections, particularly during respiratory season or when community transmission is elevated. Prompt implementation of infection prevention and control (IPAC) measures can help limit spread and reduce the duration of precautionary measures.

The recommendations in this document aim to protect the health of residents, staff, visitors, and volunteers. They provide guidance for facilities experiencing an increase in viral respiratory infections, regardless of whether the causative agent has been identified. Administrators and staff should use this information to develop policies, procedures, and plans for preventing and managing respiratory infections and outbreaks.

3.0 Reporting Requirements

Influenza, COVID-19, respiratory syncytial virus (RSV), and outbreaks of viral respiratory illness (VRI) in health facilities and institutions are notifiable events under the *Prince Edward Island Public Health Act*[3] and the *Notifiable Diseases and Conditions and Communicable Diseases Regulations*.[4] Timely reporting is essential for effective outbreak management and public health response.

3.1 Facility Operators and Staff

Health practitioners or facility administrators must report all confirmed and probable cases as soon as they are suspected. Reports should be made by phone and/or electronic transfer to the Chief Public Health Officer (CPHO) or designate.[3 4]

3.2 Laboratory

The Provincial Laboratory must report all positive laboratory results as soon as they are known. Reports should be made by phone and by mail, fax, or electronic transfer to the CPHO or designate.[3]

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 droplets and aerosols generated by coughing, sneezing, talking, and breathing
- Direct or indirect contact with contaminated respiratory secretions on surfaces and objects

Clinical Considerations

- Older residents may present atypically (e.g., confusion or delirium instead of fever)
- Monitor for clusters of residents with symptoms in the same area over a short period
- Testing should be conducted when changes in baseline condition suggest possible infection

Prevention and Management

- Initiate Droplet and Contact Precautions immediately when respiratory infection is suspected, even if the causative pathogen is unknown
- Maintain precautions while clinical suspicion remains, as these measures are effective against all viral respiratory pathogens
- Enhanced IPAC measures (e.g., masking, physical distancing) may differ in LTCFs and CCFs compared to the general population due to resident vulnerability
- Immunization against influenza, COVID-19, and RSV is safe and effective in reducing illness severity and mortality, though outbreaks can still occur among vaccinated residents[5]

4.1 Influenza

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

Clinical Features

- Fever AND cough
- May also include: sore throat, arthralgia (joint pain), myalgia (muscle pain), and prostration (extreme weakness)
- In elderly residents, symptoms may be atypical and include: absence of fever, cough, fatigue, and/or confusion
- Most people recover within 3–7 days, but older adults are at increased risk of hospitalization and complications such as pneumonia or worsening of underlying conditions [6] [7]

Prevention and Management

Influenza vaccination of both residents and staff within LTCFs and CCFs is the most effective means of preventing influenza illness and decreasing the risk of influenza-related complications. Antiviral medications are available for LTCF residents who are diagnosed with influenza to prevent progression to severe disease, provide post-exposure prophylaxis (PEP), and help prevent outbreaks in LTCFs *(See Appendix A)* [6] [7].

4.2 COVID-19

COVID-19 is caused by the SARS-CoV-2 virus. Residents in LTCFs and CCFs are at higher risk due to advanced age, chronic health conditions, and the ease of transmission in communal settings.

Clinical Features

- Symptoms may include: runny nose, headache, sneezing, sore throat, cough, and fever
- Symptoms often resemble influenza
- Illness severity ranges from asymptomatic to severe disease
- New variants have altered incubation periods, transmissibility, and symptom patterns, and this trend is expected to continue [8]

Prevention and Management

COVID-19 vaccination of both residents and staff within LTCFs and CCFs is the most effective means of preventing illness and reducing the risk of severe disease and complications. The antiviral medication Paxlovid™ (nirmatrelvir and ritonavir) is available for eligible residents with mild to moderate COVID-19 to prevent progression to severe disease [9] [10]. For eligibility and prescribing information, visit: PEI Paxlovid Information.

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 partial and temporary.

Clinical Features

- Symptoms are usually mild and cold-like: runny nose, cough, sneezing, fatigue, headache, and fever
- Older adults may present atypically
- Most healthy adults recover within 1–2 weeks, but adults over 65 years and immunocompromised individuals are at increased risk of severe disease such as bronchiolitis and pneumonia
- RSV can exacerbate chronic conditions like heart and lung disease and may lead to death in vulnerable populations [11]

Prevention and Management

RSV vaccination is recommended and available for residents of LTCFs and CCFs who are 60 years of age and older to help prevent RSV disease and reduce the risk of severe illness and complications. Currently, antiviral medications are not available to prevent or treat RSV infections in this population. [11]

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 present with symptoms similar to other viral respiratory infections, such as cough, congestion, and fever.
- Laboratory confirmation of these pathogens is unlikely in LTCFs or CCFs.

Prevention and Management

The same IPAC measures recommended for influenza, COVID-19, and RSV—such as Droplet and Contact Precautions—are effective and should be initiated when respiratory infection is suspected. [5]

4.5 Stages of Viral Respiratory Infections

Following sufficient exposure to a respiratory virus, individuals typically progress through three stages: incubation, infectious, and symptomatic periods. *(See Table 1 for an outline of these stages for each respiratory viral pathogen.)* [5]

4.5.1 Incubation Period

During this stage, the virus is replicating (copying) within the individual. Early in the incubation period, the viral load is not sufficient for transmission. By the end of this period, the viral load increases, and the individual becomes infectious.

4.5.2 Infectious Period

During this stage, the individual can spread the virus to others—even if they have not yet developed symptoms.

4.5.3 Symptomatic Period

At the beginning of the symptomatic period, the individual continues to shed the virus and can transmit infection to others. As recovery progresses, viral shedding decreases, and the risk of transmission lessens.

TABLE 1. Comparison of key features of respiratory viral pathogens

	Influenza	COVID-19	RSV	Other
Viral etiology	Influenza A & B	SARS-CoV-2	Respiratory syncytial virus	Adenovirus, human metapneumovirus, parainfluenza virus, rhinovirus
Laboratory/point of care molecular testing for LTCF and CCF	Both available	Both available	Laboratory testing done as part of respiratory panel during influenza season	Laboratory testing only done as part of an extended respiratory panel during influenza season for specific cases
Incubation Period	1-4 days median 2 days	2-14 days median 2-4 days	2-8 days median 5 days	2-10 days
Communicable Period	1 day before symptom onset to 5 days after symptom onset	2-3 days prior to symptoms to about 7-10 days after symptom onset; if asymptomatic date of positive test	1-21 days median 8 days	May be communicable a few days before and while symptomatic
Vaccine Available	Yes, publicly funded	Yes, publicly funded	Yes, publicly funded	No

Antiviral Prophylaxis or Treatment/Therapeutics	Prophylaxis and treatment are recommended in LTCF	Treatment available for eligible residents	No antiviral or treatment available in this age group	No

Actions when resident has symptoms of a Viral Respiratory Infection	**Immediate Actions:**
	• Isolate the symptomatic resident(s) and initiate Droplet and Contact Precautions immediately.
	• Collect a viral swab and test for:
	  ○ COVID-19 and Influenza using Abbott ID NOW NAAT for Point-of-Care Testing (POCT), or
	  ○ COVID-19, Influenza, and RSV using laboratory-based PCR.
	Notification:
	• Notify the Chief Public Health Office (CPHO) if **any** resident tests positive or an outbreak is suspected. During business hours, call **902-368-4996**; after hours, use the on-call number.
	• **Suspect an outbreak** if **two symptomatic residents** occur within **72 hours** with an **epidemiologic link**.
	• Notify the laboratory that the facility may be in an outbreak situation when sending specimens for PCR testing.
	Documentation:
	• Begin a resident and staff line list (see Appendix G) and fax daily to CPHO at **902-620-3354** with updates on subsequent cases.
	Reference:
	• See **Section 7.2: Screening and Management of Symptomatic Residents** for additional details.			

