Memo

To: Long Term Care Homes and Retirement Homes and Congregate Living Settings
From: Dr. Matthew Strauss. Acting Medical Officer of Health
Date: January 12, 2022
Re: Interim definitions & addressing critical staffing needs

Dear Long-Term Care Home, Retirement Home and Congregate Living Setting Colleagues:

In light of emerging evidence for Omicron variant of COVID-19 and changing guidance documents from the Ministry of Health around testing, isolation and case and contact management, Haldimand-Norfolk Health Unit (HNHU) is providing the following instructions for long-term care homes (LTCH), retirement homes (RH) and congregate living settings in Haldimand and Norfolk.

CASE DEFINITIONS

On January 4, 2022, updated COVID-19 Guidance for long-term care homes provided by the Ministry of Long Term Care included updated definitions for suspect and confirmed outbreaks. Provincial guidance on definitions have not been provided to public health units yet. Until such guidance has been received, HNNU will be using the following definition for LTCH, RH and congregate living settings.

- **COVID-19 Case definition** - in addition to the current case definition, a positive result on a rapid antigen test (RAT) in symptomatic individuals or those with a known high risk exposure shall be treated as a confirmed case.

- A **suspect outbreak** is defined as one PCR or molecular confirmed COVID-19 case in a resident or one positive RAT in a resident.

- A **confirmed outbreak** is defined as two or more PCR or rapid molecular confirmed COVID-19 cases in residents and/or staff (or other visitors) in a home OR two or more positive RAT results in residents and/or staff in a home with an epidemiological link, within a 14-day period, where at least one case could have reasonably acquired their infection in the home. Examples of reasonably having acquired infection in a home include:
  - no obvious source of infection outside the congregate living setting; or
  - known exposure in the congregate living setting
COVID-19 is a designated disease of public health significance (Ontario Regulation 135/18) and thus confirmed and suspected cases of COVID-19 are reportable to the local public health unit under the Health Protection and Promotion Act (HPPA)

HNHU will follow outbreak management as outline in COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units and COVID-19 Guidance: Congregate Living for Vulnerable Populations

STAFFING

In recognition of the staffing challenges that are being experienced, the Ministry has put in place a number of measures to help homes in times of serious staffing shortages. HNHU will be supporting organizations to make their own assessment and decisions regarding critical staffing needs.

Homes/facilities not in outbreak have the ability to implement staffing measures based on their own assessment. When a home/facility is in outbreak, they should work with HNHU when implementing these measures. The following information will support organizations with decision making related to work self-isolation of exposed, high-risk contacts in the highest-risk congregate living settings.

Action:

Plan for critical staffing shortages and ensure a robust contingency plan that includes:
- Identification of critical staffing levels and when the contingency plan will be activated
- Confirming available supports through the organization and community partners
- Determining when work self-isolation is required to support operations
- Activating all other staffing options prior to approving work self-isolation for high-risk contacts

When to call HNHU
- If your home/facility is in suspected or confirmed outbreak, a HNHU PHN will be working with you to manage the outbreak and will assist with providing support for returning staff and work-self isolation.
- If you have a positive staff person and are in critical staffing, please contact HNHU before bringing the staff person back to work early on work-self isolation.
- For all other scenarios, please follow your policies, the following key principles and Ministry guidance documents to guide decisions on staff returning to work early and work-self isolation.

Key principles for reducing risk
- The fewest number of high-risk exposed healthcare workers should be returned to work to allow for safe operations
- Returning staff should avoid working with immunocompromised individuals
- Returning staff should have a minimum of two doses of a COVID-19 vaccine 14 days prior to work
- Prioritize returning workers who have received 3 doses before those who have received 2 doses
Only bring back asymptomatic individuals
Early return of a high-risk contact with a negative test is preferred to early return of a known case
Those greater than 5 days from last exposure to a case are preferred to those less than or equal to 5 days from exposure
Those with a high-risk contact in the community are preferred to those with a household contact
Returning to work in an outbreak area is preferred to working in a non-outbreak area
While at work, the returning staff must adhere to universal masking and maintain physical distancing. Additional PPE may be as required by role and directed by organizational policies and/or as determined by point-of-care risk assessment.
If symptoms develop, the staff member must be tested and self-isolate immediately
Returning Staff to work whom work in multiple locations when one location is in outbreak should be completed in consultation with HNHU and the facilities involved.

Testing requirements for work-self isolation
If there is no ongoing exposure to the case:
  - Initial PCR test and daily RAT or
  - RAT on day 6 and 7 for return on day 7
Any staff member with ongoing exposure to a case (i.e. household contact of a case) may return to work on work self-isolation for 10 days from last exposure to the case in their period of contagiousness (up to 15 days from the date on which the household case became symptomatic or from the date of the positive test of the household case).
  - PCR test and daily RAT, or
  - RAT on day 9 and 10 for return on day 11

Staff assignments
Consider level of risk when determining approval and assignment for work self-isolation. The chart below lists a few items to consider with examples:

<table>
<thead>
<tr>
<th></th>
<th>Low Risk</th>
<th>Medium Risk</th>
<th>High Risk</th>
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<tbody>
<tr>
<td><strong>Nature of exposure</strong></td>
<td>No direct contact</td>
<td>Brief direct contact</td>
<td>Close direct contact</td>
</tr>
<tr>
<td><strong>Time since exposure</strong></td>
<td>Day 5-7 after exposure</td>
<td>Day 0-5 after exposure</td>
<td>Ongoing exposure to a household case</td>
</tr>
<tr>
<td><strong>Immunization history</strong></td>
<td>Three doses of a vaccine received more than 2 weeks ago</td>
<td>Two doses of a vaccine less than 2 weeks ago</td>
<td>Partially/unimmunized</td>
</tr>
<tr>
<td><strong>Nature of role</strong></td>
<td>Role requires on-site office work only with no interaction with others</td>
<td>Staff role requires interactions with individuals where physical distancing can be maintained</td>
<td>Staff role requires direct care</td>
</tr>
<tr>
<td><strong>Population served</strong></td>
<td>Client population does not need physical assistance</td>
<td>Client is unimmunized but otherwise healthy and</td>
<td>Client is unimmunized and immunocompromised or</td>
</tr>
<tr>
<td>Client COVID status</td>
<td>able to wear a mask during care</td>
<td>elderly and unable to mask during care</td>
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<tr>
<td>Assigned to clients that are already positive</td>
<td>Assigned to clients that are high-risk contacts</td>
<td>Assigned individuals that have no known exposure</td>
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</table>

For questions, please contact our COVID-19 hotline at 519-426-6170 ext. 9999

References: