# COVID-19 guidance document for long-term care homes in Ontario

Learn more about requirements for long-term care homes with respect to COVID-19.

## On this page



# Highlight of changes

**As of March 14, 2022 the following changes have been made to this document:**

In consultation with the Chief Medical Officer of Health, the Ministry of Long-Term Care ("the Ministry") is recalibrating its response to COVID-19, further striking a balance between reduced COVID-19 risk and the overall quality of life, health and wellbeing of residents. Effective on March 14, 2022, changes are as follows:

- The Minister's Directive on Long-Term Care Home COVID-19 Immunization Policy will be revoked, shifting from a provincial directive that requires homes to have a mandatory vaccination policy to a guidance-based approach that continues to support long-term care homes with their employer-led policies and best practices.

- All general visitors can resume visits. General visitors, with the exception of children under the age of 5, will need to follow the vaccination policy of the individual long-term care home.

    - The number of indoor visitors (including caregivers) per resident at a time increases to four.
    - Limits on outdoor visits will be lifted and homes can return to their regular practices on use of their available outdoor spaces (see Access to Home for further details). Testing for outdoor visits will no longer be required.

- All residents may go on overnight temporary absences, regardless of vaccination status (see Absences for further details).

    - Testing of residents returning from day or overnight absences at established intervals will continue until further notice to identify as early as possible any individual who may become infected with COVID-19 in order to reduce transmission in the home.

- Cohorting will no longer be required for social activities with the exception that this practice must be maintained for dining.

- Social group activities can be increased in size (more than 10); while larger social group activities where potential crowding can occur should continue to be avoided, and IPAC measures should continue to be followed by staff, residents and visitors to promote safety and wellbeing (e.g., masking, distancing, good ventilation, etc.).

# Purpose

The purpose of this document is to provide licensees of long-term care homes, as defined in the Long-Term Care Homes Act, 2007 (the Act), with general information on requirements set out by the Province of Ontario with respect to the COVID-19 pandemic, including those set out in Directive #3, issued by the Chief Medical Officer of Health (CMOH), and to help homes in developing approaches for operating safely while providing the greatest possible opportunities for maximizing resident quality of life.

This document is to be followed in conjunction with any applicable legislation, directives, and orders and is not intended as a substitute and does not constitute legal advice. This document should be followed unless there are reasonable health and safety reasons to exercise discretion or as ordered by the local public health unit. Where homes are undertaking COVID-19 measures that exceed the requirements in this document or the associated legislation, directives and orders, it is expected that the home will consult with their local public health unit, the Residents' Council and Family Council prior to implementation.

In the event of any conflict between this document and any legislation, directive, or order; the legislation, directive, or order prevails. Additionally, this document is not intended to take the place of medical advice, diagnosis, or treatment.

For the purpose of interpreting this document, "fully vaccinated" against COVID-19 has the same meaning as the current version of COVID-19 Fully Vaccinated Status in Ontario (gov.on.ca).

# Layers of protection against COVID-19

SARS-CoV-2, the virus which causes COVID-19, primarily spreads from one person to another when an infected person breathes, talks, coughs, or sneezes and releases respiratory emissions of different sized virus-laden particles into the air.

There is not one specific measure that will prevent SARS-CoV-2 transmission. However, the use of multiple layers of prevention provides the best protection, especially when people cannot avoid closed spaces, crowded places, and close contact.

# Recalibrated Approach

Since February 2022, Ontario is experiencing a decrease of COVID-19 cases. With the Omicron wave now receding and the steps being taken to re-open Ontario, including easing measures for long-term care homes, the ministry is shifting public health

measures in the long-term care sector to a stabilization and recovery emphasis while ensuring preparedness in case of another wave. The key approach is to further rebalance the risks associated with COVID-19 and the risks that measures / restrictions present to residents' overall health and well-being. The Ministry continues to work with the Office of the Chief Medical Officer of Health (OCMOH) to monitor trends and will respond as necessary to any new or emerging issues related to the pandemic, such as a new variant of concern, for example.

Up-to-date information and evidence regarding variants of concern can be found on Public Health Ontario's website.

# COVID-19 Vaccination

The vaccination program in long-term care homes has been a tremendous success, with staff, residents, and family members having stepped up to get vaccinated to protect themselves, their colleagues, and the residents they support each day.

The Minister's Directive on Long-Term Care Home COVID-19 Immunization Policy ensured all long-term care homes had a vaccine policy in place that met specific criteria suitable to the specific point in time of the pandemic. Revoking this directive signals a shift from a provincial directive back to a guidance-based approach that supports homes with their employer-led policies and promotes best practices.

**Employer-led vaccination policies**

Long-term care homes, as employers, retain their ability to mandate vaccination requirements for existing and new staff, students, and volunteers, provided they comply with all applicable law, such as the Human Rights Code. The revocation of the provincial directive provides homes, as the employers, the ability to decide how their existing vaccination policies will be updated going forward (for example, continuing to require two or three doses among all existing and new staff, requiring all medically recommended boosters, etc.). In addition, nothing prevents licensees from having proof-of vaccination requirements for caregivers, visitors and support workers provided the

licensee's requirements are consistent with the Long-Term Care Homes Act, 2007, including the Residents' Bill of Rights and section 5 of the Act (right to a safe and secure home), and comply with all applicable laws. Licensees should seek independent legal advice as needed regarding their ongoing policies.

To augment continued employer-led vaccination policies, long-term care homes are strongly encouraged to consider best practices regarding promoting awareness of the benefits of vaccination, ensuring up to date information regarding booster eligibility is available, and offering on site vaccination.

**Best practices**

Promoting awareness of the benefits of vaccination

There continues to be an increased risk for severe outcomes as a result of COVID-19 in the elderly population due to age and underlying medical conditions, particularly in shared living spaces like long-term care homes. Vaccination remains the best defense against COVID-19, including the Omicron variant.

Regardless of a home's specific vaccination policy, everyone should continue to be strongly encouraged to get vaccinated (with boosters), including residents. All vaccines provided as part of Ontario's vaccine rollout are safe and effective.

Booster doses provide better protection against the Omicron variant. Evidence shows that vaccine effectiveness against symptomatic infection due to the Omicron variant wanes over time, with little to no protective effect six months after the second dose, and that protection from Omicron infection is restored shortly after receiving a third dose to between 50 and 70%. Additionally, evidence shows that boosters are highly effective against severe outcomes, including hospitalizations and death, with a third dose restoring protection from hospitalization to 95%.

Additional information about COVID-19 vaccination can be found online on the COVID-19 vaccines for Ontario website.

Eligibility for booster doses

Currently, residents of long-term care homes are eligible for a fourth dose of an mRNA vaccine if at least three months have passed since their third dose. Residents who have not yet received their third or fourth dose are likely becoming increasingly susceptible to COVID-19 infection due to waning immunity and should be strongly encouraged to get booster doses.

All adults are eligible for a booster dose of an mRNA vaccine if at least three months have passed since their second dose, and youth aged 12-17 are eligible six months after their second dose.

Onsite vaccination

Onsite vaccine administration by homes remains the preferred approach to ensure vaccines can get to residents, caregivers, and staff as quickly as possible. Homes that are set up for self-administration of COVID-19 vaccines should work with their local public health units to request vaccine and relevant ancillary supplies for administering vaccine doses to residents, staff and caregivers onsite.

Homes that are not yet set-up for self-administration are asked to either take the necessary steps to onboard for self-administration, and/or consider other avenues for administering vaccines onsite, such as working with their local public health unit to arrange for a local pharmacy, community family physicians, and / or Emergency Medical Services staff to administer boosters.

Onsite vaccine administration should be inclusive of residents, staff and caregivers regardless of whether the home is administering or another partner. Notwithstanding the benefits of onsite administration, homes should also continue to strongly encourage staff and caregivers to leverage resources available in the community to get their booster dose as soon as they are eligible. Staff and caregivers can book booster appointments on the provincial COVID-19 vaccination portal, by calling the Provincial Vaccine Contact Centre at 1-833-943-3900, or through select pharmacies and primary

care settings. Homes are also encouraged to support staff and remove any barriers to getting a booster (e.g., support paid time to go to a vaccine appointment).

# Infection prevention and control (IPAC)

The importance of ongoing adherence to strong and consistent IPAC processes and practices cannot be overstated. It is critical that homes strive to prevent and limit the spread of COVID-19 by ensuring that strong and consistent IPAC practices are implemented and continuously reviewed. Appropriate and effective IPAC practices must be carried out by all people attending or living in the home, at all times, regardless of whether there are cases of COVID-19 in the home or not, and regardless of the vaccination status of an individual.

**IPAC audits**

Per Directive #3, homes must be completing IPAC audits every two weeks unless in outbreak. When a home is in outbreak IPAC audits must be completed weekly.

Homes are reminded that IPAC audits should be rotated across shifts, including evenings and weekends.

At minimum, homes must include in their self-audit the PHO's COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes.

Results of the IPAC self-audit should be kept for at least 30 days and shared with inspectors from PHU, Ministry of Labour, Skills, Training and Development, and MLTC for LTCHs upon request.

**General IPAC requirements**

As a reminder, licensees are subject to Section 86 of the Act, which requires that every home have an IPAC program. Additionally, section 229 of Ontario Regulation 79/10 under the Act contains additional requirements, including that homes are to follow an

interdisciplinary team approach in the coordination and implementation of the IPAC program and that every long-term care home must have an IPAC coordinator in place. The importance of ongoing adherence to strong IPAC processes and practices cannot be overstated.

Specific requirements for long-term care homes in the context of the COVID-19 pandemic are also set out in the Required Infection and Prevention Control (IPAC) Practices section of Directive #3.

Long-term care homes are reminded that they must be in compliance with current requirements under the Act as well as COVID-19 related directives.

**Everyone in a long-term care home, whether staff, student, volunteer, caregiver, support worker, general visitor or resident, has a responsibility to ensure the ongoing health and safety of all by practicing these measures at all times.**

Licensees should ensure that they have adequate stock levels of all supplies and materials required on a day-to-day basis regardless of outbreak status.

Further IPAC requirements including personal protective equipment (PPE) can be found in Directive #1, Directive #3 and Directive #5 issued by the CMOH.

For further guidance/elaboration on best practices related to IPAC, refer to the following Public Health Ontario websites:

- Infection Prevention and Control for Long-Term Care Homes: Summary of Key Principles and Best Practices
- COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes
- Heating, Ventilation and Air Conditioning (HVAC) Systems in Buildings and COVID-19

### Physical distancing

Consistent with Directive #3, homes must ensure that physical distancing (a minimum of two metres or six feet) is practiced by all individuals at all times, except for the purposes of providing direct care to a resident or when the following **exceptions** apply:

- between residents and their visitors
- between residents, either one-on-one or in small group settings
- for the purposes of compassionate or end-of-life visits
- while providing personal care services (for example, haircutting).

### Universal masking

- Homes must ensure that all staff and essential visitors wear a medical mask for the entire duration of their shift/visit, both indoors (including in the residents' room) and outdoors, regardless of their immunization status.
- General visitors must wear a medical mask for the entire duration of indoor visits (including in the resident's room). Additionally, a medical or non-medical mask is required for the entire duration of an outdoor visit.
- Removal of masks for the purposes of eating should be restricted to only areas designated by the home.

**For residents**: homes are required to have policies regarding masking for residents. While there is no requirement for residents to wear a mask inside of the home, a home's policies must set out that residents must be encouraged to wear/be assisted to wear a medical mask or non-medical mask when receiving direct care from staff, when in common areas with other residents (with the exception of meal times), and when receiving a visitor, as tolerated.

**Exceptions** to the masking requirements are:

- children who are younger than two years of age

- any individual (staff, visitor or resident) who is being accommodated in accordance with the *Accessibility for Ontarians with Disabilities Act, 2005* or the Ontario Human Rights Code
- if entertainment provided by a live performer (that is, a general visitor) requires the removal of their mask to perform their talent, provided the performance is in accordance with all applicable laws including regulations under the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020*.

Homes must also have policies for individuals (staff, visitors, or residents) who:

- have a medical condition that inhibits their ability to wear a mask
- are unable to put on or remove their mask without assistance from another person

### Personal protective equipment (PPE)

**Requirements**

1. Long-term care homes must follow the precautions described in the applicable directives issued by the Chief Medical Officer of Health.
2. Homes must provide training on PPE to all people regularly attending a home, including staff (permanent or temporary), student placements, volunteers, visitors, and service providers coming to the home from a third party (for example, an agency).

### Grouping staff

To the extent possible, staff should be cohorted to work on consistent floors or areas of a home, including during breaks, even when the home is not in an outbreak. Staff gatherings should be limited in size and only when necessary, and where possible, virtual meetings are encouraged.

# Activities

## Communal dining

Communal dining is an important part of many homes' social environment.

All long-term care homes may provide communal dining with the following precautions:

- during regular dining, residents must continue to be grouped in their cohorts and homes should ensure physical distancing (a minimum of two metres or six feet) is maintained between the tables
- when not eating or drinking, residents should be encouraged to wear a mask where possible or tolerated
- caregivers and general visitors may accompany a resident for meals to assist them with eating; however, caregivers or general visitors must remain masked at all times and not join in the meal
- frequent hand hygiene of residents, and staff, caregivers and volunteers assisting residents with eating must be undertaken

Unless otherwise directed by the local public health unit, homes may offer buffet or family-style service, including during regular daily meals and as part of special occasions/celebrations (for example, to celebrate a holiday).

## Group activities: organized events and social gatherings

Homes are to provide opportunities for residents to gather for group activities including for social purposes, physical activities, hobbies/crafts, celebrations such as for birthdays, and religious ceremonies/practices consistent with licensees' requirement to ensure that there is an organized program for the home to ensure that residents are given reasonable opportunity to practice their religious and spiritual beliefs, and to observe the requirements of those beliefs, pursuant to section 14 of the Act.

Social group activities can be increased in size (more than 10); while larger social group activities where potential crowding can occur should continue to be avoided, and IPAC

measures should continue to be followed by staff, residents and visitors to promote safety and wellbeing (e.g., masking, distancing, good ventilation, etc.). General visitors and caregivers may join residents during the activities in all homes, both indoors and outdoors, unless otherwise directed by the local public health unit.

### What happens in an outbreak?

In the event of a COVID-19 outbreak, residents must be be cohorted for all non-essential activities including communal dining, organized events and social gatherings. Different cohorts are not to be mixed, and residents from different cohorts should not visit one another. Additional guidance on cohorting of residents can be found in the COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units.

### What happens when a resident is isolating or fails screening?

Residents in isolation or who fail screening are not to join in group organized events/activities or social gatherings. However, homes should attempt to have these residents join-in virtually where possible to provide these residents with an alternative to in-person social interaction.

## Personal care services

Personal care services such as hairdressing and barber services are permitted in long-term care homes in accordance with all applicable laws including regulations under the Reopening Ontario (A Flexible Response to COVID-19) Act, 2020.

Residents should be encouraged to wear masks where possible or tolerated.

## Screening

Refer to Directive #3 for requirements related to active screening.

## Staffing

In recognition of the staffing challenges that long-term care homes are experiencing the ministry has put in place a number of measures to help homes in times of serious staffing shortages that cannot be filled by other means including staffing agencies. Homes not in outbreak have the ability to implement these measures based on their own assessment. When a home is in outbreak, they should work with the PHU when implementing these measures.

**Operational flexibility:**

The *Reopening Ontario Act, 2020* (ROA) is set to expire on March 28, 2022. The Ministry is planning for this change alongside the recalibration efforts and pandemic easements, with the goal of supporting a return to greater normalcy for residents, their families and friends, and the staff who support them every day.

There are four orders within the ROA that pertain specifically to long-term care homes.

- O. Reg. 146/20 – limiting work to a single long-term care home
- O. Reg. 77/20 – work deployment measures in long-term care homes
- O. Reg. 210/20 – management of long-term care homes in outbreak
- O. Reg. 95/20 – streamlined requirements for long-term care homes

The Ministry is exploring the use of transitional regulations that could be created under the new *Fixing Long-Term Care Act, 2021* (FLTCA, targeted for an April proclamation date) to support homes through transition. These opportunities would be focused on supporting some flexibility that is provided through O. Reg. 95/20 where not already included in the existing regulation under the *Long-Term Care Homes Act, 2007* and proposed to continue in the FLTCA regulation.

The single work site order will sunset as of March 28th and the work deployment order will sunset as of April 27th. This means that homes will need to plan forward, respecting existing collective agreements, and working with labor partners and staff, to update homes emergency plans to include those provisions that would support the ability to

respond appropriately to critical staffing needs in an emergency, such as experienced through the pandemic.

Until this time of the expiry of ROA orders, homes are reminded that the following regulations are in place to provide operational flexibility to homes, specifically:

- O. Reg. 95/20: Streamlining Requirements for Long-Term Care homes
- O. Reg 195/20: Treatment of Temporary COVID-19 Related Payments to Employees
- O. Reg 146/20: Limiting Work to a Single Long-Term Care Home

Homes should read the applicable regulations for a full understanding of all requirements. A quick reference guide has been included in the appendix to further aid homes.

**Multiple work locations when in outbreak**

Based on the advice from the Office of the Chief Medical Officer of Health (OCMOH), the ministry is removing the policy under the Limiting Work to a Single Long-Term Care Order that restricts fully vaccinated staff from only working in one location when a home is in outbreak. In these circumstances if a staff is critically required to work in another facility while working in an outbreak facility, this should be done in consultation with the public health unit and homes should ensure the following:

- The staff member working in an area of outbreak at one home/health care facility also work in an area of outbreak at the other work location.
- Staff have received all recommended doses of the vaccine (third dose for those eligible, otherwise two doses).
- Staff member has not had a known high-risk contact with a case.
- The home(s)/health care facility and staff member maintain excellent IPAC practices including appropriate PPE

- The staff member be actively screened every day and be rapid antigen tested every day, the same as those under test-to-work who have an ongoing exposure in an outbreak (see below).

**Test-to-work/Return to work**

The Ministry of Health, in consultation with the Chief Medical Officer of Health, has updated its COVID-19 testing and isolation guidelines to ensure publicly funded testing and case and contact management resources are available to focus on the highest-risk settings and protect the most vulnerable including those in long-term care.

This includes testing and isolation requirements specific to health care workers returning to work in settings such as long-term care, that differ from the general public's requirements, as well as a risk-based framework to advise homes on return to work.

All staff, student placements, volunteers and caregivers who are COVID positive, have COVID-19 symptoms or are a high-risk close contact with someone who is COVID positive should notify the home right away and follow the steps below:

- be PCR tested and where delays in PCR testing exist also be rapid antigen tested to confirm if they are COVID positive
- isolate for five days (or longer if remain symptomatic) and do not return to the home for 10 days.

**Return-to-Work Risk-Based Framework**

In circumstances of serious staffing shortages homes may have fully vaccinated staff return, prior to the 10 days. The options below are for staff who are high risk **close contacts** with someone who is COVID-19 positive or who are **COVID-19 positive**. This framework outlines testing and isolation requirements for various risk of transmission levels (lowest risk, moderate risk and highest risk). Homes are to evaluate their own circumstances to determine the best risk option to apply; however, homes are encouraged to use the lowest risk option whenever possible.

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| All staff, who are fully vaccinated, who are high risk **close contacts** with someone who is COVID positive can return to work under the follow circumstances: | |
| Lowest risk | • after a negative PCR* test collected on, or after, day 7 from last exposure,<br>OR<br>• on day 7 after two negative rapid antigen tests (RATs) on day 6 and 7, taken 24 hours apart, after last exposure |
| Moderate Risk | • after initial negative PCR test<br>OR<br>• after two negative RATs taken 24 hours apart,<br>AND<br>• continue daily RATs until end of isolation period (10 days)<br>OR<br>• until individual can meet criteria under the lowest risk testing option |
| Highest Risk | • after single negative RAT<br>AND<br>• continue daily RATs until end of isolation period (10 days)<br>OR<br>• until individual can meet criteria under the lowest risk testing option |
| All staff, who are fully vaccinated, who are **COVID-19 positive**, or have COVID-19 symptoms may return to work under the following circumstances: | |
| Lowest Risk | • after ten days from symptom onset or positive test (whichever is earliest)<br>OR<br>• after a single negative PCR or two negative RATs collected 24 hours apart any time prior to the 10 day isolation requirement<br>AND<br>• if symptoms have been improving for 24 hours (48 hours if vomiting / diarrhea) |

| | |
|---|---|
| Moderate Risk | • on day 7 from symptom onset or positive test (whichever is earliest) without testing AND only if caring for covid-19 positive residents<br>AND<br>• if symptoms have been improving for 24 hours (48 hours if vomiting / diarrhea)<br>**Note:** this can only be employed where there is a serious staffing shortage AND positive residents are grouped together closely to enable care for only this group |
| Highest Risk | • LTC homes cannot take an approach that is high risk in this category. |

*PCR test includes laboratory based and rapid molecular testing

For further information on the risk-based framework, please refer to the COVID-19 Interim Guidance: Omicron Surge Management of Critical Staffing Shortages in Highest Risk Settings. Homes should review the COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge and encourage all staff, students, volunteers, and caregivers to review as well. The testing and isolation requirements for residents are set out in Directive #3 and the Ministry of Health COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units and are not impacted by these updates.

**Key principles for reducing risk:**

- The fewest number of high-risk exposed healthcare workers should be returned to work to allow for business continuity and safe operations in clinical and non-clinical areas.
- Those who have received three doses should be prioritized to return before those who have received only two doses.
- Staff should avoid working with immunocompromised residents.
- Only bring back asymptomatic individuals, and exposed individuals should have daily negative RAT
- Early return of a high-risk contact with negative test is preferred to early return of a known case

- Those greater than five days from last exposure to a case are preferred to those less than or equal to five 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

**Staffing resources available across the system are extremely limited.** Facilities must rely upon their business continuity plans and system partners to support wherever possible. In the event that challenges continue after exhausting your contingency plans, staffing agency partnerships, community partners, and corporate or municipal supports (where applicable) homes should escalate to Ontario Health.

# Admissions and transfers

For matters related to admissions and transfers as well as applicable isolation/testing requirements for long-term care homes, refer directly to Directive #3 and the Ministry of Health COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, specifically Appendix E: Algorithm for Admissions and Transfers for LTCHs and RHs.

# Absences

**Requirements**

All long-term care homes must establish and implement policies and procedures in respect of resident absences, which, at a minimum set out the definitions and requirements/conditions described below.

For **all absences**, residents must be:

- provided with a medical mask when they are leaving the home

- provided a handout that reminds residents and families to practice public health measures such as physical distancing and hand hygiene when outside of the home
- actively screened upon their return to the home

There are four types of absences:

1. **medical absences** are absences to seek medical and/or health care and include:
    - outpatient medical visits and a single visit (less than or equal to 24 hours in duration) to the Emergency Department
    - all other medical visits (for example, admissions or transfers to other health care facilities, multi-night stays in the Emergency Department)
2. **compassionate and palliative absences** include, but are not limited to, absences for the purposes of visiting a dying loved one
3. **short term (day) absences** are absences that are less than or equal to 24 hours in duration. There are two types of short term (day) absences:
    - **essential absences** include absences for reasons of groceries, pharmacies, and outdoor physical activity
    - **social absences** include absences for all reasons not listed under medical, compassionate/palliative, and/or essential absences that do not include an overnight stay
4. **temporary absences** include absences involving two or more days **and** one or more nights for non-medical reasons

**New**: Effective March 14, 2022, all residents, regardless of vaccination status, may resume temporary (i.e. overnight) absences.

Residents, regardless of vaccination status, are able to go on short-term day absences.

As per Directive #3, homes cannot restrict or deny absences for medical and/or palliative or compassionate reasons at any time. This includes when a resident is in isolation or when a home is in an outbreak.

**Isolation and testing requirements for residents when returning from absences**

The following are the testing and isolation requirements for residents who go on day and overnight absences. Please note that residents are exempt from these requirements if they are within 90 days from a COVID-19 infection that occurred since December 20, 2021, assuming they do not have symptoms.

Day absences (medical, compassionate, or short term):

- Rapid antigen test and PCR test on day 5 following the absence. No isolation is required unless a positive result is received. If a timely PCR test is not available, 2 RATs 24 hours apart may be used as an alternative.
    - Residents that go on absences on a daily or frequent basis are to have a laboratory-based PCR test and rapid antigen test, on the same day, two times per week (for example, PCR and rapid test on Tuesday; and PCR and rapid antigen test on Friday).
- If a resident has a known exposure to a case while on their absence, they must be treated as a high-risk contact as per the Ministry of Health COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units, which would require:
    - residents vaccinated with at least three doses of a COVID-19 vaccine to isolate until a PCR test on day five is negative
    - Residents who are not vaccinated or do not have their third dose of the COVID-19 vaccine to isolate for 10 days with a PCR test on day five.

Overnight absences (temporary, medical or compassionate):

Overnight absences should be treated the same as an admission, and homes should follow the requirements as outlined in the the Ministry of Health COVID-19 Guidance:

Long-Term Care Homes and Retirement Homes for Public Health Units, specifically Appendix E: Algorithm for Admissions and Transfers for LTCHs and RHs.

**Residents leaving home for extended absences**

Residents who may wish to leave a long-term care home due to COVID-19 will be discharged and the bed may then be available for occupancy by another resident.

- Before the resident leaves the long-term care home, the licensee is required to provide specified information, including information on the resident's care requirements and that the resident (or the resident's substitute decision maker, if applicable) assumes full responsibility for the care, safety and wellbeing of the resident.
- During the time the person is away, the bed will be available for occupancy by another resident.
- The process for returning to the home they were discharged from differs according to the time the resident was away from the home:
    - For absences that are three months or less, the resident would be deemed eligible and accepted for admission by the licensee, and simply placed into the "re-admission" category (this category is the highest-ranking category for vacant beds; it ranks higher than the "crisis" category).
    - Longer absences require a truncated assessment by the placement coordinator with the ability for the licensee to refuse the admission if the circumstances for refusing an admission in the LTCHA exist. If accepted, the person would be placed into the "re-admission" category for that long-term care home.

## Off-site excursions

Off-site group excursions (for example, to an attraction) are considered social absences and are permitted to reflect the reopening of attractions, music/theatre venues, etc.

Where an off-site excursion involves transporting residents in a vehicle, cohorting of residents and physical distancing should be maintained to the maximum extent possible during travel in the vehicle including during the use of public transportation.

Homes should also encourage consistent seating in vehicles and maintain seating records.

For all off-site group excursions, residents must be:

- provided with a medical mask when they are leaving the home
- reminded to practice public health measures such as physical distancing and hand hygiene when outside of the home
- actively screened per Directive #3 upon their return to the home
- following testing and isolation rules under isolation and testing requirements for residents when returning from absences will apply

# Visitor Policy

All homes are required to establish and implement a visitor policy that complies with this document and Directive #3 (as amended from time to time) in addition to all other applicable laws.

Homes are reminded that residents have a right under the *Long-Term Care Homes Act, 2007*, to receive visitors and homes should not develop policies that unreasonably restrict this right.

**Requirements**

1. Every long-term care home must have and implement a visitor policy that, at a minimum:
    - reflects the following guiding principles:
        - **safety** – any approach to visiting must balance the health and safety needs of residents, staff, and visitors, and ensure risks are mitigated

    - **emotional well-being** – welcoming visitors is intended to support the mental and emotional well-being of residents by reducing any potential negative impacts related to social isolation
    - **equitable access** – all residents must be given equitable access to receive visitors, consistent with their preferences and within reasonable restrictions that safeguard residents
    - **flexibility** – the physical/infrastructure characteristics of the home, its workforce/human resources availability, whether the home is in an outbreak and the current status of the home with respect to personal protective equipment (PPE) are all variables to consider when setting home-specific policies
    - **equality** – residents have the right to choose their visitors. In addition, residents and/or their substitute decision-makers have the right to designate caregivers
- sets out the parameters, requirements, and procedures prescribed in the current version of this document with respect to visitors, including but not limited to:
    - the definitions of the different types of visitors;
    - the requirement to designate caregivers;
    - restrictions with respect to visitors in the event of an outbreak or when a resident is isolating; and
    - non-compliance by visitors of the home's visitor policy.
- includes provisions around the home's implementation of all required public health measures as well as infection prevention and control practices.
- reflects the requirements related to the active screening, and surveillance testing of visitors, consistent with Directive #3, the current Minister of Long-Term Care's Directive COVID-19: Long-term care home surveillance testing and access to homes, and this guidance document, as applicable.

2. Per Directive #3, homes must maintain visitor logs of all visits to the home. The visitor log must include, at minimum:
    - the name and contact information of the visitor
    - time and date of the visit

- the purpose of the visit (for example, name of resident visited)

These visitor logs or records must be kept for a period of at least 30 days and be readily available to the local public health unit for contact tracing purposes upon request

3. Homes must ensure that all visitors have access to the home's visitor policy.
4. Homes must provide education/training to all visitors about physical distancing, respiratory etiquette, hand hygiene, IPAC practices, and proper use of PPE.

The home's visitor policy should include guidance from the following Public Health Ontario resources to support IPAC and PPE education and training:

- guidance document: recommended steps: putting on personal protective equipment
- video: putting on full personal protective equipment
- video: taking off full personal protective equipment
- videos: how to hand wash and how to hand rub

## Types of visitors

### Not considered visitors

Long-term care home staff (as defined under the Act), volunteers, and student placements are not considered visitors as their access to the home is determined by the licensee. Infants under the age of 1 are also not considered visitors and are excluded from testing requirements.

### Essential visitors

A home's visitor policy must specify that essential visitors are persons visiting a home to meet an essential need related to the residents or the operations of the home that could not be adequately met if the person does not visit the home.

There are no limits on the total number of essential visitors allowed to come into a home at any given time.

Essential visitors are the only type of visitors allowed when there is an outbreak in a home or area of a home or when a resident has failed screening, is symptomatic or in isolation.

There are four types of essential visitors:

- **people visiting very ill or palliative residents** who are receiving end-of-life care for compassionate reasons, hospice services, etc.
- **government inspectors with a statutory right of entry**. Government inspectors who have a statutory right to enter long-term care homes to carry out their duties must be granted access to a home in accordance with the applicable legislation. Examples of government inspectors include inspectors under the *Long-Term Care Homes Act, 2007*, the *Health Protection and Promotion Act*, the *Electricity Act, 1998,* the *Technical Standards and Safety Act, 2000,* and the *Occupational Health and Safety Act*.
- **support workers**: support workers are persons who visit a home to provide support to the critical operations of the home or to provide essential services to residents. Essential services provided by support workers include but are not limited to:
    - assessment, diagnostic, intervention/rehabilitation, and counselling services for residents by regulated health professionals such as physicians and nurse practitioners
    - Assistive Devices Program vendors –- for example, home oxygen therapy vendors
    - moving a resident in or out of a home
    - social work services
    - legal services
    - post-mortem services

- emergency services (for example, such as those provided by first responders)
- maintenance services such as those required to ensure the structural integrity of the home and the functionality of the home's operational systems such as Heating, Cooling and Ventilation (HVAC), mechanical, electrical, plumbing and telecommunication systems, and services related to exterior grounds and winter property maintenance, including septic and well water system maintenance
- food/nutrition and water/drink delivery
- Canada Post mail services and other courier services
- election officials/workers

- **Caregivers**: A caregiver is a type of essential visitor who is visiting the home to provide *direct care* to meet the essential needs of a particular resident. Caregivers must be at least 16 years of age and must be designated by the resident or their substitute decision-maker. Direct care includes providing support/assistance to a resident that includes providing direct physical support (for example, eating, bathing and dressing) and/or providing social and emotional support.
  - Examples of direct care provided by caregivers include but are not limited to the following:
    - supporting activities of daily living such as bathing, dressing, and eating assistance
    - providing cognitive stimulation
    - fostering successful communication
    - providing meaningful connection and emotional support
    - offering relational continuity assistance in decision-making
  - Examples of caregivers include:
    - friends and family members who provide meaningful connection
    - a privately hired caregiver

- paid companions
- translator

An important role of the caregiver is that of providing meaningful connection and emotional support. A person should not be excluded from being designated as a caregiver if they are unable to provide direct physical support.

**Designating a caregiver**

- Caregivers must be designated and must be at least 16 years of age.
- The maximum number of designated caregivers per resident is 4 (unless designated before December 15th, 2021).
- A resident and/or their substitute decision-maker may change a designation in response to a change in the:
  - resident's care needs that is reflected in the plan of care
  - availability of a designated caregiver, either temporary (for example, illness) or permanent.
- A resident and/or their substitute decision-maker may not continuously change a designation in order to increase the number of people able to enter the home.