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

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 all staff and stakeholders. *(See Table 2 for preparation steps for the viral respiratory season and Appendix B for full details.)*

This document will help facilities:

- Create setting-specific policies and procedures
- Share these policies with staff, physicians, residents, families, visitors, and volunteers ahead of any outbreak

TABLE 2. Steps in Preparing for Viral Respiratory Season

Policies and Procedures
• Ensure facility-specific policies and procedures are in place, including:
  ○ Infection Prevention and Control (IPAC) measures
  ○ Staff education on influenza, COVID-19, and RSV, and other clinical presentations
  ○ Environmental management protocols
  ○ A clear communication plan for all staff

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** for staff.

Testing Supplies
• Ensure an adequate supply of:
  ○ Nasopharyngeal (NP) swabs for PCR testing (COVID-19, influenza, RSV)
  ○ Abbott ID NOW testing kits (verify expiry dates)
• Provide staff education on proper specimen collection techniques

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 (see Appendix A).
COVID-19 Treatment Access • Set up a process to access Paxlovid™ for eligible symptomatic COVID-19-positive residents.
Consent for Vaccines and Treatments • Obtain resident or substitute decision-maker consent for COVID-19, influenza, and RSV vaccines and treatments.

Immunization Planning
• Plan for annual immunization of:
  ○ Residents: influenza, COVID-19, RSV (if not previously received)
  ○ Staff: influenza, COVID-19

Goals of Care • Review and update Goals of Care/Advance Directives for all residents.

5.2 Immunization of Staff and Residents

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. All staff should receive an annual influenza vaccine for their own protection and the protection of residents. Vaccines are available in early fall. [12]

Resident Influenza Immunization

Immunization of residents in LTCFs and CCFs against influenza remains a critical strategy to prevent viral respiratory infections and severe outcomes.

- For residents 65 years of age and older, NACI preferentially recommends High-Dose Quadrivalent Influenza Vaccine (High-Dose QIV).
- Residents under 65 years of age are eligible to receive the standard Quadrivalent Influenza Vaccine (QIV).
- Both vaccines are available in early fall. [12]

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 one of the most effective ways to protect staff, co-workers, and vulnerable residents from severe disease, hospitalization, and death.

- COVID-19 vaccination is available in the fall for those not previously vaccinated and those previously vaccinated.
- For those previously vaccinated, a dose can be given if it has been 3–6 months since their last COVID-19 vaccine or COVID-19 infection (whichever is later). [10]

Resident COVID-19 Immunization

NACI recommends that COVID-19 immunization is particularly important for those at increased risk of severe disease from a COVID-19 infection. Residents in LTCFs and CCFs fall in this category. As mentioned above, residents can receive their primary series of COVID-19 vaccine or subsequent dose of vaccine in the fall. (10)

5.2.3 RSV Immunization

Resident RSV Immunization

RSV vaccination is an important preventive measure and is recommended for older adults, particularly those living in congregate settings such as LTCFs and CCFs.

- The vaccine is publicly funded for residents of LTCFs and CCFs aged 60 years and older.

5.3 Routine Practices

Routine practices apply to all staff, residents, and visitors at all times in LTCFs and CCFs. These include, but are not limited to:

- Conducting a Point-of-Care Risk Assessment (PCRA) before every resident interaction
- Hand hygiene performed according to facility protocols
- Appropriate use of PPE based on risk assessment
- Respiratory hygiene, including:
    - Turning away from others when coughing or sneezing
    - Covering coughs/sneezes with a tissue or into the sleeve
    - Disposing of tissues immediately
    - Performing hand hygiene after coughing or sneezing

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

Prior to any resident interaction, all staff have the responsibility to assess the infectious risks posed to themselves, other staff, residents, and visitors from a resident, situation, or procedure.

Purpose of PCRA

- Helps staff select appropriate actions and/or PPE to minimize exposure to known and unknown infections
- Supports the appropriate use of PPE

Resident Factors to Consider During PCRA

- Signs, symptoms, or clinical syndromes requiring Additional Precautions
- Volume of respiratory secretions and ability to control behaviors (e.g., shouting), secretions, and cough
- Ability to comply with IPAC practices (e.g., hand hygiene, medical mask use, respiratory hygiene)
- Requirement for extensive or prolonged direct 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
    - *Handwashing with soap and water is required for food handling*
- 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 (e.g., medical equipment, bed, table, door handle), regardless of glove use
- Any other time hands are potentially contaminated (e.g., after handling blood, body fluids, bedpans, urinals, or wound dressings)
- After personal hygiene practices (e.g., blowing nose, touching face, using toilet facilities)

Note: Handwashing with soap and water is required when hands are visibly soiled and after personal hygiene practices.

5.5.2 Residents Hand Hygiene Recommendations

Residents should perform hand hygiene:

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

Note: Handwashing with soap and water is required when hands are visibly soiled and after personal hygiene practices.

5.6 Droplet and Contact Precautions (Appendix E)

Droplet and Contact Precautions must be implemented for all residents who are diagnosed with or presenting with signs and symptoms of a viral respiratory illness.

Required PPE:

- Gloves and a long-sleeved cuffed gown (covering the front of the body from neck to mid-thigh) upon entering the resident's room
- A well-fitting medical-grade mask
- Face or eye protection, which includes:
    - 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:

- The area where PPE is donned should be separated as much as possible from the area where PPE is removed and discarded
- Hand hygiene must be performed before putting on and after removing PPE

NOTE:

- For interactions with residents suspected or confirmed to have a viral respiratory illness, PPE consistent with Droplet and Contact Precautions (gloves, gown, well-fitting medical-grade mask, and eye protection) must be worn
- An N95 or equivalent respirator should replace a medical mask when performing or exposed to an Aerosol-Generating Medical Procedure (AGMP)
- Use of an N95 or equivalent respirator may also be considered in other circumstances where risk of exposure to aerosolized virus exists [18]

6.0 Case Definitions of Respiratory Viral Infections

In LTCFs and CCFs, when staff notice a change in a resident's baseline condition that could be related to a respiratory virus, active daily screening and documentation must be initiated.

Purpose of Active Screening:

- Detect viral respiratory illness early, especially symptoms that may present atypically in older adults (e.g., confusion or delirium)
- Support timely implementation of IPAC measures to prevent spread

Testing Guidance:

- Widespread asymptomatic testing is not recommended
- Testing a resident without respiratory symptoms may be appropriate based on clinical judgment and staff knowledge of the resident's baseline condition [5]

6.1 Viral Respiratory Illness (VRI)

VRI Case Definition	VRI Outbreak Definition
New/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/dyspnea • Decreased O_2 saturation or increased O_2 requirement • Sore throat/painful swallowing/hoarse voice • Runny nose/nasal congestion/sneezing • Loss of/change to sense of taste or smell **Other:** • Fever* • Headache • Myalgia or arthralgia • Fatigue (significant and unusual) Nausea/vomiting/diarrhea	Two or more cases of viral respiratory illness (**VRI**) within a seven-day period with a common epidemiological (epi) link AND testing is not available or all negative

*Fever is as follows:
- Single oral temp >37.8C OR
- Repeated oral temps >37.2C or rectal temps >37.5 OR
- Single temp >1.1C over the individual's baseline (oral or rectal)

6.2 Influenza Illness

Influenza Case Definition	Influenza Illness 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 epi link, including **at least one** *__test-confirmed__ case of influenza within the surveillance setting Or Two or more *__test-confirmed__ cases of influenza which are epi linked to a specific setting or location

***Test-confirmed influenza case**: case with a positive result on lab-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 which are epi linked to a specific setting or location

***Test-confirmed COVID-19 case**: case with a positive result on lab-based PCR or Abbott ID Now NAAT. A case with a positive result on a rapid antigen test may be considered to be a test-confirmed case of COVID-19 upon review by the Chief Public Health Officer or designate.

6.4 RSV Illness

RSV Case Definition	RSV Outbreak Definition
A person with laboratory confirmation testing of RSV	Two or more cases of VRI within a seven-day period with an epi link, including **at least one** laboratory confirmed case of RSV within a surveillance setting

7.0 Outbreak Management for Viral Respiratory Illnesses

Despite stringent Infection Prevention and Control (IPAC) measures, controlling outbreaks in LTCFs and CCFs can be challenging. To prevent the spread of infection, staff must initiate IPAC measures promptly—without waiting for laboratory confirmation of the viral respiratory pathogen.

Core IPAC Measures:

- Routine Practices
- Hand Hygiene
- Droplet and Contact Precautions

7.1 General Outbreak Management Principles

Immediate Actions:

- Prompt isolation of symptomatic residents in their rooms or designated cohort areas.
- Initiate Droplet and Contact Precautions (see Appendix D and E for posters).
- Post Outbreak Signage in affected units/areas (Appendix H).

Testing:

- Collect specimens (e.g., nasopharyngeal swab) from symptomatic residents to determine the viral pathogen.
- Follow CPHO guidance for testing asymptomatic close contacts if required.

Notification and Reporting:

- Notify the CPHO immediately; CPHO will declare the start and end of outbreaks.
- Once confirmed by CPHO, report subsequent cases daily using the line list in Appendix G.

Resident Monitoring:

- Conduct daily active monitoring of all residents for symptoms.

Staff Screening and Work Exclusion:

- Passive screening before every shift (e.g., signage, self-check) and self-monitoring during shifts.
- Exclude staff who meet symptom criteria from work until 24 hours symptom-free or as directed by IPAC or CPHO.

Environmental Cleaning:

- Enhance cleaning and disinfection of resident and staff areas.
- Clean high-touch surfaces at least every 4 hours during outbreaks.
- Use approved disinfectants and adhere to recommended contact times.

Personal Protective Equipment (PPE):

- Ensure stringent adherence to masking and eye protection for staff working in affected areas.

Communication:

- Notify families and staff about outbreak status and precautionary measures.

End-of-Outbreak Criteria:

- Outbreak is considered over as per table 3 or as determined by CPHO.

7.2 Screening and Management of Symptomatic Residents

Active Screening:

- Conduct daily active screening of all residents.
- Pay special attention to changes from baseline, including:
    - New confusion or delirium (possible early sign of viral respiratory infection).
- Refer to:
    - Section 4.0 for summary of viral respiratory illnesses.
    - Section 6.0 for case and outbreak definitions.

7.2.1 Steps for Managing Symptomatic Residents and Close Contacts

Step 1: Isolation and Precautions

- Immediately isolate symptomatic resident.
- Implement Droplet and Contact Precautions.
- Care for the resident in a single room with a dedicated toilet and sink, if possible.
- Roommates:
    - Do not move to a new shared room.
    - If possible, place in a single room and monitor closely for symptoms.

Step 2: Testing

- Swab symptomatic resident for Point-of-Care Testing (POCT) for COVID-19.
    - If POCT is not available, send swab for lab-based PCR.
- If POCT is negative for COVID-19, test for influenza.
- During respiratory season:
    - If POCT is negative for both COVID-19 and influenza, consider lab-based PCR because:
        - POCT is less sensitive than PCR.
        - Early infection may yield false negatives.
        - RSV or other pathogens may be circulating.
- See Appendix G for Mid Turbinate and NP swab collection process.

Step 3: Reporting

- If a viral respiratory outbreak is suspected, report immediately to CPHO.
- Refer to Section 6.0 for outbreak definitions.

7.3 Managing Testing and Testing Results of Residents

7.3.1 Symptomatic Residents with COVID-19

Precautions:

- Place residents with COVID-19 symptoms on Droplet and Contact Precautions immediately.

Testing:

- Symptomatic residents can be tested using:
  - Abbott ID NOW NAAT Point of Care Testing (POCT), or
  - Laboratory-based PCR.
- When sending specimens for PCR:
  - Notify the laboratory that the facility may be in an outbreak situation.
  - The lab will advise on the number of specimens required (usually 2 specimens are sufficient).
- Do not retest a newly symptomatic resident who tested positive for COVID-19 within the previous 60 days.
  - Alert the house physician or nurse practitioner for FLUVID/RSV PCR testing orders instead.

Treatment:

- Symptomatic residents who test positive for COVID-19 may be eligible for Paxlovid™ treatment.

Testing During Confirmed Outbreak:

- Once a COVID-19 outbreak is confirmed (2 epidemiologically linked positive residents):
  - Additional testing of symptomatic residents is generally not necessary unless directed by CPHO.
  - If POCT is not available and a PCR test is required, notify the laboratory and provide the reason for the additional testing.
  - Exceptions for additional testing:
    - Resident requires access to Paxlovid™.
    - Resident develops new or worsening symptoms while on treatment.
    - Resident with no epidemiological link to the outbreak presents with symptoms.

Communication:

- Maintain regular contact with CPHO/IPAC if the outbreak spreads to other units or areas.
- Work with CPHO/IPAC to determine when to declare the outbreak over.

Duration of Precautions:

- Symptomatic residents diagnosed with COVID-19 should remain on Droplet and Contact Precautions for:
  - 5 days following symptom onset or positive test date (regardless of vaccination status), AND
  - Until fever has resolved for 24 hours without fever-reducing medication, AND
  - Symptoms have improved.
- **NOTE:** Moderately or severely immunocompromised residents may require an extension of precautions. Discuss with IPAC or CPHO.

Close Contacts of Cases with COVID-19

Definition of Close Contacts:

- Roommates, dining table mates, and other residents with significant contact with the symptomatic resident.

Monitoring:

- Monitor close contacts for symptoms at least twice daily for 4 days following last exposure.
    - Day 0 = day of last exposure.

