

2026-2027

Guide to Respiratory Virus Outbreak Management in Long-Term Care Facilities

Updated October 1, 2026



Important: This is an evergreen document and will be updated periodically. Therefore, long-term care facility staff and clinicians should access [Public Health](#) to obtain the most up-to-date version.

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List of Acronyms

Acronym	Definition
ABHR	Alcohol based hand rub
AGMP	Aerosol generating medical procedures
ARC	Adult Residential Centre
CIG	Canadian Immunization Guide
CLS	Congregate living setting
DCG	Designated caregiver
DIN	Drug Identification Number
DHW	Department of Health and Wellness
DSLTC	Department of Seniors and Long-Term Care
ED	Emergency Department
HANS	Health Association of Nova Scotia
HCP	Health Care Provider
ILI	Influenza-like illness
IPAC	Infection Prevention and Control
LTC	Long Term Care
LTCF	Long Term Care Facility
MOH	Medical Officer of Health
NACI	National Advisory Committee on Immunization
NP	Nasopharyngeal
NSH	Nova Scotia Health
OB	Outbreak
OHSW	Occupational Health Safety and Wellness
OSD	Department of Opportunities and Social Development
PCR	Polymerase chain reaction
PCRA	Point of care risk assessment
PH	Public Health
PHN	Public Health Nurse
POCT	Point of care testing
PPE	Personal protective equipment
PCP	Primary Care Provider
PPHLN	Provincial Public Health Laboratory Network
RRC	Regional Rehabilitation Centre
RSV	Respiratory syncytial virus
RCF	Residential Care Facility
RVI	Respiratory virus infection
SDM	Substitute decision maker
UM	Universal masking

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Pharmacy Services, Nova Scotia Health

Provincial Public Health Laboratory Network of Nova Scotia (PPHLN)

Document Highlights and Key Changes

Notable changes and updates for fall 2026 include the following:

Additional Precautions	Section 4.2	Enhanced explanation of Droplet and Contact Precautions as well as additional LTC IPAC resources.
Approach to Testing	Section 6.3	More reasoning given for number of swabs to complete during an outbreak, along with updated testing algorithm.
Management of Residents on an Outbreak Unit	Section 8.3	See 8.3.1 and 8.3.2 for restrictions on resident movement during an outbreak/suspect outbreak.
Outbreak Quick Reference Guide	Appendix L	A quick reference guide to initial outbreak management steps.

Evergreen Document Updates

Release Date	Page	Update
October 1, 2026	58	Updated typographical error in Appendix L. Unknown outbreak with epi link corrected from 7 days to 4 days.
October 1, 2026	52	Figure 5: Clarified return to work criteria after mandatory exclusion period.
October 1, 2026	54	Figure 6: Clarified return to work criteria after mandatory exclusion period.
October 1, 2026	34	Residents, who are not contacts, on a unit with a suspect OB are not restricted to the unit.

1.0 Introduction

Respiratory virus infections (RVIs) are a major cause of morbidity and mortality in long-term care facilities (LTCFs) (Andrews et al., 2021; Watson & Wilkinson, 2021). RVIs spread readily in congregate living settings (CLS), including LTCFs. Residents in LTCFs are often at higher risk for such complications from RVIs as myocardial infarction, bacterial pneumonia, and death (Bosco et al., 2021; Falsey et al., 2006), owing to pre-existing comorbidities and diminished physiological reserve.

LTCFs are especially vulnerable to RVI outbreaks (OBs) during the respiratory season, which tends to run from November to April. However, RVI OBs can occur at any time of the year.

The Guide to Respiratory Virus Outbreak Management in Long-Term Care Facilities (hereafter ‘The Guide’) provides LTCF staff and clinicians with a systematic approach, grounded in the best available evidence, to reduce the burden of respiratory virus disease on LTCFs while ensuring that infection prevention and control (IPAC) measures are implemented in ways that preserve residents’ quality of life and safeguard their dignity. The Guide should be used proactively by LTCFs and CLS at elevated risk (see below) to develop policies, procedures, and plans to prevent and manage RVI transmission and OBs.

The Guide is intended for healthcare professionals and administrators in the following settings*:

- Department of Seniors and Long-Term Care (DSLTC)-licensed LTCFs (nursing homes and Residential Care Facilities [RCFs]).
- CLS at elevated risk: Department of Opportunities and Social Development (OSD)-licensed Adult Residential Centres (ARC) and Regional Rehabilitation Centres (RRC). *

**All other OSD-licensed facilities (including DCS-licensed small option homes, group homes, developmental residences and RCFs, regardless of capacity, are to follow the Congregate Living Settings guidance document located at <https://novascotia.ca/dhw/cdpc/documents/guidance-respiratory-viruses-congregate-living-settings.pdf>*

Facilities licensed by DSLTC are encouraged to consult with NSH-PH, NSH-IPAC, and Occupational Health Safety and Wellness (OHSW) as needed.

IPAC and OHSW do not provide consultative services outside of DSLTC and CLSs are encouraged to consult with NSH-PH as needed.

To reduce the burden of RVIs on LTCF residents, it is important that OB control instructions provided by NSH-PH be followed. NSH-PH is always available to discuss any questions or concerns.

2.0 Summary of Respiratory Virus Infections

2.1 Overview

The main polymerase chain reaction (PCR) respiratory virus swab test performed in Nova Scotia can identify three viral infections: COVID-19, influenza, and respiratory syncytial virus (RSV). Of all the respiratory viruses that typically cause disease and OBs in Nova Scotia LTCFs, these are the three for which vaccines exist and, for COVID-19 and influenza, therapeutics. This chapter will predominantly focus on these three viruses. A summary of the three viruses is also provided in [Appendix A](#).

2.2 Influenza

Seasonal influenza, caused predominantly by influenza A and B viruses, leads to considerable morbidity and mortality in LTCF residents (Lansbury et al., 2017). The disease burden in any given year varies, depending on factors such as the virulence of circulating viral strains, vaccine match to these strains, and vaccine uptake (Breznick et al., 2025; Trombetta et al., 2022).

Common presenting symptoms include fever, cough, sore throat, headache, malaise, and myalgias. Elderly individuals may present with fewer symptoms (including with no fever) and/or altered mental status.

Annual influenza immunization of LTCF residents is an important preventative measure at both the individual, health-care facility and health system level. Every year individuals with influenza and influenza-related complications increase pressure on the healthcare system during the fall and winter months (Andrew, 2021; Watson & Wilkinson, 2021).

Antiviral treatment is available for diagnosed influenza in LTCF residents. Antiviral prophylaxis will be recommended by NSH-PH for use in uninfected residents during influenza outbreaks. It is the responsibility of attending staff in the LTCF to prescribe influenza prophylaxis and treatment. Details are provided in [Appendix B](#).

2.3 COVID-19

COVID-19 is a respiratory infection caused by the SARS-CoV-2 virus. It can cause a spectrum of disease from mild to severe and lead to hospitalization, complications (e.g., respiratory failure, stroke) and/or death.

The risk of severe illness and death from COVID-19 increases with age although several studies demonstrate that outcomes are better predicted using a clinical frailty scale rather than simply age itself (Prendiki et al., 2022; Su & Jin, 2023).

Common symptoms of COVID-19 include fever, nasal congestion, sneezing, cough, myalgias, headache, sore throat, diarrhea, and/or smell/taste abnormalities. Difficulty breathing may occur in more serious disease.

Similar to influenza, immunization of LTCF residents against SARS-CoV-2 is an important preventative measure, especially against severe disease. COVID-19 therapeutics are available for eligible LTCF residents, and LTCFs should ensure a process is in place for therapeutics referral when indicated. For information on how to access COVID-19 treatment for residents, please see [Appendix C](#).

2.4 Respiratory Syncytial Virus

RSV is a common seasonal virus that causes respiratory tract infections. Upper respiratory tract symptoms, such as nasal congestion and sore throat, are common. The infection can also affect the lower respiratory tract, causing coughing, wheezing, and dyspnea. Older adults (≥ 65 years) and those with lung or cardiovascular disease are more susceptible to developing severe diseases such as bronchiolitis and pneumonia (Killikelly et al., 2024).

An effective, publicly funded vaccine is available for adults 60 years of age and older who reside in LTCF and should be recommended to all eligible residents. Treatment for RSV is usually supportive.

2.5 Other Respiratory Viruses

There are many other respiratory viruses which can cause disease and OBs in LTCF. Overlap of symptoms among these viruses is very common, but treatment is generally supportive. General IPAC measures (e.g., Droplet and Contact Precautions, careful respiratory hygiene and hand hygiene) are effective in interrupting transmission of any respiratory virus and should be implemented whenever respiratory pathogens are causing infection in a facility.

Testing (extended multiplex) to identify these other viruses rarely changes management, is expensive and should not be undertaken unless explicitly requested by NSH-PH.

3.0 Strategies for Prevention and Control of RVIs in LTCFs

It is recommended that planning for the prevention and control of RVIs should occur well in advance of each respiratory season and engage all LTCF staff and clinicians, including leaders and physicians, using facility-specific plans. In turn, these plans should be communicated to staff, physicians, residents, designated caregivers (DCG), and volunteers.

The key strategies for the prevention and control of RVIs in LTCFs are:

- Planning, teaching, and communication of protocols and procedures ([section 3.0](#))
- Routine Practices/Additional Precautions ([section 4.0](#))
- Immunization of residents **and** staff against influenza and COVID-19, and immunization of residents against RSV ([section 5.0](#))
- Screening and testing for RVIs ([section 6.0](#))
- Managing symptomatic residents ([section 7.0](#))
- Outbreak Management ([section 8.0](#))

3.1 Planning

Table 1: LTCF Policy and Procedure Development (in advance of respiratory season):	
☐	Review the most updated version of the Guide.
☐	Engage with NSH-PH, IPAC, OHSW, and other partners as needed to clarify content of this document and address facility-specific questions.
☐	Develop, review and/or update facility-specific policies and procedures relating to respiratory virus management, in accordance with the principles of this Guide.
☐	Ensure that facility IPAC resources are up-to-date and displayed/stored in places easily accessed by staff, including: • Posters • Line Lists • Any other appropriate documents, e.g., flow charts • This Guide
☐	Develop policies and procedures for environmental management of respiratory viruses, including for: • Environmental cleaning and disinfection • Routinely replacing soap, alcohol-based hand rub (ABHR), and refilling towel dispensers • Cleaning and disinfecting reusable equipment • Displaying hand hygiene posters around the facility

☐	Develop a communication/teaching plan for all staff that: • Outlines RVI prevention and control policies and procedures • Provides key contact information, including how and when to report to PH.
☐	Ensure an up-to-date copy of floor plans with resident room numbers is available to send to NSH-PH upon request.
☐	Establish and/or update contingency plans for low staffing scenarios. Ensure facility leaders and supervisors are aware of these plans.
☐	Obtain resident or substitute decision-maker (SDM) consent for COVID-19, influenza and RSV vaccines, and treatments/prophylaxis for COVID-19 and influenza, if not already done.
☐	Have standing order policies permitting healthcare providers to administer influenza, COVID-19, and RSV vaccines to residents as per the National Advisory Committee on Immunization (NACI) and provincial guidance.
☐	Communicate resident and staff influenza, COVID-19, and RSV immunization rates to regulatory authorities as required, as well as to staff, residents, and families.

Table 2: Readiness for RVI Prevention and Control

☐	Ensure sufficient personal protective equipment (PPE) (gowns, eye protection, face masks, gloves, N95 respirators of different sizes/fits) supply is available on all units, and that there is a clear process to order more when needed.
☐	Conduct regular N95 respirator fit testing for staff.
☐	Ensure the facility has an appropriate supply of PCR respiratory virus testing swabs and transport media (see Appendix E).
☐	Ensure all staff know how to order viral swabs, as outlined in Appendix D
☐	Ensure all staff are familiar with testing protocols (see section 6.0).
☐	Ensure the facility has a sufficient point of care test (POCT) supply. Orders for POCTs can be placed here . Tests should be delivered within 7 business days of ordering (see Appendix D).
☐	Ensure lab requisitions are available, and staff know how to complete them and ship PCR tests to the lab (see Appendix K).
☐	Review CANImmunize documentation process (Clinic Flow) with staff, ensure resident lists are updated, and review with staff the process for vaccine administration documentation.

☐	Document staff influenza and COVID-19 vaccine status.
☐	Ensure signed standing orders for influenza treatment and/or prophylaxis are available for each resident. Work with your designated pharmacists to calculate an appropriate oseltamivir dose for each resident. Please review Appendix B for details.
☐	Work with local pharmacy to develop a plan to ensure that LTCF staff are aware of who to contact to obtain influenza antivirals both during and after working hours.
☐	Have a procedure and contact information for staff to arrange assessment of appropriate residents for COVID-19 therapeutics. See Appendix C and COVID-19 Non-Severe Therapy Consult Service: Long-Term Care Referral Information for more information.
☐	Have up to date (within 6 months) goals of care documented for each resident.
☐	Complete vaccine program planning and staff education.
☐	Arrange staff influenza and COVID-19 vaccination clinics.
☐	Review vaccine ordering.
☐	Review vaccine storage. The Nova Scotia Standards for the Storage and Handling of Immunizing Agents link will be posted when available.

Table 3: IPAC Topics for Staff Education

☐	How to conduct a Point of Care Risk Assessment (PCRA) (see section 4.1).
☐	Routine Practices, including hand hygiene and respiratory hygiene (see section 4.0).
☐	Additional Precautions: Droplet, Contact, and Airborne (see section 4.2).
☐	Safely putting on (donning) and taking off (doffing) PPE, including using a buddy system (see section 4.2).
☐	Use of universal masking (UM) during OBs.
☐	Reprocessing instructions for reusable PPE, if applicable (e.g., goggles). For more information see Cleaning and Disinfection Instructions for Face/Eye Protection .
☐	Proper specimen collection techniques for obtaining nasopharyngeal swabs (direction, depth, duration, and dialing). See Nasopharyngeal swabbing for respiratory viruses – the 4 D’s .

Table 4: Education on General Public Health Messaging for Everyone

☐	Stay home when experiencing symptoms of RVI (see section 6.1 for a list of symptoms).
☐	Frequent/appropriate hand hygiene.
☐	Proper respiratory hygiene practices.
☐	Masking and/or physical distancing when advised and feasible.

Table 5: Communication

☐	Communicate regularly with residents, families, and staff regarding the facility's plans for managing RVI OBs and the role they can play in this process.
☐	Ensure vaccine providers have all necessary information to appropriately answer/address resident, family, and staff questions and concerns about influenza, COVID-19 and RSV vaccines.

4.0 Routine Practices / Additional Precautions

Routine Practices are the IPAC system to be used in all healthcare settings, with all residents, during all care, to prevent and control transmission of microorganisms. These practices are based on the premise that all residents are potentially infectious, even when asymptomatic, and that the same safe standards of practice should be used routinely with all residents to prevent exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin, and/or soiled items.

Key elements of routine practices for RVI outbreaks include:

- [Point of care risk assessment](#) (PCRA)
- [Hand hygiene program](#)
- Source control
- Resident accommodation, placement, spatial separation, and flow
- PPE available at point of care
- Management of the resident care environment
- Cleaning and disinfection of multiuse equipment
- Resident and visitor education
- Visitor management

NSH-IPAC has a [Routine Practices learning module](#) available.

4.1 Point-of-Care Risk Assessment (PCRA)

All elements of Routine Practices are important, but for the purposes of this Guide, we will focus on the [Point-of-Care Risk Assessment](#) (PCRA). The PCRA is an assessment (see Figure 1) completed before an interaction between staff and a resident that determines the risk of exposure to and/or transmission of infectious agents. It considers the clinical situation (including the resident's clinical condition, and their physical, emotional, and mental state), the facility/environment (including existing engineering and administrative controls), and the availability/use of PPE.

All staff should conduct a PCRA prior to each interaction with each LTCF resident to determine the risk of exposure and implement appropriate precautions required for safe care. Completing a PCRA allows you to determine which PPE should be used for each patient interaction. PCRA should be performed even if the patient has been placed on Additional Precautions as additional PPE may be required.

PCRA questions to determine Additional Precautions include:

- What are the residents' symptoms?
- What diagnosis is being considered or confirmed?
- What is the degree of contact?
- What is the degree of contamination?

- What is the resident's level of understanding and cooperation?
- What is the degree of difficulty of the procedure being performed and my experience level?
- What is my risk of exposure to blood, body fluids, excretions, secretions, non-intact skin and mucous membranes?

Will my hands be exposed to blood, excretions, secretions, tissues, non-intact skin or contaminated items in the environment?  If YES, perform hand hygiene and wear gloves	Will my face be exposed to a splash, spray, cough or sneeze (i.e. when doing wound irrigation, or intubation)? Will I be within 2 metres of a coughing patient?  If YES, wear facial protection (includes mask and protective eyewear)
Will my skin or clothing be exposed to splashes or items contaminated with blood, body fluids, excretions, secretions or non intact skin?  If YES, wear a gown	Does the patient have a suspected or confirmed airborne illness (e.g. measles, tuberculosis, chicken pox)? Am I performing an aerosol generating medical procedure (AGMP) on a patient/resident/client with suspected or confirmed COVID?  If YES, wear a fit tested and seal checked respirator (N95)

Figure 1: [Point-of-Care Risk Assessment](#) Key Considerations

4.2 Additional Precautions

Additional Precautions are required when a resident is infected with a microorganism for which transmission cannot be prevented with the use of Routine Practices alone. Additional Precautions are always used in addition to Routine Practices. Additional Precautions are based on how particular pathogens spread. For RVI, Droplet and Contact Precautions are indicated.

