Health and Social Services Haldimand and Norfolk

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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, HNHU 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:

	Low Risk	**Medium Risk**	**High Risk**
Nature of exposure	No direct contact	Brief direct contact	Close direct contact
Time since exposure	Day 5-7 after exposure	Day 0-5 after exposure	Ongoing exposure to a household case
Immunization history	Three doses of a vaccine received more than 2 weeks ago	Two doses of a vaccine less than 2 weeks ago	Partially/unimmunized
Nature of role	Role requires on-site office work only with no interaction with others	Staff role requires interactions with individuals where physical distancing can be maintained	Staff role requires direct care
Population served	Client population does not need physical assistance	Client is unimmunized but otherwise healthy and	Client is unimmunized and immunocompromised or

		able to wear a mask during care	elderly and unable to mask during care
Client COVID status	Assigned to clients that are already positive	Assigned to clients that are high-risk contacts	Assigned individuals that have no known exposure

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

References:

- COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge. Version 1.0 – December 30, 2021
- COVID-19 guidance document for long-term care homes in Ontario. January 2022 (not available publicly online)