Testing and Restrictions:

- No need to test or restrict asymptomatic roommates or close contacts from activities.
- If close contacts become symptomatic during a declared outbreak:
    - No testing required unless requires access to Paxlovid™.
    - If POCT is not available and a PCR test is required, notify the laboratory and provide the reason for the additional testing.
    - Place on Droplet and Contact Precautions for the same duration as above.

7.3.2 Symptomatic Residents with VRI/Influenza

Precautions:

- Place residents with viral respiratory illness (VRI) or influenza symptoms on Droplet and Contact Precautions immediately.

Testing:

- Test as soon as possible, ideally within 24 hours of symptom onset, using:
    - Abbott ID NOW NAAT POCT, or
    - Laboratory-based PCR.
- When sending specimens for PCR:
    - Notify the laboratory that the facility may be in an outbreak situation.
    - The lab will advise on the number of specimens required (usually 2 specimens are sufficient).

Testing During Confirmed Influenza Outbreak:

- Once an influenza outbreak is confirmed (2 epidemiologically linked positive residents):
    - Additional testing of symptomatic residents is generally not necessary unless directed by CPHO.
    - If POCT is not available and a PCR test is required, notify the laboratory and provide the reason for the additional testing.
    - Exceptions for additional testing:
        - Resident develops new or worsening symptoms while on treatment/prophylaxis.
        - Resident with no epidemiological link to the outbreak presents with symptoms.

Communication:

- Maintain regular contact with CPHO/IPAC if the outbreak spreads to other units or areas.
- Work with CPHO/IPAC to determine when to declare the outbreak over.

Duration of Precautions:

- Residents with VRI symptoms or confirmed influenza should remain on Droplet and Contact Precautions for:
    - At least 5 days following symptom onset, AND
    - Until clinically improving, AND
    - Fever resolved for 24 hours without fever-reducing medication, AND
    - Resident is not moderately or severely immunocompromised.
- **NOTE:** Moderately or severely immunocompromised residents may require an extension of precautions. Discuss with IPAC or CPHO.

Additional Guidance for LTCF Residents

- Once antiviral prophylaxis is started:
    - A daily line list is no longer required by CPHO but may be useful for facility outbreak management.
- If influenza is circulating in the community:
    - CPHO will determine if resident testing is needed and when prophylaxis should begin.

Close Contacts of Cases with VRI/Influenza

Definition of Close Contacts:

- Roommates and other residents with significant contact with the symptomatic resident.

Monitoring:

- Monitor close contacts for symptoms at least twice daily for 2 days following last exposure.
    - Day 0 = day of last exposure.

Testing and Restrictions:

- No need to test or restrict asymptomatic roommates or close contacts from activities.
- If close contacts become symptomatic during a declared outbreak:
    - No testing required.
    - Place on Droplet and Contact Precautions for the same duration as above.

7.3.3 Symptomatic Residents with RSV

Precautions:

- Place residents with RSV symptoms on Droplet and Contact Precautions immediately.

Testing:

- Test as soon as possible (within 24 hours of symptom onset) and send to the lab for FLUVID/RSV PCR if:
    - Abbott ID Now NAAT POCT for COVID-19 and influenza were negative.
    - POCT is not available.
- When sending specimens for PCR:
    - Notify the laboratory that the facility may be in an outbreak situation.
    - The lab will advise how many specimens to send (usually 2 specimens are sufficient).

Testing During Confirmed RSV Outbreak:

- Once an RSV outbreak is confirmed (2 epidemiologically linked positive residents):
    - Additional testing of symptomatic residents is generally not necessary unless directed by CPHO.
    - If POCT is not available and a PCR test is required, notify the laboratory and provide the reason for the additional testing.
    - Exceptions for additional testing:
        - Resident develops new or worsening symptoms.
        - Resident with no epidemiological link to the outbreak presents with symptoms.

Communication:

- Maintain regular contact with CPHO/IPAC if the outbreak spreads to other units or areas.
- Work with CPHO/IPAC to determine when to declare the outbreak over.

Duration of Precautions:

- Residents with confirmed RSV should remain on Droplet and Contact Precautions for:
    - At least 8 days following symptom onset, AND
    - Until fever has resolved for 24 hours without fever-reducing medication, AND
    - Symptoms have improved.
- **NOTE:** Moderately or severely immunocompromised residents may require an extension of precautions. Discuss with IPAC or CPHO.

Close Contacts of Cases with RSV

Definition of Close Contacts:

- Roommates and other residents with significant contact with the symptomatic resident.

Monitoring:

- Monitor close contacts for symptoms at least twice daily for 5 days following last exposure.
    - Day 0 = day of last exposure.

Testing and Restrictions:

- No need to restrict asymptomatic roommates or close contacts from activities within the facility.
- If close contacts become symptomatic during a declared outbreak:
    - No testing required.
    - Place on Droplet and Contact Precautions for the same duration as above.

7.4 New Admissions, Re-Admissions, and Transfers During Viral Respiratory Outbreaks

General Principles:

- Admissions, readmissions, and transfers may be allowed to affected areas during an outbreak in certain circumstances.
- Decisions should be based on a risk-benefit assessment and the ability to maintain safe care.

Key Considerations:

- **Scope of outbreak:**
  - Is the outbreak limited to one household/unit/section or the entire facility?
- **Outbreak status and management:**
  - Length of time since last case, attack rate, severity of illness.
- **Staffing:**
  - Is there adequate staff available to provide care safely?
- **Resident-specific factors:**
  - Is the area where the resident is returning to affected by the outbreak?
  - Past exposure to viral respiratory pathogens.
  - Co-morbidities and overall health status.
  - Immunization status or antiviral prophylaxis.
- **Consent and communication:**
  - Has the resident/substitute decision maker and most responsible provider been informed of the outbreak and consented to the move?
- **Risk vs. benefit:**
  - What is the overall benefit vs. risk of immediate vs. delayed placement?

Transfers for Medical Necessity:

- For hospital admissions or urgent appointments (e.g., dialysis):
  - Notify the receiving facility/unit and transport personnel of:
    - The outbreak status.
    - Any additional precautions required for the resident.
  - Ensure the receiving hospital or clinic can provide care safely.

Post-Transfer Notification:

- Inform all facilities that accepted a resident from your facility within the last 10 days of the outbreak.

Testing and Precautions for Admissions:

- Test only if symptoms are present at admission using:
  - POCT, if available, or collect a viral swab for PCR lab testing.
- Place on Droplet and Contact Precautions only if symptomatic.
- If POCT is negative:
  - Continue precautions. Alert the house physician or nurse practitioner for orders to send a specimen for FLUVID/RSV PCR.

7.5 Screening and Management of Symptomatic Staff

Testing:

- Staff are not routinely tested for viral respiratory illnesses unless:
    - Ordered by a physician or nurse practitioner for other purposes outside facility outbreak concerns.

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.
    - Ensure they are wearing a well-fitting medical mask.
    - 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 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 monitor themselves for signs and symptoms of viral respiratory illness before entering the LTCF or CCF.**

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

They may return only when **BOTH** conditions 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 any procedure that can induce the production of aerosols of various sizes, including droplet nuclei.

General Guidance:

- Consider discontinuing CPAP/BiPAP during an outbreak in consultation with the physician or nurse practitioner.

