FAQs

Directive #3 and MLTC COVID-19 Guidance Document for LTCHs

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Table of Contents

GENERAL

1. Why have an updated Directive #3 and a new Guidance Document been released?

The vast majority of residents have now been fully immunized and there has been significant progress in vaccinating staff and essential caregivers. As a result, the number of COVID-19 related infections, hospitalizations, and deaths among long-term care residents have dropped dramatically. We have also heard feedback on the mental, emotional, and physical toll the current restrictions have taken on residents. The changes in these documents represent a cautious modification of restrictions to improve residents' quality of life while still keeping in mind the context of the provincial stay-at-home-order and a rise in variants of concern.

DEFINITIONS

2. What is meant by "fully immunized" in Directive #3 and also referenced in the MLTC guidance document?

A person is **fully immunized** against COVID-19 if:

- they have received the total required number of doses of a COVID-19 vaccine approved by Health Canada (e.g., both doses of a two-dose vaccine series, or one dose of a single-dose vaccine series); and
- they received their final dose of the COVID-19 vaccine at least 14 days ago.

Currently, the required number of doses for the Pfizer, Moderna, and AstraZeneca vaccines to complete the vaccine series is two.

3. What are "immunization coverage rates/thresholds"?

For the purposes of interpreting the new MLTC guidance document, immunization coverage rates refer to the percentage of residents who are fully immunized and the percentage employees of the long-term care licensee who are fully immunized. The level of precautions homes must implement for communal dining and social activities depends on whether they have immunization coverage rates of 85% of residents and 70% of employees fully immunized.

4. What does “cohorting” refer to?

Cohorting is an important IPAC measure to limit the potential transmission/spread of infection throughout the home in the event COVID-19 has been introduced into the home. Cohorting is a way of grouping residents and staff to prevent the spread of infection within a facility, especially during an outbreak. Public Health Ontario resources on cohorting during an outbreak of COVID-19 in long-term care homes are available here.

Residents should be cohorted to the maximum extent possible even when the home is not in outbreak:

Residents:

Residents should be cohorted to the maximum extent possible even when the home is not in outbreak.

- Residents are to be cohorted into small groups which are together consistently for the purposes of dining, activities, etc.
- Cohorts can consist of fully immunized, partially immunized, and/or unimmunized residents.
    - However, in homes which have not met the 85%/70% immunization coverage threshold, physical distancing should be maintained during group activities (i.e. communal dining and indoor activities/social gatherings).
- To the extent possible, residents should be cohorted within a single floor/unit
- Resident cohort sizes should be as small as possible.
- Each cohort should stay physically distant from other cohorts to the maximum extent possible and mixing of cohorts is to be avoided
- Scheduling of dining, indoor activities, etc. should be staggered to prevent cohorts from mixing together
- Cohort sizes should balance the psychosocial needs of the resident, the home’s staffing needs, and take into consideration capacity limits for common areas and inclusion of essential caregivers as required.

Staff cohorting means having each staff member provide service to only one cohort (group) of residents. To the maximum extent possible, staffing assignments should be organized for consistent cohorting in specific resident areas (e.g., within a single floor or a unit) to limit interactions with other staff and residents in different areas of the home.

ACTIVITIES

5. Can homes resume communal dining?

Yes. All long-term care homes can now resume communal dining with the following precautions:

- when not eating/drinking, residents should be encouraged to wear a mask where possible/tolerated
- residents are to be cohorted and seating arrangements consistent
- no buffet style service, no shared use of serving spoons, no shared utensils, etc.
- frequent hand hygiene of residents and staff/essential caregivers/volunteers assisted with feeding should be undertaken
- two-metre physical distancing between all diners is to be maintained and capacity limits of the dining room/area are to be reduced.
    - **Additional flexibility should be introduced where homes have met a 85% resident and 70% employee immunization coverage rate**. Specifically, physical distancing can be suspended in cohorted groups for the duration of the dining period.

Fully immunized staff and essential caregivers may accompany a fully immunized resident for meals by joining the resident's cohort, regardless of the immunization coverage rate in the home. Essential caregivers must continue to mask and practice physical distancing from other residents and staff.

For all indoor activities, regardless of the immunization coverage rate in the home, workers, caregivers, and volunteers in the home are to adhere to all required IPAC measures, including universal masking/eye protection requirements, maintaining at least two metres from residents at all times (other than in the circumstances that are set out as exceptions to the physical distancing requirement in Directive #3 such as hugging between a fully immunized essential caregiver and fully immunized resident), and engaging in frequent hand hygiene.