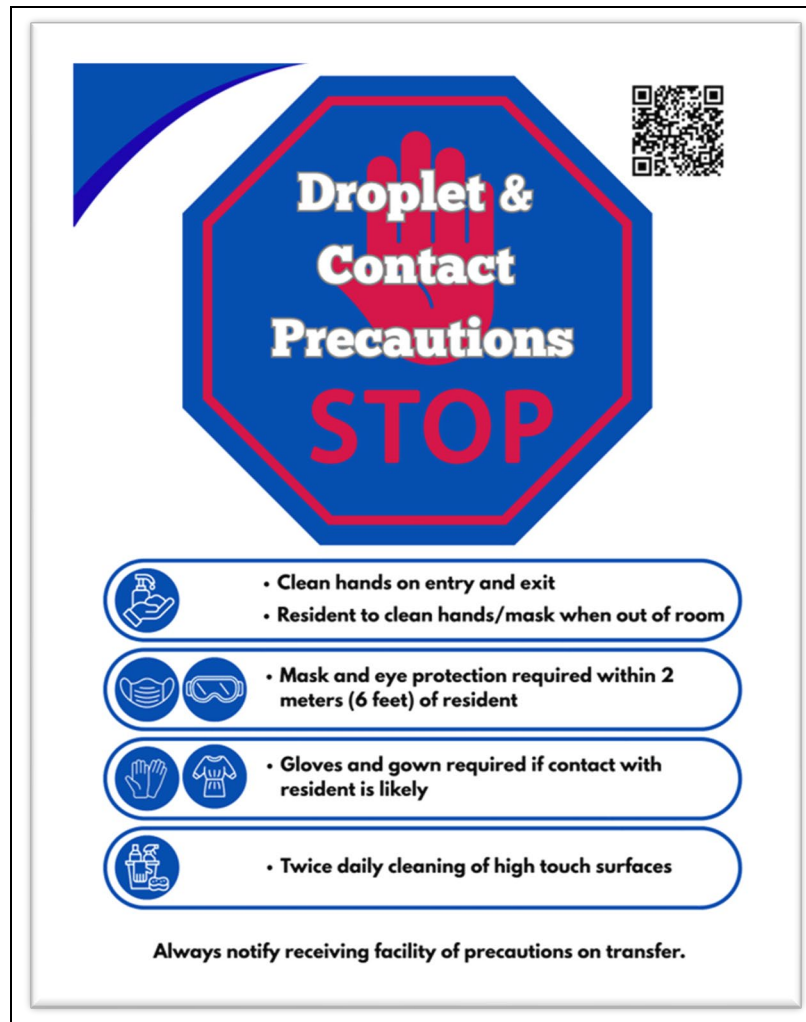


Figure 2: [Droplet and Contact Precautions Diagram](#)

Table 6: Droplet and Contact Precautions Considerations	
Accommodation	• A single room and bathroom are recommended whenever possible. • Droplet and Contact Precautions sign visible on entry to room or bed space. ○ Room door may remain open. • If room-sharing: ○ Ensure separation of at least two (2) meters between residents.

	○ Dedicate a bathroom or commode for each resident. ○ Pull privacy curtains or use dividers between beds.
Hand Hygiene	• Perform hand hygiene using ABHR or soap and water as described in Routine Practices (see section 4.0). • Use plain soap and water when hands are visibly soiled or when caring for residents with diarrhea and/or vomiting. • Before accessing and putting on a gown, gloves, mask, and/or eye protection. • After taking off any type of PPE. • Show residents and visitors how to clean hands and discuss when to use hand hygiene products.
Personal Protective Equipment	• Click here for a video on donning and doffing PPE for Droplet and Contact Precautions.
Gowns	Wear a new gown to enter resident room or bed space when: • Providing direct care (e.g., providing hands-on care such as bathing, washing, turning the resident, changing clothing, continence care, dressing changes, care of open wounds or toileting). • Having any contact with items in resident room (including gathering and handling specimens). • Cleaning any areas in resident room. Put on gown before putting on gloves; gloves should cover the gown cuffs. ○ Do not wear a gown outside resident rooms or bed spaces unless carrying contaminated items or assisting with resident transfer to another facility or area. Remove damaged or heavily soiled gowns as soon as possible. • Take off gloves and perform hand hygiene before taking off gown. • Do not reuse gowns. • After removing gown: ○ Place in waste container if disposable ○ Place in linen bag if reusable ○ Perform hand hygiene

Gloves	Wear new non-sterile gloves to enter resident room or bed space when: • Providing direct care (e.g., bathing, washing, turning the resident, changing clothing, continence care, dressing changes, care of wounds or toileting). • Having any contact with items in resident room (including gathering and handling specimens). • Cleaning any areas in the resident room. Other considerations for glove use: • Gloves are single use. Use only once, then dispose of them immediately after use. • Put on gown first and then gloves after; gloves should cover gown cuffs. • Change gloves and perform hand hygiene between care activities for the same resident (e.g., when moving from a contaminated body site to a clean body site). • Do not wear gloves outside resident rooms or bed spaces unless carrying contaminated items or assisting with resident transfer to another facility or area. • Never wash disposable gloves or use ABHR on any gloves. • Take off gloves and perform hand hygiene before taking off gown and facial protection. Hand hygiene should be performed again after removal of other PPE items. • Discard used gloves in a waste container.
Facial/Eye Protection	• A medical mask and eye protection (shield or reusable goggles) are to be worn within three meters of a resident on Droplet and Contact Precautions.
Resident Care Items and Equipment	• Use disposable care equipment when possible. • Dedicate re-useable equipment to a single resident until Droplet and Contact Precautions are discontinued (e.g., thermometers, blood pressure equipment). ○ If reusable equipment cannot be dedicated to a single resident for use, clean and disinfect it between residents. ○ Refer to manufacturer's instructions for equipment-specific cleaning information. • Rooms should contain a dedicated linen bag. Double bag only if leaking. • Do not share items (e.g., puzzles, books, electronics) that cannot be cleaned and disinfected. • When Droplet and Contact Precautions are discontinued; discard single-use care equipment and reprocess (clean and disinfect) reusable care items.

	Used meal trays and dishes do not require special handling. Disposable meal trays, dishes, and utensils are not necessary.
Ambulation Outside Room	- Residents should not leave their room or bed space unless necessary and/or part of their care plan (planned outdoor time is considered part of the care plan). - If residents must leave their room, instruct them or assist them with: - Performing hand hygiene - Putting on a medical mask
Environmental Cleaning	- All high touch surfaces in resident's room, including bathrooms and commodes, must be cleaned/disinfected at least twice daily. - Use facility-approved healthcare grade disinfectant with Drug Identification Number (DIN). - When Droplet and Contact Precautions are discontinued, notify facility Environmental Services to request a terminal cleaning of room.
Visitors	- Encourage visitors to perform hand hygiene. - Instruct family and visitors how to put on and take off PPE, if required.

Aerosol Generating Medical Procedures (AGMPs) in LTC

Residents with suspect or confirmed COVID-19 should be cared for using Droplet and Contact Precautions. Additionally, Airborne Precautions are used when AGMPs are performed.

The full NSH-IPAC AGMP guidance document may be accessed at [AGMP Guidance](#)

N95 Respirators for Airborne Precautions:

- Staff must be properly fit tested for N95 respirators – information about respiratory protection programs and booking fit tests through NSH OHSW can be found [here](#)
- A seal check must be done each time an N95 respirator is worn.

For information on ordering supplies from Nova Scotia COVID-19 PPE Portal through Shopify, please see [Appendix M](#).

5.0 Immunization

The influenza, COVID-19, and RSV vaccines provide protection against their associated RVIs, especially to those at risk of severe respiratory disease/complications. Additionally, pneumococcal vaccination protects against many strains of *Streptococcus pneumoniae*, a common cause of bacterial pneumonia, including secondary pneumonia that can complicate an RVI. COVID-19, influenza, RSV, and pneumococcal vaccines can be co-administered.