The decision to designate an individual as a caregiver is **the responsibility of the resident or their substitute decision-maker** and not the home. The designation of a caregiver should be made in writing to the home. Homes should have a procedure for documenting caregiver designations.

**Caregivers – scheduling and length and frequency of visits**

Homes may not require scheduling or restrict the length or frequency of visits by caregivers. However, in the case where a resident resides in an area of the home in outbreak, is symptomatic or isolating under additional precautions, only one caregiver may visit at a time.

A caregiver should not visit any other home for 10 days after visiting another:

- resident who is self-isolating, including those experiencing symptoms of COVID-19 and are being assessed
- home or area of a home affected by an outbreak

Recognizing there are caregivers who want to volunteer to support more than one resident, in the event of an outbreak, caregivers may support up to two residents who are COVID-19 positive, provided the home obtains consent from all involved residents (or their substitute decision makers). Caregivers may also support more than one resident in non-outbreak situations, with the same expectation regarding resident consent.

**General visitors**

A general visitor is a person who is not an essential visitor and is visiting to provide non-essential services related to either the operations of the home or a particular resident or group of residents. General visitors include those persons visiting for social reasons as well as visitors providing non-essential services such as personal care services, entertainment, or individuals touring the home.

Homes should prioritize the mental and emotional well-being of residents and strive to be as accommodating as possible when scheduling visits with general visitors.

# Access to homes

**New**: Effective March 14, 2022, all general visitors, including children under the age of 5, can resume visits. General visitors, with the exception of children under the age of 5, will need to follow the vaccination policy of the individual long-term care home.

- Up to four visitors (including caregivers) per resident may visit at a time for indoor visits.

There are no sector limits on the number of visitors permitted at outdoor visits, and homes can return to their regular practices on use of their available outdoor spaces.

Homes should ensure physical distancing (a minimum of two metres or six feet) is maintained between groups.

General visitors younger than 14 years of age must be accompanied by an adult and must follow all applicable public health measures that are in place at the home (for example, active screening,  physical distancing, hand hygiene, and masking for source control).

### Restrictions during outbreaks or when a resident is isolating

**Essential visitors**

Essential visitors are the only type of visitors allowed when a resident is isolating or resides in a home or area of the home in an outbreak.

**General visitors**

General visitors are not permitted:

- when a home or area of a home is in outbreak
- to visit an isolating resident
- when the local public health unit so directs

**Direction from the local public health unit**

In the case where a local public health unit directs a home in respect of the number of visitors allowed, the home is to follow the direction of the local public health unit.

## Surveillance testing

All staff, students, volunteers, support workers, visitors and caregivers, must be tested in accordance with the Minister's Directive. Refer directly to the Minister of Long-Term Care's Directive COVID-19: Long-term care home surveillance testing and access to homes for requirements related to surveillance testing.

# Residents' Councils

Resident Councils (RC) play an important role in every long-term care home. As a reminder:

- licensees are not to interfere with the meetings or operation of the Residents' Council (RC) per section 65 under the Act
- licensees are to co-operate with the RC, appoint an assistant, and respond to council concerns and recommendations per s. 57(2) of the Act within 10 days

All homes need to ensure that the RC is provided an opportunity to meet. When in-person meetings of the RC are possible, it is expected that the RCs will be provided with the appropriate PPE and adequate space to meet so that physical distancing can be maintained and IPAC guidelines can be followed. Homes are to accommodate the continuation of RC meetings when in-person meetings are not possible.

The Ontario Association of Residents' Councils (OARC) has developed a number of resources to help homes facilitate RC meetings; please visit OARC's Tools webpage to access these important resources.

# Outbreaks

## Outbreak definition

For matters related to the definition of an outbreak in long-term care homes, refer directly to Directive #3 and the Ministry of Health COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units.

Only the local public health unit can declare an outbreak and declare when it is over. It is not the long-term care home's responsibility to determine whether cases have an epidemiological link. Local public health units will determine whether cases have an epidemiological link as part of their investigation, which will inform their decision as to whether or not they declare an outbreak.

## Outbreak management

Please refer to:

- Directive #3
- COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units
- COVID-19 Integrated Testing & Case, Contact and Outbreak Management Interim Guidance: Omicron Surge

Homes must follow direction from their local public health unit in the event of a suspect or confirmed outbreak.

## Reporting outbreaks and cases

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).

Homes must follow the critical incident reporting requirements set out in section 107 of Ontario Regulation 79/10 made under the Act.

Homes are required to immediately report any COVID-19 outbreak (suspect or confirmed) to the Ministry of Long-Term Care using the Critical Incident System during regular working hours or calling the after-hours line at 1-888-999-6973 after hours and on weekends.