6. Can homes resume indoor activities/social gatherings?

Yes. Homes need to provide safe opportunities for residents to gather in small cohorts for group activities.

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

- Cohorting
- Masking, including for residents where possible/tolerated
- Avoiding high risk activities (e.g., singing)

- Limited capacity in a room to allow physical distancing
- All participants should physically distance from one another unless staff are providing direct support
- Cleaning and disinfection of high touch surfaces between activities/room use
- Natural ventilation wherever possible (e.g., open windows)

Where homes have met the 85% resident and 70% employee immunization coverage rate, physical distancing can be suspended for the duration of the activity/social gathering.

For all indoor activities, regardless of the immunization coverage rate in the home, workers, caregivers, and volunteers in the home are to adhere to all required IPAC measures, including universal masking/eye protection requirements, maintaining at least two metres from residents at all times (other than in the circumstances that are set out as exceptions to the physical distancing requirement in Directive #3 such as hugging between a fully immunized essential caregiver and fully immunized resident), and engaging in frequent hand hygiene.

7. How do homes know what their immunization coverage rates are?

Residents: Homes must establish and implement a process to collect information on resident's vaccine status, using a consent-based model and adhering to existing laws. The overall resident immunization coverage rate should be updated as occupancy in the *home changes over time.*

Employees: Homes must also establish and implement a process to collect information on employee's vaccine status. All long-term care home employees are asked to voluntarily show a copy of their COVID-19 vaccine receipt(s) to the home. Any employee who does not share these receipt(s) cannot be considered fully immunized. Homes must handle this information in accordance with existing laws. As employees are retained or leave, ongoing updating of the overall employee immunization coverage rate is required, at a monthly frequency at a minimum.

How can homes calculate their immunization coverage rate?

$$\text{TOTAL RESIDENT COVERAGE RATE} = \frac{\text{\# fully immunized residents}}{\text{total \# residents in home}} \times 100$$

$$\text{TOTAL EMPLOYEE COVERAGE RATE} = \frac{\text{\# fully immunized employees}}{\text{total \# employees in home}} \times 100$$

8. What can homes do to encourage staff and essential caregivers to be vaccinated?

Licensees and home leadership should work to continually amplify messages about the benefits of vaccination and to find opportunities for additional actions such as:

- Having one-to-one conversations with team members
- Tailoring messages to the unique staff characteristics and needs within homes
- Working with local public health units to find onsite vaccine opportunities wherever possible to vaccinate new residents who have not been vaccinated pre-admission and remaining staff
- Giving staff the opportunity to go to an offsite vaccination clinic during paid work time and covering the transportation costs (where onsite options are not feasible)
- Assisting staff with booking vaccine appointments, and
- Identifying vaccine champions in homes' communities including primary care physicians, seasoned staff, and faith/cultural leaders to talk to staff directly (e.g., through a virtual event) and share their personal stories.

Homes are also encouraged to promote and share widely the ministry's COVID-19 Vaccine Promotion Toolkit which contains a welcome letter, posters, fact sheets, tips for holding effective conversations, an FAQ, and sample Facebook and Twitter posts that users can share in social networks. The kit is available in English, French, and ten other languages.

SCREENING REQUIREMENTS

9. What are the active screening requirements? Has anything changed compared to previous requirements?

All individuals (staff, visitors, and residents returning from an absence) must be actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the home. All staff and visitors should self-monitor for symptoms while in the home, but do not need to be actively screened again during their shift/visit or at exit. LTC homes can use a 'Screening App' if they wish but results must be checked and validated at the entrance prior to entrance.

There no changes to the third party screening requirements:

- LTC homes may use a vendor of their own choosing or may use a dedicated hire of their own.
- Vendor arrangements and dedicated hires are acceptable regardless of how long these have been in place.
- Individuals performing the oversight function can be coupled with existing staff who have been trained to assist with confirming PCR testing and active screening.

- Individuals do not need to be security personnel and/or uniformed personnel.

There is an exception to screening requirements for first responders: they must be permitted entry without screening in emergency situations.

All residents must be assessed at least twice daily (once during the day and one during the evening) for signs and symptoms of COVID-19, including temperature checks.