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

AGMPs should be avoided if possible and only performed when:

- The procedure is medically necessary.
- Performed by the most experienced person available.
- The minimum number of persons required to safely perform the procedure are present.
- All persons in the room are wearing:
    - A fit-tested and/or fit-checked N95 respirator (see Appendix F),
    - Gloves,
    - Gown, and
    - Face or eye protection.
- The door of the room is closed during the procedure.
- After the AGMP is completed, keep the door closed for at least 1 hour (or as per facility ventilation specifications) before allowing entry without airborne precautions.

7.8 Specimen Collection

Specimen Type:

- Collect a mid-turbinate swab for Point-of-Care Testing (POCT), or
- Collect a nasopharyngeal (NP) swab for PCR laboratory-based testing.

Personnel:

- Swabs must be collected by qualified staff trained in proper collection techniques to ensure accuracy and patient safety. (See Appendix F for collection process)

During Sample Collection:

- 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.

Handling Laboratory Specimens:

- Treat all specimens as potentially infectious.
- Place specimens in biohazard bags.
- Handle and transport specimens according to Routine Practices and facility protocols.

7.9 Environmental Cleaning and Disinfection

Cleaning and Disinfection Principles

- Cleaning and disinfecting high-touch surfaces is critical for controlling the spread of microorganisms.
- Use hospital-grade disinfectants registered in Canada with:
    - A Drug Identification Number (DIN) or Medical Device License (MDL).
    - Labelled as effective against both enveloped and non-enveloped viruses.

Alternative Disinfectant (Bleach Solution)

- If hospital-grade disinfectants are unavailable:
    - Use diluted bleach solution:
        - Minimum concentration: 5000 ppm or 0.5% chlorine (equivalent to a 1:9 dilution of 5% liquid bleach).
    - Cleaning must precede disinfection when using bleach.

Frequency and Scope

- High-touch surfaces (e.g., call bells, bedrails, door handles, light switches, tables, sinks, toilets, grab bars):
    - **Routine (non-outbreak):** Clean and disinfect at least twice daily and when visibly soiled.
    - **Outbreak or heightened transmission risk:** every 4 hours (or more frequently if visibly soiled), especially in resident rooms and common areas.
- Resident care equipment (e.g., BP cuffs, thermometers, oximeters, stethoscopes):
    - Clean and disinfect after each use and between residents using hospital-grade disinfectant and recommended contact time.
- Low-touch surfaces (e.g., shelves, chairs, windowsills):
    - Clean and disinfect at least once daily.
- Floors and walls:
    - Keep visibly clean and free of spills, dust, and debris.
- Shared staff equipment (e.g., computer carts, medication carts, charting desks):
    - Clean and disinfect at least daily and when soiled.
    - Staff must perform hand hygiene before touching shared equipment.

Environmental Services Staff

- Must wear the same PPE as other staff when cleaning and disinfecting resident rooms.

Special Considerations

- **Carpeted areas:**
    - Do not vacuum during an outbreak (risk of aerosolization).
    - If contaminated:
        - Blot with paper towel.
        - Apply disinfectant suitable for carpets.
        - Steam clean thoroughly if possible**.**

- **Post-discharge/transfer cleaning:**
    - Follow facility protocol.
    - Discard toilet brushes (if using), unused toilet paper, and disposable supplies.
    - Remove and launder bedside privacy curtains.

Resident Care Equipment

- Dedicate reusable equipment and supplies to the resident with suspected or confirmed viral respiratory infection.
- If sharing is necessary:
    - Clean and disinfect with hospital-grade disinfectant.
    - Ensure adequate contact time 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 activities on affected units as appropriate to reduce transmission risk.
- Prioritize low-risk activities during an outbreak, such as:
    - Arts and crafts
    - Bingo
    - Card games
    - Other small group activities that allow for safe spacing.

Dining and Food Service:

- Remove shared food containers from dining areas (e.g., water/juice pitchers, salt and pepper shakers, butter dishes).
- Dispense food and snacks directly to residents.
- If using single-serve condiment packets, provide packets directly to each resident.
- Cease activities involving resident participation in food preparation.
- Disposable plates and cutlery for symptomatic residents are not required.
- Close kitchen/nourishment areas accessed by residents or visitors.

7.11 Resident Off-Site Outings

- Minimize the frequency of resident off-site outings during an outbreak, especially for residents from affected units.
- Residents who are on precautions or symptomatic should not leave the facility except for:
    - Essential medical care, or Emergency care.

7.12 Outbreak Visitation

General Principles:

- Facility decisions regarding visitation should be based on operational capacity.
- During an outbreak, visitation should balance:
  - Physical, psychological, emotional, and spiritual needs of residents.

Visitor Guidelines:

- Visitors must:
  - Limit movement within the facility to directly visiting the resident and then exit promptly.
  - Follow all IPAC protocols, including wearing appropriate PPE.
  - Maintain safe spacing from other residents and staff.
- Family or visitors may visit at any time provided the visit does not negatively impact care for other residents.

8.0 Declaring the Outbreak Over

General Principles:

- The facility Outbreak Management Team should have a plan to discontinue additional precautions for:
  - Individual residents
  - Rooms
  - Units
  - The entire facility.
- IPAC control measures must continue until the outbreak is officially declared over.

Criteria for Declaring an Outbreak Over

- An outbreak may be considered over when:
  - No new cases of viral respiratory illness in residents or staff with an epidemiological link have been identified for the required duration (see Table 3 below).
  - Decision is made in consultation with the Chief Public Health Office (CPHO).

Factors to Assess:

- Are residents in the affected room/unit/facility still symptomatic?
- Have precautions been effective in controlling spread?
- Is the number of new symptomatic residents decreasing, and for how many days?
- Is staffing adequate to care for residents?

Table 3. Closing a Viral Respiratory Outbreak

Respiratory Virus	Declaring the Outbreak Over*
Confirmed Influenza	4 days
Confirmed COVID-19	10 days
Confirmed RSV	10 days
Outbreak: Unidentified/Other Respiratory Pathogen	5 days

*Two incubation periods following the last known exposure to an infectious person in the affected unit/area.

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

Antiviral Treatment – Specific to LTCFs Only

Treatment with antiviral medication is recommended for influenza when it is diagnosed early in the illness (usually within 48 hours of symptom onset). The Association of Medical Microbiology and Infectious Diseases Canada (AMMI) recommends that antiviral medication should still be used even if it has been more than 48 hours since the onset of symptoms when the individual belongs to a group at high risk for complications of influenza.

Prescribing antiviral medication to individuals who have been exposed to influenza but who have not yet developed symptoms is known as post-exposure prophylaxis (PEP). PEP is recommended for residents in long term care facilities to reduce the risk of transmission to other residents and to minimize the impacts of an influenza outbreak in this vulnerable population. The Chief Public Health Office provides antiviral medication (oseltamivir) for post-exposure prophylaxis of residents in both public and private long-term care facilities (LTCF) in PEI.

1. The decision on the use of antiviral medications to control the outbreak will be made in consultation with the CPHO after reviewing the information collected.
2. The CPHO may recommend antiviral medication after consultation with the attending physician.
3. Table 1 outlines the AMMI recommendations for antiviral treatment and prophylaxis.
4. Antiviral medication (Oseltamivir®75mg and 30mg doses) is now pre-positioned within each facility for all residents (long term care and dual long-term care/community care facilities). Table 2 can be used to determine if additional antiviral doses are required over and above what is pre-positioned in the facility. The CPHO will arrange for further doses as required.
5. If a resident develops viral respiratory illness while on the prophylaxis dose, the resident should be switched to the treatment dose as per Table 1 and start as if on day one.

Table 1: Influenza Treatment and Post-Exposure Prophylaxis Dosages LTCF Only

Creatinine Clearance	Tamiflu Treatment	Tamiflu Prophylaxis
greater than 60 ml/min	75 mg capsule twice daily for 5 days	75 mg capsule once daily until outbreak is over
30 ml/min-60 ml/min	75 mg capsule once daily or 30 mg twice daily x 5 days	30mg capsule once daily until outbreak is over
10 - 30 ml/min	30 mg once daily for 5 days	30 mg capsule on alternate days until outbreak is over
Less than 10 ml/min (renal failure)	1 single 75 mg dose for the duration of illness	No data available Consult with primary physician or specialist
Residents on Dialysis	Low-flux HD: 30 mg at onset of influenza symptoms, then 30mg after each dialysis session	30 mg before dialysis, then 30 mg after alternate dialysis sessions
	High-flux HD: 75 mg after each dialysis session	No data available Consult with primary physician or specialist
	CAPD dialysis: 30 mg once before the start of dialysis	30 mg before dialysis, then 30 mg once weekly
	CRRT high-flux dialysis: 30 mg daily or 75 mg every second day	No data available Consult with primary physician or specialist

Table 2: Facility Specific Information for Influenza Antiviral Medication Replacement for LTCF Only

Number of doses pre-positioned in the facility	**75 mg:** **30 mg:**
Total # of residents at the facility:	
# Of residents who are symptomatic	
• # with CC greater than 60 ml/min:	
• # with CC 30 ml/min-60 ml/min:	
• # with CC < 10ml/min	
• # with CC 10 - 30 ml/min	
• # on dialysis	
# Of residents needing PEP:	
• # with CC greater than 60 ml/min:	
• # with CC 30 ml/min-60 ml/min:	
• #with CC < 10ml/min	
• # with CC 10 - 30 ml/min	
• # on dialysis	

Creatinine Clearance and Standing Order Template LTCF Only

Obtain the resident's weight (in Kg) and serum creatinine and then calculate the resident's creatinine clearance using the formula below.

NOTES:

- Creatinine level within the past 12 months is adequate.
- When a resident cannot be weighed, an estimate of the weight is adequate.

Calculating Creatinine Clearance (ml/min)

Male $\frac{(140 - \text{AGE IN YRS}) \times (\text{WEIGHT IN Kg})}{\text{SERUM CREATININE (umol/L)} \times 0.81}$ = ml/min

Female $\left\{ \frac{(140 - \text{AGE IN YRS}) \times (\text{WEIGHT IN Kg})}{\text{SERUM CREATININE (umol/L)} \times 0.81} \right\} \times .85$ = ml/min

RESIDENT INFORMATION

Name:	Health Number:
Age in years:	Weight in Kg
Serum Creatinine (umol/L)	Date:
Creatinine Clearance (ml/min):	

Standing order for Tamiflu® (Oseltamivir) Post- Exposure Prophylaxis during an VRI outbreak: Yes No

Standing order for treatment with Tamiflu® (Oseltamivir) during an VRI outbreak: Yes No

Attending Physician Signature: _____Date: _____

Appendix B – Viral Respiratory Season Preparation Checklist

Health and Wellness

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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

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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

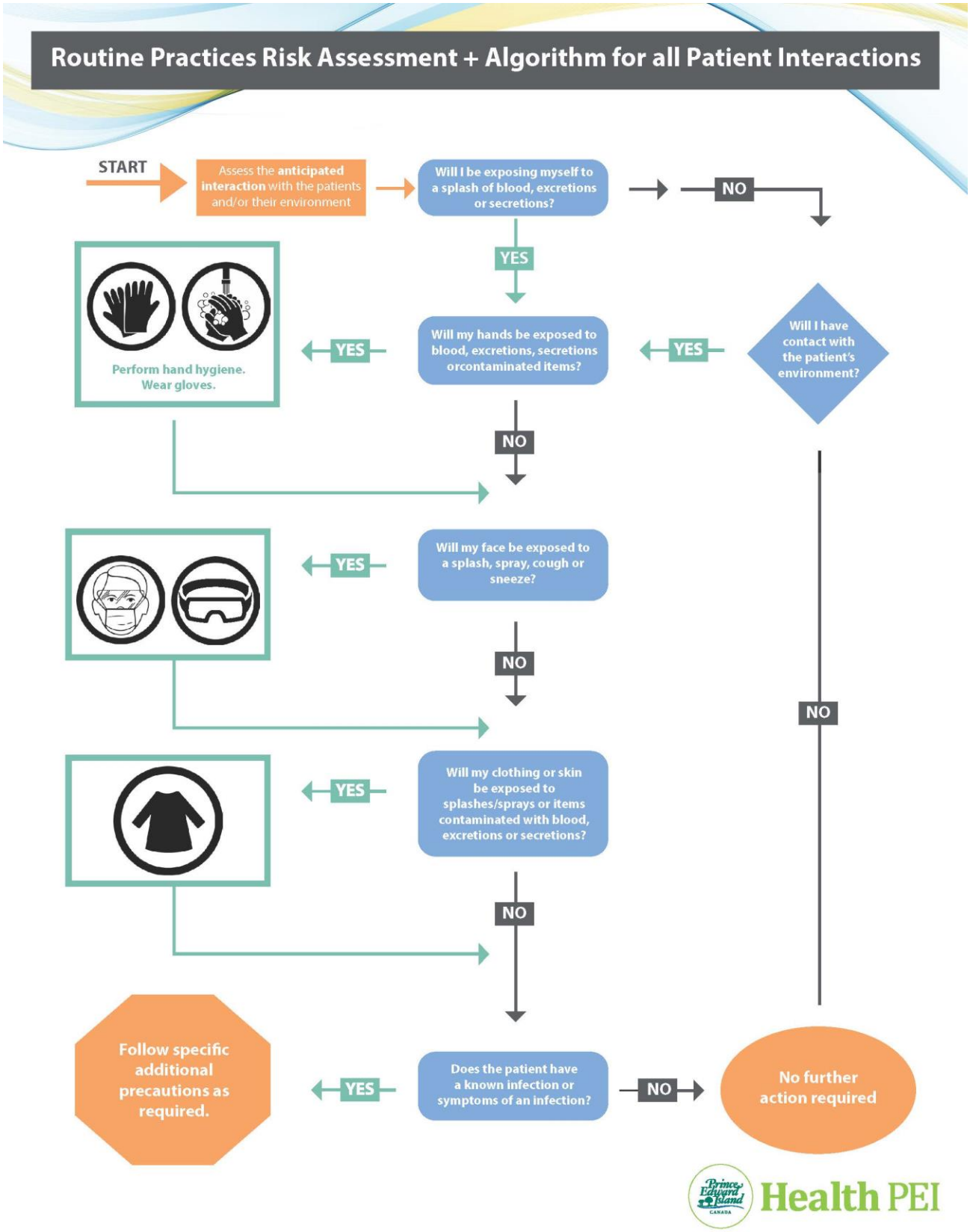
Immunization:

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

Treatment:

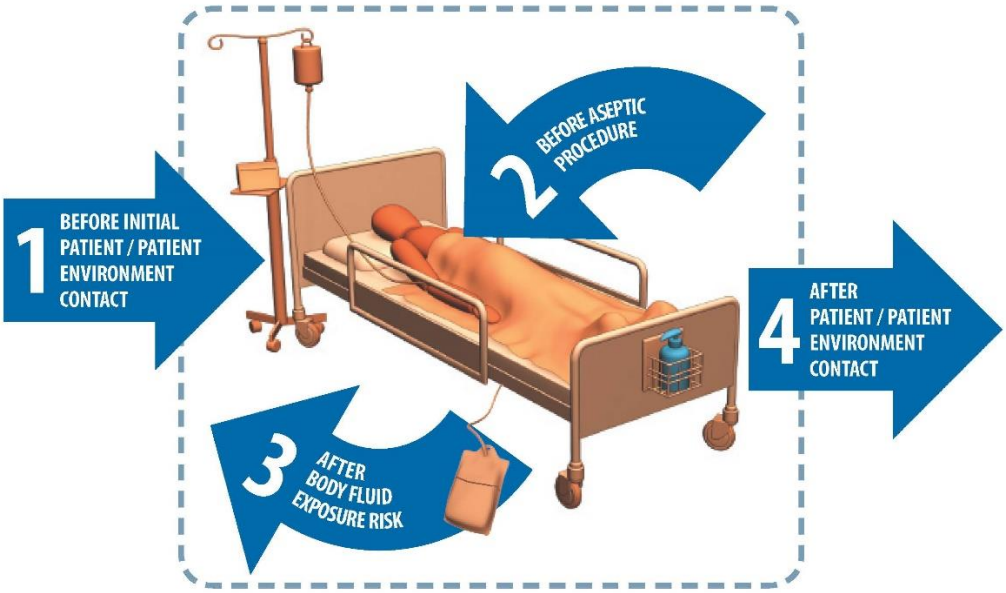
- ☐ Processes prepared for accessing and administering antiviral treatments (Tamiflu/Paxlovid)

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



Appendix D – Hand Hygiene

Your 4 Moments for Hand Hygiene



1 BEFORE initial patient / patient environment contact	WHEN?	Clean your hands when entering: • before touching patient or • before touching any object or furniture in the patient's environment
	WHY?	To protect the patient/patient environment from harmful germs carried on your hands
2 BEFORE aseptic procedure	WHEN?	Clean your hands immediately before any aseptic procedure
	WHY?	To protect the patient against harmful germs, including the patient's own germs, entering his or her body
3 AFTER body fluid exposure risk	WHEN?	Clean your hands immediately after an exposure risk to body fluids (and after glove removal)
	WHY?	To protect yourself and the health care environment from harmful patient germs
4 AFTER patient / patient environment contact	WHEN?	Clean your hands when leaving: • after touching patient or • after touching any object or furniture in the patient's environment
	WHY?	To protect yourself and the health care environment from harmful patient germs

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Appendix E – Droplet and Contact Precautions

STOP

All Visitors and Staff Leaving Room:

1 **Remove gloves – grasp outside edge of glove near wrist and peel away from your body. DO NOT touch outside of glove. Place fingers inside second glove to remove.**

2 **Remove gown – unfasten ties. Remove gown pulling away from body. DO NOT touch outside of gown.**

3 **Exiting patient's room:**

Wash hands with soap and water or use alcohol hand rinse.

4 **Remove goggles or face shield if worn. Remove mask – pull away from face using ear loops/ties. DO NOT touch outside of mask/visor.**

5

Wash hands with soap and water or use alcohol hand rinse.

Droplet/Contact Precautions

Health PEI

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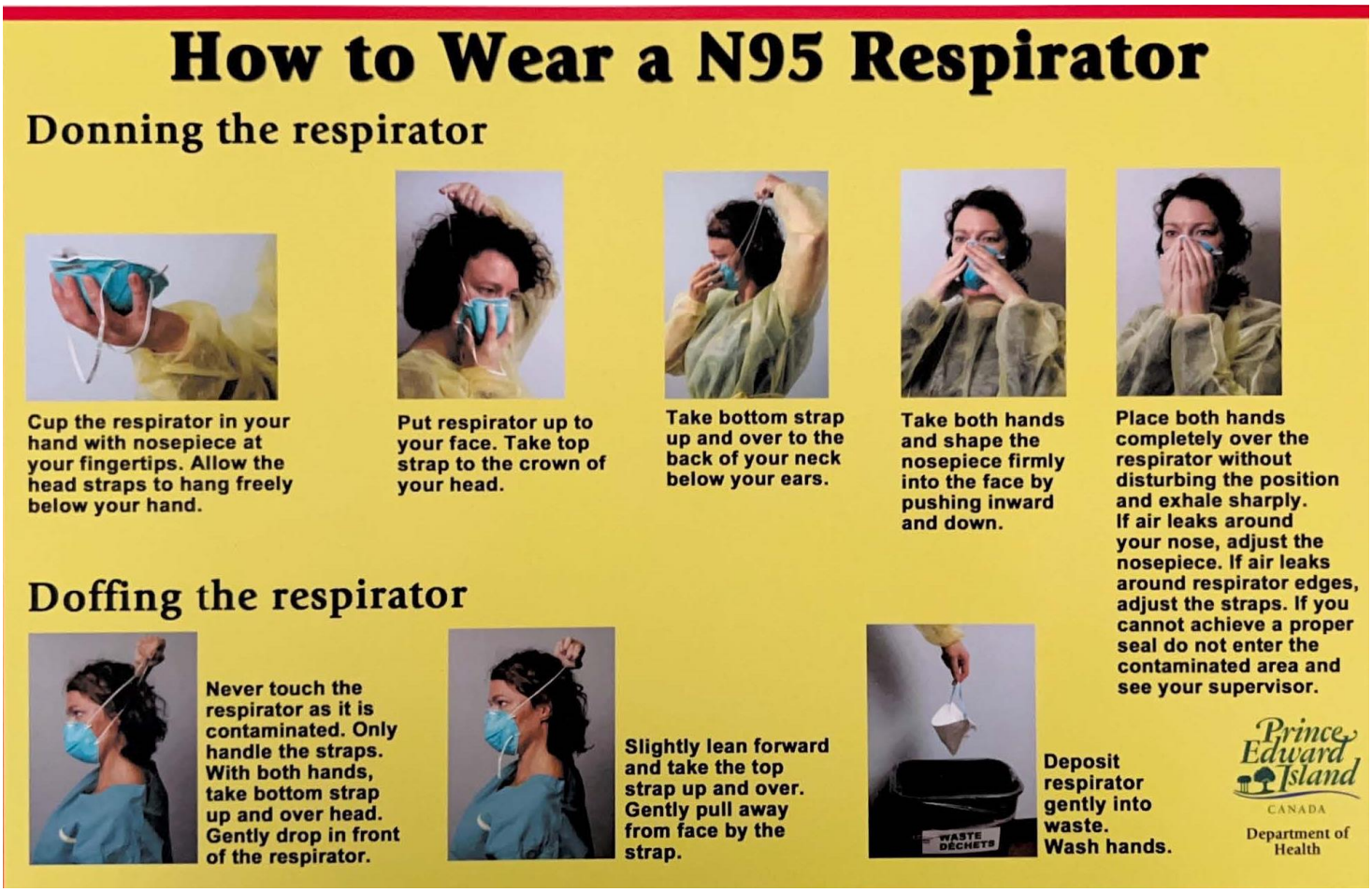
Appendix F – How to Fit Check and Wear a N95 Respirator

Fit checking involves a quick check - each time the mask is put on - to ensure that the respirator is properly applied, that a good seal is achieved over the bridge of the nose and mouth and there are no gaps between the respirator and face. Fit checking is the appropriate minimum standard at the point of use for healthcare workers using N95 respirators. No clinical activity should be undertaken until a satisfactory fit has been achieved.