When residents are admitted to an LTCF, review their immunization status and provide any immunizations they are missing and eligible for. See [Publicly Funded Vaccine/Immunoglobulin Eligibility Policy](#) for more information.

The information below assumes that a primary COVID-19 vaccine series has been received. For guidance on administering a primary vaccine series, please see the Canadian Immunization Guide (CIG).

For further guidance on vaccine administration, precautions, contraindications, etc., please refer to the [Canadian Immunization Guide](#).

Table 7: Publicly Funded Respiratory Virus Vaccines LTCF Residents are Eligible to Receive			
Vaccines	Eligibility	Number of Doses Required	Timeframe in between Doses
COVID-19*	Individuals in LTCF or in hospital awaiting LTCF placement	2 doses	One dose in fall and one dose in spring at least 3 months apart and at least 3 months after any COVID-19 infection.
Influenza adjuvanted vaccine for individuals $\geq$ 65 yrs old. Standard Dose (IIV3-SD) vaccine for individuals < 65 years old.	Individuals in LTCF or in hospital awaiting LTCF placement	1 dose	Annually

RSV for individuals 60 years and older	For residents of LTCF or in hospital awaiting LTC ≥ 60 yrs old**	1 dose	Once only, on admission
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** This applies to individuals who have been previously vaccinated against COVID-19. For guidance on administering a primary dose/series in those requiring it, please see the [Canadian Immunization Guide COVID-19 chapter](#) and/or reach out to Public Health.*

***Although not publicly funded in Nova Scotia, residents who are over the age of 18 but less than 60 years old are recommended to get RSV vaccine by the National Advisory Committee for Immunization (NACI) and the Canadian Immunization Guide (CIG).*

For more information on administering influenza, COVID-19 and RSV vaccination programs see: [Publicly Funded Respiratory Virus Immunizations Information for Health Care Providers 2025-26](#). Updated link will be posted once available.

5.1 Staff Immunization Against Respiratory Viruses

NACI considers receipt of influenza vaccination, provided there are no contraindications, to be an essential component of the standard of care for all healthcare workers and other care providers for their own protection, as well as for protection of patients and residents. NACI also strongly recommends that healthcare workers be appropriately immunized against SARS-COV2.

Vaccination remains one of the best ways for people to protect themselves, co-workers, and vulnerable residents/clients from severe disease, hospitalization, and death. To book immunizations that you are eligible for, see the [Nova Scotia Immunization Booking Page](#).

Employers and operators of high-risk settings are responsible for setting immunization policies for influenza and COVID-19.

5.2 Influenza Immunization

LTCF residents and residents of other chronic care facilities are a high-priority population for influenza vaccination, and influenza vaccine should be highly encouraged for all such residents. Healthcare providers (HCP) should offer the seasonal influenza vaccine in the early fall, as seasonal influenza activity may occur as early as October in the Northern Hemisphere.

Individuals under 65 years of age will be eligible to receive a standard-dose influenza vaccine. Individuals 65 years of age and older will be eligible to receive an adjuvanted influenza vaccine. Individuals having an allergy to the adjuvanted vaccine, or any of its components, will be eligible to receive high-dose influenza vaccine. If a resident has an allergy to a component of an influenza vaccine, contact the BioDepot at PublicHealthVaccineOrders@nshealth.ca. Specify the allergy and required vaccine, so the appropriate vaccine can be provided.

5.3 COVID-19 Immunization

LTCF residents are a priority population for COVID-19 immunization, and all residents should be highly encouraged to be vaccinated.

There is no preference between the Pfizer and Moderna vaccines. A small quantity of Nuvaxovid will be available for those with allergies to mRNA vaccines.

Individuals 6 months and older who previously received COVID-19 vaccine can receive one dose of the updated formulation at least 3 months after their last COVID-19 vaccine or confirmed infection.

Adult residents of LTCFs, as well as individuals 6 months of age and older who are moderately to severely immunocompromised, are recommended to receive two doses of the COVID-19 vaccine. These should be provided at least three months apart (and at least three months after any confirmed COVID-19 infection). Generally, these are given in the fall and spring, respectively.

LTCF's that experience a COVID-19 OB should, once the OB ends, immunize residents who are not up to date on their COVID-19 vaccinations and who did not become infected with COVID-19.

5.4 Respiratory Syncytial Virus (RSV) vaccine

Individuals 60 years and older, residing in a LTCF or in hospital awaiting LTCF placement, are eligible to receive a single dose of RSV vaccine. **RSV vaccine is not given annually.**

LTCF staff should review immunization records to determine if residents being admitted to LTCF from the community or hospital have received the RSV vaccine. Those not previously immunized should receive the RSV vaccine if they are eligible. The RSV vaccine dose is optimally administered just before the start of the RSV season.

For the most current information on COVID-19, influenza, and RSV vaccines, please see the links below.

Table 8: Vaccine types and available resources	
Vaccine	Resources
COVID-19	2026-2027 NACI Statement on COVID-19 COVID-19 Vaccines: Authorized vaccines - Canada.ca
Influenza	2026-2027 NACI Statement on Influenza Influenza vaccines: Canadian Immunization Guide - Canada.ca
RSV	Respiratory syncytial virus (RSV) vaccines: Canadian Immunization Guide - Canada.ca

6.0 Screening, Testing, and Management of Symptomatic Residents

Older adults may not exhibit fever or the same respiratory symptoms as younger people when infected with a respiratory virus. The diagnosis of an RVI should therefore be considered in any older adult **with an unexplained change in baseline health status**, including new onset confusion/delirium.

6.1 Screening of Symptomatic Residents

When LTCF staff notice that a resident has a change from their baseline health status that may be the result of a respiratory virus, testing should be undertaken *if appropriate* (see guidance on swabbing in [section 6.3](#)). Symptom monitoring should be done and documented at least once daily while ill.

Staff should have a **low threshold** for suspecting and initiating *appropriate* testing of RVI, especially during RVI season. The box below is a guide for when an RVI should be suspected.

If any one of the following¹ new, worsening and/or unexplained symptoms are present in a resident:

- Cough
- Fever (temperature of 37.8°C or greater), chills, sweats²
- Shortness of breath or difficulty breathing
- Loss or change in sense of smell or taste
- Sore throat
- Runny nose/nasal congestion/excessive sneezing
- Muscle aches
- Headaches
- Any unexplained change in baseline including confusion/delirium

OR

- **Unexplained, less typical** symptoms, including but not limited to, nausea/vomiting or/diarrhea and/or extreme fatigue.