The chart below summarizes the active screening requirements in latest version of Directive #3:

	Staff, Visitors, and Anyone Entering the Home	**Current Residents of the Home**
Who does this include?	Staff working at the LTCH and all visitors, including essential visitors and anyone else entering the home. Exception is provided to first responders, who should, in emergency situations, be permitted entry to the home without screening.	Residents currently living in the home.
What are the screening practices?	• Conduct active screening (at the beginning of the day or shift). At a minimum, homes should ask the questions listed in the COVID-19 Screening Tool for Long-Term Care Home and Retirement Homes. • Temperature checks are not required. • All visitors coming into the home must adhere to the home's visitor policies.	• Conduct symptom assessment of all residents at least twice daily (at the beginning and end of the day) to identify if any resident has symptoms of COVID-19, including any atypical symptoms as listed in the COVID-19 Reference Document for Symptoms. • Twice daily symptom screening includes temperature checks. • All residents returning from any type of absence must be screened at entry upon their return.
What if someone does not pass screening (i.e., screens positive)?	Staff, visitors, and those attempting to enter the home who are showing symptoms of COVID-19 or had a potential exposure to COVID-19, and have screened positive must: • Not enter the home, • Instructed to immediately to self-isolate, and • Be encouraged to be tested for COVID-19 at an assessment centre.	Residents with symptoms of COVID-19 (including mild respiratory and/or atypical symptoms) must be isolated under Droplet and Contact Precautions and tested. For a list of typical and atypical symptoms, refer to the COVID-19 Reference Document for Symptoms.

10. Why is temperature checking during the screening process for staff, visitors, and returning residents no longer required?

Directive #3 provides minimum requirements with which all homes must comply. Removing temperate checking as a requirement when screening staff, visitors, and returning residents upon entry to the home aligns active screening advice for long-term care homes with other sectors in Ontario, including acute care. It is challenging to ensure temperature checks are done consistently, reliably, and accurately (e.g., using the device correctly, ensuring it is calibrated for use, etc.) Additionally, fever is only one among a number of other symptoms that may be suggestive of COVID-19.

ABSENCES

11. Do residents have to request approval from the home to go out for a short term (day) absence. Is this still required under the latest updated version of Directive #3?

No. Residents DO NOT need to seek approval from the home to go out on a short term absence where permitted by Directive #3.

12. Can residents participate in physical activity such as walks in the immediate area of the home during a stay-at-home order?

It is important for residents to be able to engage in physical activity and take part in activities that bring them joy, comfort, and dignity while still remaining safe. Residents who are not under isolation requirements or symptomatic can leave the home to take a walk in the immediate area to support overall physical and mental well-being, including during the stay-at-home order. Ontario's stay-at-home order includes outdoor exercise as one of the essential reasons to leave your home, and this is no different for residents of long-term care homes.

13. What protocols should continue to be followed by homes when residents are leaving to go out for an absence?

Homes must provide residents with a surgical/procedure mask and remind residents to comply with routine public health measures, including masking (as tolerated), physical distancing, frequent hand hygiene, and respiratory etiquette. Residents should maintain their distance from others (unless they require assistance/direct care) and avoid socialization while they are out (as consistent with the provincial messaging around essential outings).

14. Do residents need to be screened upon return from an absence?

Yes. Returning residents must be actively screened for symptoms and exposure history for COVID-19 before they are allowed to enter the LTCH. Any resident returning to the LTCH following an absence who fails active screening must be permitted entry but isolated under Droplet and Contact Precautions and tested for COVID-19 as per the COVID-19: Provincial Testing Requirements Update.

WARD ROOMS:

15. Can a resident from a three (3) or four (4) bed ward room return to that room if they leave the home?

It depends on whether the resident has left to go on a temporary absence or whether the resident was discharged from the home:

- A bed in a ward room must be left vacant if a resident who occupied a bed in the ward room is discharged from the LTCH **and** there are two or more residents who continue to occupy a bed in the ward room.
- Residents who are currently occupying a bed in a ward room with two (2) or more residents must be permitted to return to their bed following a temporary absence, including medical absences requiring an admission or a transfer to another health care facility, after completing their testing and isolation (if required) per Directive #3.

OUTBREAK CASE DEFINITION

16. What is the definition of a COVID-19 outbreak in long-term care homes?

The definition of outbreak has been moved out of Directive #3 and is now found in both the new MLTC guidance document as well as the MOH COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units. The definition has NOT changed from what was last set out in Directive #3:

- A **suspect outbreak** in a long-term care home is defined as one single lab-confirmed COVID-19 case in a resident.
- A **confirmed outbreak** in a long-term care home is defined as two or more lab-confirmed COVID-19 cases in residents and/or staff (or other visitors) in a home with an epidemiological link, within a 14- day period, where at least one case could have reasonably acquired their infection in the home.

Only the public health unit can declare an outbreak, and declare that an outbreak is over.