Instructions to fit check a N95 mask:

1. Place the respirator on your face.
2. Place the headband or ties over your head and at the base of your neck.
3. Compress the respirator to ensure a seal across your face, cheeks, and the bridge of your nose.
4. Check the positive pressure seal of the respirator by gently exhaling. If air escapes, the respirator needs to be adjusted.
5. Check the negative pressure seal of the respirator by gently inhaling. If the respirator is not drawn in towards your face, or air leaks around the face seal, readjust the respirator and repeat process, or check for defects in the respirator.



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

Before You Begin

1. Use the swab supplied with the viral transport media.
2. Explain the procedure to the resident to reduce anxiety and improve cooperation.
3. Don PPE (gown, gloves, mask, eye protection) before collection.
    - Change gloves and perform hand hygiene between each resident.
    - Refer to Appendix E & F for donning/doffing steps.
4. If the resident has excess nasal mucus, ask them to gently clear it with a tissue or clean the nostril with a cotton swab (e.g., Q-Tip).

Nasal Mid-Turbinate Swab Collection

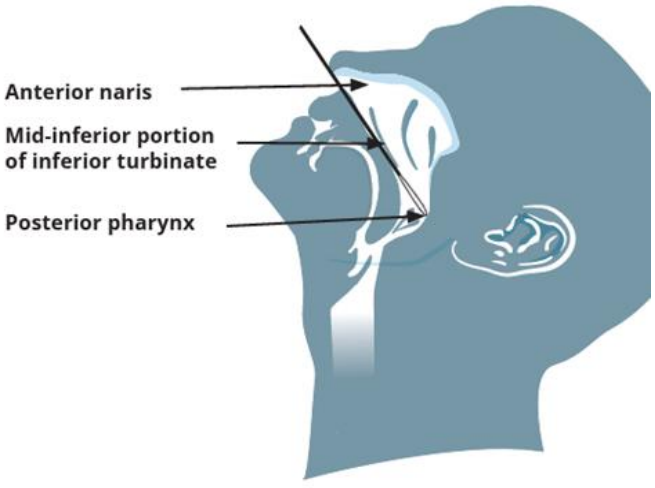
1. Insert swab into nostril until resistance is met (~2 cm or 1 inch).
2. Rotate swab several times, brushing against mid-turbinate area for 5–10 seconds.
3. Repeat in the other nostril using the same swab.
4. Follow the procedure for Abbott ID NOW point-of-care testing (POCT).

After Collection: NP Swab only:

1. Label tube with **at least 2 unique resident identifiers**, ideally include:
    - Resident name
    - Date of birth
    - MRN
    - **Must include Date/time of collection**
2. Place tube in zippered portion of biohazard specimen bag; seal tightly.
3. Complete requisition form, fold once (no staples), and place in outer pocket of bag.
4. Remove PPE as per doffing protocol.
5. Refrigerate specimen until transport to the laboratory (within 72 hours).

Nasopharyngeal Swab (NP) Collection

1. Estimate insertion depth: Measure from the corner of the nose to the front of the ear; insert swab approximately two-thirds of this length.
2. Seat the resident comfortably and tilt head slightly back to straighten nasal passage.
3. Insert swab along the nasal floor and medial septum until reaching the posterior nasopharynx.
    - If resistance is encountered, try the other nostril (possible deviated septum).
4. Hold swab in place for 5–10 seconds.
5. Rotate swab several times to collect epithelial cells.
   Note: This may induce coughing.
6. Withdraw swab and place into the collection tube with viral transport medium.



Tilt the head back at a 70° angle as illustrated in the picture.

Prince Edward Island Health and Wellness CANADA

Appendix H – Line List

Viral Respiratory illness- Surveillance Line List LTC and CCF

Facility Name: ______________________________ **Date:** ____________

RESIDENTS: Total Number of Residents ________ **Number of Residents ill:** ______

Name, MRN, and DOB	Onset Date	Unit	Symptoms				Vaccine		Swabbed If Yes, Date	Comments
				Fever		Sudden onset cough	Influenza	Y or N	Date	
				Muscle/body aches		Sore throat	Covid	Y or N	Y or N	
				Headache		Other	RSV	Y or N		
				Fever		Sudden onset cough	Influenza	Y or N	Date	
				Muscle/body aches		Sore throat	Covid	Y or N	Y or N	
				Headache		Other	RSV	Y or N		
				Fever		Sudden onset cough	Influenza	Y or N	Date	
				Muscle/body aches		Sore throat	Covid	Y or N	Y or N	
				Headache		Other	RSV	Y or N		
				Fever		Sudden onset cough	Influenza	Y or N	Date	
				Muscle/body aches		Sore throat	Covid	Y or N	Y or N	
				Headache		Other	RSV	Y or N		

STAFF: Total Number of Staff ________ **Number of Staff ill:** ______

Name	Onset Date	Date Last Worked	Symptoms				Vaccine		Swabbed If Yes, Date	
				Fever		Sudden onset cough	Influenza	Y or N	Date	
				Muscle/body aches		Sore throat	Covid	Y or N	Y or N	
				Headache		Other				
				Fever		Sudden onset cough	Influenza	Y or N	Date	
				Muscle/body aches		Sore throat	Covid	Y or N	Y or N	
				Headache		Other				
				Fever		Sudden onset cough	Influenza	Y or N	Date	
				Muscle/body aches		Sore throat	Covid	Y or N	Y or N	
				Headache		Other				
				Fever		Sudden onset cough	Influenza	Y or N	Date	
				Muscle/body aches		Sore throat	Covid	Y or N	Y or N	
				Headache		Other				

Fever = 1) single oral temp >37.8°C 2) Repeated oral temps >37.2°C or rectal temps >37.5° or 3) Single >1.1C over baseline from any site.

Any new or worsening respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat or difficulty swallowing), or

Any new onset non-respiratory symptoms including chills , muscle aches, diarrhea, malaise, headache, sudden loss of taste or smell or other unexplained symptoms or change in clinical s

Appendix I – Outbreak Signage

OUTBREAK!

In This Facility

Do not visit if you are sick

Visiting is Restricted
Please check with front desk or staff

Clean Your Hands
before entering
when leaving

Protect Yourself and Others

Prince Edward Island CANADA Health and Wellness