Consider appropriate testing and/or diagnosis of an RVI:

1. *Residents only having chronic stable symptoms (cough, sneeze, etc.) due to established medical condition(s) (asthma, allergies, etc.) should not be tested or put on Droplet and Contact Precautions, and are permitted to participate in visits, outings or facility programs/activities.*
2. *Note that elderly individuals may not show signs of fever.*

6.2 Initial Management for Suspected RVI

Step 1: Immediately place any symptomatic resident on Droplet and Contact Precautions

Step 2: Use a PCR test (test for COVID-19, influenza and RSV **only**) for the first 3 symptomatic residents (see [Figure 3](#) for testing guidance).

Step 3: Report to Public Health (see [Appendix F](#) for contact information) and obtain an OB number if there is a suspected or confirmed ([see section 8](#)) respiratory virus OB of any kind.

Step 4: Ensure the OB number is on all specimens collected. If there is no OB number yet, put “Suspect Outbreak” on the requisition.

No additional PCR testing is required to define an outbreak unless requested by Public Health. Indications may include:

- New affected unit/household.

OR

- If, after consultation with the Medical Officer of Health (MOH), further testing is needed because OB is lasting longer than anticipated.

OR

- Residents’ presenting symptoms change, and co-circulating viruses are suspected.

6.3 Approach to Testing

The approach outlined in [Figure 3](#) below is based in part on a 2015 Canadian study (Schleihau et al., 2015) that demonstrated greater than 96 percent of influenza OBs in any setting were detected with 3 PCR swabs. Specific therapeutics and/or prophylaxis exist for COVID-19 and influenza, but no such therapies exist for the other RVIs that typically cause OBs in Nova Scotia. The testing strategy below allows for sensitive detection of COVID-19 and influenza but otherwise minimizes testing that is rarely helpful, costly, and may be unpleasant for staff and residents to obtain.

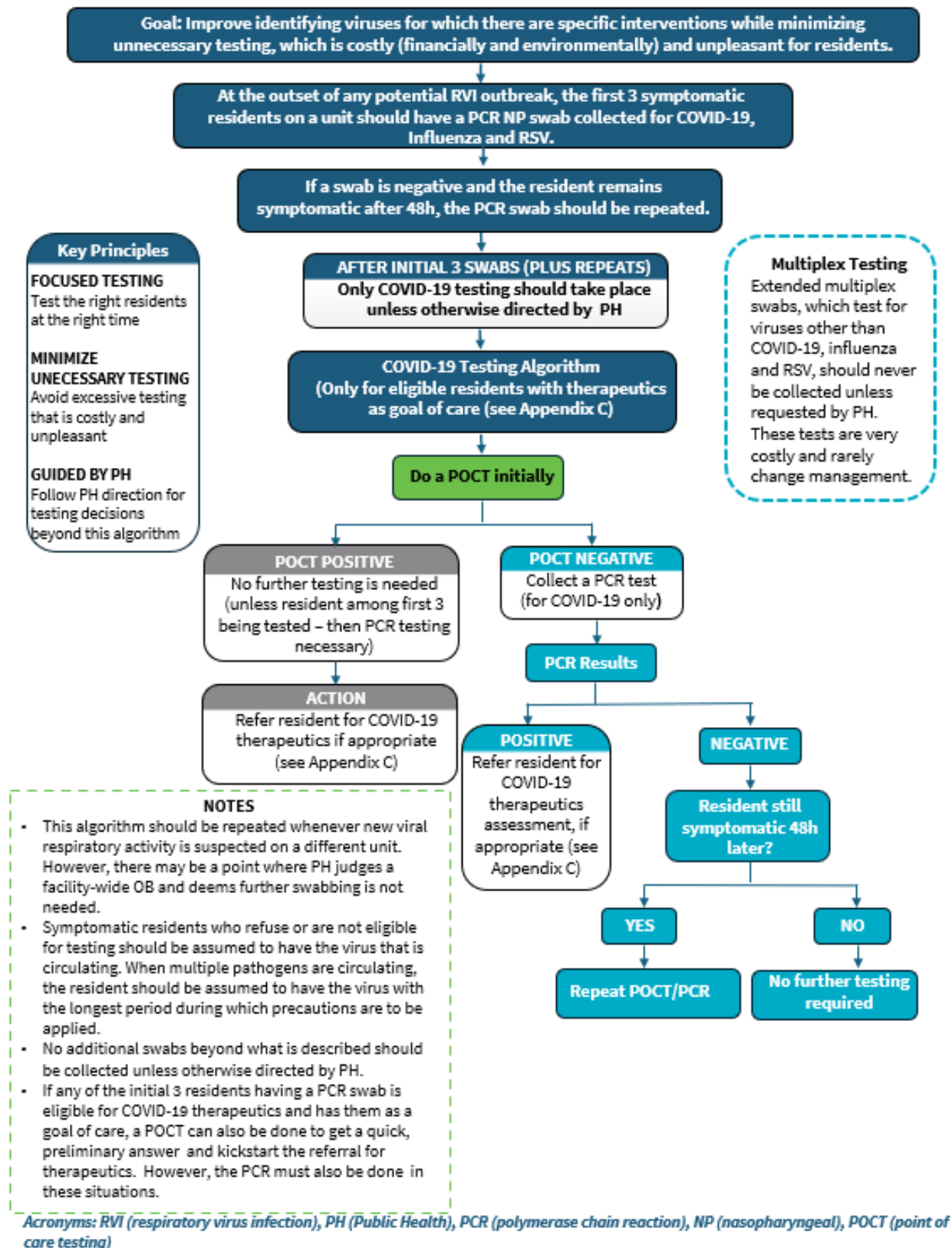


Figure 3: Approach to Testing Respiratory Virus Outbreaks

This is an evergreen document. LTCFs should access [Public Health](#) to obtain the most up-to-date version. Last updated 2026/10/01

6.4 Screening and Management of Symptomatic Non-Residents

Anyone who does not live in the facility will be considered a non-resident (staff, volunteers, family, visitors, students, essential care partners/workers, etc.). Signs should be widely displayed indicating that all non-residents should monitor themselves for signs and symptoms of respiratory viruses prior to entering the LTCF and to **not enter if ill**.