# Contact information

- Questions regarding COVID-19 related policies and guidance can be emailed to the Ministry of Long-Term Care at MLTCpandemicresponse@ontario.ca
- Contact your local public health unit
- Questions regarding surveillance testing can be sent to:
    - MLTCpandemicresponse@ontario.ca

- covid19testing@ontariohealth.ca
- your Ontario Health primary contact

# Resources

**General**

- COVID-19 Long-Term Care Communications
- ltchomes.net for long-term care home licensees and administrators
- Centre for Learning, Research and Innovation in Long-Term Care: Supports During COVID-19

**Vaccination**

- COVID-19 vaccines for Ontario
- Ministry of Health, COVID-19 Vaccine-Relevant Information and Planning Resources
- Ministry of Health, COVID-19 Vaccine Third Dose Recommendations

**Infection prevention and control**

For information and guidance regarding general IPAC measures (for example, hand hygiene, environmental cleaning), please refer to the following documents:

- Infection prevention and control (IPAC) program guidance (Ministry of Long-Term Care)
- Public Health Ontario:
  - Infection Prevention and Control for Long-Term Care Homes: Summary of Key Principles and Best Practices
  - At a Glance: Prevention and Management of COVID-19 in Long-Term Care Homes and Retirement Homes
  - COVID-19: Infection Prevention and Control Checklist for Long-Term Care and Retirement Homes

    - COVID-19 IPAC Fundamentals Training
    - Interim Guidance on Infection Prevention and Control for Health Care Providers and Patients Vaccinated Against COVID-19 in Hospital and Long-Term Care Settings
    - Key Elements of Environmental Cleaning in Healthcare Settings (Fact Sheet)
    - Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings
    - PIDAC Routine Practices and Additional Precautions in All Health Care Settings
    - Cohorting During an Outbreak of COVID-19 in Long-Term Care Homes
- Recommendations for Control of Respiratory Infection Outbreaks in Long-Term Care Homes
- Infection Prevention and Control in Long-Term Care (Ontario CLRI)
- McMaster University offers a free online IPAC learning course for caregivers and families.

**Signage**

- resources to prevent COVID-19 in the workplace (Ministry of Labour, Training and Skills Development)
- Public Health Ontario
- Local public health units may have additional signage on their websites that may be helpful or useful to homes.

**Ventilation/Air Flow**

Below is a list of Public Health Ontario knowledge related to the use of portable fans, air conditioning units, and portable air cleaners.

- At a glance: the use of portable fans and portable air conditioning units during COVID-19 in long-term care and retirement homes
- FAQ: use of portable air cleaners and transmission of COVID-19

- Focus on: heating, ventilation and air conditioning (HVAC) systems in buildings and COVID-19

# Appendix: Quick Reference of Regulation Flexibility related to Staffing

This quick reference chart highlights regulations under the *Reopening Ontario (A Flexible Response to COVID-19), Act, 2020* that may be of particular interest to long-term care (LTC) homes as they continue to meet resident needs while addressing COVID-19 related staffing challenges.[1] LTCHA refers to the *Long-Term Care Homes Act, 2007*.

| Regulation | Summary |
|---|---|
| O.Reg. 95/20 | LTC homes may:<br>• Fill any staff position with the person who, in their reasonable opinion, has the adequate skills, training and knowledge to perform the duties required of that position.<br>• Use flexible processes for the admission, transfer and discharge of persons if they have the required consent from the persons.<br>• Adopt flexible practices related to the administration of drugs to residents if the practices are consistent with and within the scope of practice of the person administering the drug (nothing prevents a resident from self-administering a drug where they are already permitted to do so under the LTCHA and O.Reg 79/10).<br>• Note: Under O. Reg. 79/10, where homes are not able to meet the requirement for 24-hour RN coverage as a result of a pandemic, other regulated health professionals (for example RPNs) may fill the role with appropriate supervision.<br><br>LTC homes are not required to:<br>• Ensure the minimum number of staffing hours set out in the LTCHA and O. Reg. 79/10 are met for a position if all the care requirements are met.<br>• Meet the screening measures if they adopt other measures that ensure resident care and safety.<br>• Meet the training and orientation requirements set out in the LTCHA and O. Reg. 79/10 as long as they ensure staff and volunteers take measures to ensure resident care and safety.<br>• Hold care conferences at intervals set out in O.Reg. 79/10 if they ensure care conferences take place based on the clinical needs of the resident. |

[1] Homes should review ROA regulations in their entirety to ensure the proper implementation of any measure taken and note the regulations do not derogate from a licensee's responsibility under the *Long-Term Care Homes Act, 2007* and Ontario Regulation 79/10 to ensure a safe and secure environment for residents. Also, despite anything in the regulations, licensees shall comply with any order or directive issued under the *Health Protection and Promotion Act*. This document does not constitute legal advice. The licensee should seek independent legal advice for guidance on what appropriate measures might be adopted to ensure a safe and secure environment for residents.

| Regulation | Summary |
|---|---|
| | • Ensure that a physical examination of a resident occurs annually but must ensure that a physical examination occurs within a reasonable period after the resident's last examination.<br>• Follow all steps under the LTCHA and O. Reg. 79/10 when seeking approval from the Director to obtain a licence or management contract under the LTCHA, unless otherwise required by the Director. |
| O.Reg. 146/20 | LTC employees who are fully vaccinated may work in more than one LTC home or in a retirement home or other health care setting.<br><br>Note: Per the MLTC Guidance Document ,this includes where one or more of the locations is experiencing an outbreak and it is critical the staff member can work,. This should be done in consultation with the public health unit and consideration of how best to mitigate risk – for example:<br>• The staff member working in an area of outbreak at one home/health care facility also work in an area of outbreak at the other work location.<br>• Staff have received all recommended doses of the vaccine (third dose for those eligible, otherwise two doses).<br>• Staff member has not had a known high-risk contact with a case.<br>• The home(s)/health care facility and staff member maintain excellent IPAC practices including appropriate PPE<br>• The staff member be actively screened every day and be rapid antigen tested every day, the same as those under test-to-work who have an ongoing exposure in an outbreak. |
| O.Reg. 195/20 | Temporarily suspends subsections 11(1) and (2) of the *Protecting a Sustainable Public Sector for Future Generations Act, 2019 beginning April 24, 2020*.<br>LTC homes may provide temporary COVID-19 related payments for work performed during the suspension period. |