If a non-resident becomes symptomatic for an RVI while in the LTCF, they should:

- immediately perform hand hygiene
- ensure they are wearing a well-fitting medical mask
- inform a staff member
- avoid further resident and staff contact
- leave the facility
- do not return to the facility until no longer infectious (see [Table 10](#))

Please see [Appendix G](#) and [Appendix H](#) for Occupational Health Information for Staff

6.5 Testing Best Practice

Detection of respiratory viruses depends on the collection of high-quality specimens, rapid transport to the lab, and appropriate storage.

Video describing correct technique for obtaining nasopharyngeal swabs:

[Nasopharyngeal Swabbing for Respiratory Viruses – The 4 Ds](#)

6.5.1 Collection Kits

- The standard viral collection kits contain two swabs
 - A smaller caliber, more flexible swab with a flocked head that should be used when collecting a nasopharyngeal (NP) sample.
 - A larger, more rigid swab that can be used when a throat and nares specimen is preferred.

Please see [Appendix I](#) and [Appendix J](#) for specimen collection information, and [Appendix D](#) for up-to-date information on ordering swabs.

6.5.2 Test Requisitions

- Ensure the OB number is on the requisition. If there is no OB number yet, put “Suspect Outbreak” on the requisition.

- The facility's medical director and/or the resident's primary care provider (PCP) in the facility is the ordering HCP for RVI testing (see [Appendix D](#)).

6.5.3 POCT test for LTCF staff and residents

Nova Scotia Health continues to offer COVID-19 rapid testing to LTCFs. Orders for these tests can be placed [here](#). Tests should be delivered within 7 business days (see [Appendix D](#)). Please check the expiry date on the tests. Expired tests should not be used and can be disposed of per your local waste management guidelines. General information and instructions for rapid testing can be found [here](#).

Table 9: Managing Resident Test Results			
Affected Individual	Test Results	Clinical Status	Guidance
Resident	Negative for all viruses	Continues to be symptomatic	Repeat testing as outlined in Figure 3 , 48 hours after the first test and keep on Droplet and Contact Precautions until symptoms are improving and as per guidance in Section 9 .
Resident	Negative for all viruses	Symptoms have resolved in the first 48 hours	No further testing required. Discontinue Droplet and Contact Precautions.
Resident	Positive (any virus)	Symptomatic	Maintain Droplet and Contact Precautions for duration appropriate for condition (see Section 9.1)
Resident	Refuses testing or testing not indicated	Symptomatic	Maintain Droplet and Contact Precautions for the circulating OB pathogen(s) as per Table 12 or, if unsure, 7 days and improving symptoms. Consult PH/IPAC if not improving after 7 days.
Roommate	No testing as long as remains asymptomatic	Asymptomatic	Continue active screening twice per day until symptomatic roommate is off Droplet and Contact Precautions.
Roommate	Positive (any virus)	Symptomatic	Maintain Droplet and Contact Precautions for duration appropriate for condition as per Table 12 .

Table 10: Guidance for Non-Residents excluding Staff*

Affected Individual	COVID-19 PCR or POCT Test Result	Clinical Status	Guidance
Non-resident	Positive	Symptomatic	Exclude from LTCF for 5 days from symptom onset or positive test result, whichever is longer. Medical masking mandatory at all times between day 6-10.
Non-resident	Negative	Symptomatic	Exclude from LTCF until improving 24h and with no fever. Medical masking mandatory up until day 10 of symptom onset.

*For staff guidance see [Appendix G](#) and [Appendix H](#)

6.5.4 Steps to take with First Positive Test Results

The first positive RVI test result(s) must be reported by phone to PH	
Monday – Friday 8:30am – 4:30pm Notify PH in your zone	After hours and holidays: Call QEII locating at 902-473-2222 and ask for the Public Health Nurse (PHN) on call for your zone
See Appendix F for Public Health contact information	

After **one** positive test is reported and OB measures are initiated (see [section 8.5](#)), the LTCF does not need to continue reporting resident cases by phone **but needs to submit daily line lists to NSH-PH.**

Generic line list can be found [here](#). See [section 8.2](#) for detailed information about line lists.

A newly symptomatic individual who tested positive for COVID-19 in the **previous 90 days** is less likely to have reinfection with COVID-19. Any positive results in such individuals should be discussed with NSH-PH to facilitate interpretation.

Keep in mind that more than one virus may be circulating in a LTCF, especially during RVI season. When multiple pathogens are circulating and symptomatic residents refuse or are not eligible for testing, they should be assumed to have the virus with the longest period during which precautions are to be applied.

Consult with NSH-PH for further guidance if you have concerns/questions about OB management.

7.0 Managing the Symptomatic Resident

7.1 General Measures

- Wear appropriate PPE when providing care to ill residents and ensure adequate and frequent hand hygiene.
- Post visible [signage](#) on the affected resident's door or bed space indicating Droplet and Contact Precautions are needed.
- Notify appropriate people and partners of OB.

Do not wait for confirmation of pathogen involved to implement OB control measures. Residents with RVI must be placed on Droplet and Contact Precautions for the appropriate length of time that corresponds to their specific infection (see [Table 12](#)).

7.2 Residents on Droplet and Contact Precautions

- Must stay in their room and receive meals in their room.
- If feeling well enough, may participate in up to one hour per day of outdoor time. There should be sufficient supervision to prevent transmission to others. When moving through the facility to get outdoors, the resident must wear a well-fitting medical mask and take the route that best minimizes encounters with others.
- Should **not** participate in any LTCF group activities / events / gatherings.
- Should not attend non-essential appointments.
- Should wear a well-fitting medical mask (when tolerated) when anyone is in their room (this may not be practical if the symptomatic resident has a roommate).
- Please see [section 4.0](#) for additional information.

7.3 Therapeutics

- Residents with a confirmed COVID-19 infection who are medically stable/not requiring hospital assessment may be eligible for therapeutics. If therapeutics are part of their care plan, they should be referred to the Non-Severe COVID-19 Treatment Team for therapeutics assessment (see [Appendix C](#)).
- Residents diagnosed with influenza should generally be started on an appropriate antiviral (see [Appendix B](#)).
- Any resident who is unwell/unstable should receive appropriate medical assessment, including, if warranted and part of the resident's care plan/goals of care, an in-hospital/Emergency Department (ED) visit. Ensure to notify receiving unit and transport staff of Additional Precautions required.

8.0 Outbreak Management

8.1 Definitions

Communicable disease OBs of any kind in LTCFs must be reported to NSH-PH.

The OB definitions below provide a standard classification for surveillance of respiratory infections in LTCF in Nova Scotia.

Please note that in the definitions below, ‘epidemiologically linked’ means the affected individuals shared time together in the same space (e.g., on the same unit, at the same table, at bingo together).

Table 11: Outbreak Definitions
Suspect Respiratory Infection Outbreak
Two individuals with new onset respiratory symptoms, epidemiologically linked within the LTCF, in a 72-hour period. OR One laboratory confirmed case of a known respiratory pathogen in a resident with or without a second symptomatic resident.
Lab Confirmed COVID-19 Outbreak
Two or more laboratory-confirmed resident cases, AND at least one is a facility acquired case, with all cases epidemiologically linked within the LTCF in a 10-day period.
Lab Confirmed Influenza Outbreak
Two or more resident cases of influenza-like illness (ILI), where at least one is a laboratory confirmed case of influenza, epidemiologically linked within the LTCF in a 7-day period.
Lab Confirmed Respiratory Syncytial Virus (RSV) Outbreak
Two or more symptomatic residents, where at least one is a laboratory confirmed case of RSV, epidemiologically linked within the LTCF in a 7-day period.
Respiratory Infection Outbreak: Unidentified/Other Pathogen
Three or more cases with new onset respiratory illness, epidemiologically linked within the LTCF in a 4-day period.

When residents exhibit symptoms that are primarily nausea/vomiting/diarrhea not associated with an RVI, follow IPAC protocols and contact NSH-PH to consider an enteric outbreak.

8.2 Line Lists

The line list is an important tracking tool that summarizes key information about resident cases during an OB. Each row corresponds to a symptomatic resident and documents relevant dates, demographics, resident unit/room, symptoms, and test results. The list allows for identification of trends and creation of an epidemic (epi) curve, which can be useful to determine how the OB will likely evolve. A line list should be started as soon as a first symptomatic resident is identified and updated appropriately as symptomatic residents emerge and test results return. An updated line list should be submitted daily to NSH-PH.

Best practices for creating Line Lists:

- Start your line list as soon as you identify a resident with symptoms of an RVI.
- Use of the electronic line list is preferred. However, if you do not have access to a computer, use the printable version of the line list.
- Make sure you add any new cases daily – **do not remove any of the previously entered cases.**
- As the OB unfolds, you do not have to edit previous entries as symptoms develop/ resolve in residents. However, do update if the resident has additional testing, is sent to hospital or expires.
- There should be one line list per OB. Include the room number and section where the resident resides. This means that each unit/floor does not need their own line list. For larger facilities where this may be impractical, seek guidance from NSH-PH.
- The line list can be found [here](#).

8.3 Contact Management

A person is generally considered to be a contact when they have spent at least 15 minutes within two meters of an infected individual without appropriate respiratory protection (this includes roommates).

An individual may also be a contact if exposed to an infected individual's respiratory secretions (e.g., kissing, sharing food, drinks, cosmetics, cigarettes, vaping devices). At MOH discretion, sustained outdoor face-to-face contact may be assessed as an exposure.

8.3.1 Asymptomatic Resident Contacts (Roommates and Non-Roommates)

Regardless of vaccination status, an asymptomatic roommate does not require Additional Precautions; however, active screening of the roommate twice per day until the infected roommate has recovered is required. Broad active screening of the entire unit/facility is not required.

Non-roommate resident contacts should be monitored for symptoms for 72 hours post-exposure.

Additional Considerations:

- Resident contacts do not have to be placed on Additional Precautions as long as they remain asymptomatic.
- Resident contacts on a unit with a suspect or confirmed OB should not move between units until the OB ends to minimize transmission risk in the facility.
- Resident contacts may leave the facility for off-site visits and essential appointments. Ensure notification of facility OB prior to visit has occurred.
- Resident contacts should wear a well-fitting medical mask (when tolerated) when others are **in** their room (it is understood this may not be practical for roommates).
- Resident contacts are recommended to utilize risk reduction measures such as masking (when tolerated) and/or physical distancing from others when **out** of their room.
- Resident contacts should avoid group activities for 72 hours after initial exposure.

8.3.2 Residents who are NOT contacts

- Additional Precautions for residents are not required.
- Residents, who are not contacts, on a unit with a confirmed OB **should not** move between units until the OB ends to minimize transmission risk in the facility.
- Residents, who are not contacts, on a unit with a suspect OB are not restricted to the unit.
- Individual resident testing is **not** required if asymptomatic.

8.3.3 Non-Residents

Non-residents may be deemed contacts if they have sufficiently interacted with a resident with a RVI without appropriate use of the recommended PPE and IPAC practices.

In consultation with NSH OHSW, the facility will notify staff contacts of their need for testing (COVID-19 only) and work exclusion requirements.

For information regarding assessment of staff exposures, work exclusion, and testing requirements, email OHSW.ContCareID@nshealth.ca.

The facility should also notify any other non-residents (volunteers, student learners, etc.) of the exposure and need for testing/exclusion (see [Table 10](#)).

8.4 Staff Measures during Outbreak

The following additional measures should be considered for a LTCF experiencing staffing challenges during OBs:

8.4.1 Masking

- Implement universal masking (UM) for the duration of the OB.
- Individuals wishing to wear a mask even when it is not required should be provided appropriate supplies by the facility.
- More information on masking can be found at: [Respiratory Virus Masking Guidance](#).

8.4.2 Cohorting

- Cohorting of staff/assignments.
- If feasible, staff who have not been exposed should work exclusively with residents who are not contacts and staff contacts should work exclusively with resident contacts.
- External staff may be deployed to work in the facility. If external staff are required to manage an OB, the following approaches should be taken:
 - The temporary assignment should occur for a continuous series of days at only one facility, not randomly between two or more facilities.
 - Reinforcement of PPE/IPAC principles should occur.
 - Where possible, external staff should provide care on unaffected units and/or for uninfected residents and residents who are not contacts. This will help to prevent the introduction of pathogens in other facilities where these external staff may also work.

**For more information on staff testing and work exclusions (see [Appendix G](#))*

Refer to [Section 7.0](#) for managing a symptomatic resident.

8.5 Outbreak Control Measures

Have a low threshold for implementing enhanced PH measures (e.g., UM, physical distancing) during OBs, particularly in respiratory season, given resident vulnerability. Strategies and measures to be considered are outlined below.

8.5.1 General Outbreak Control measures

- Ensure use of Droplet and Contact Precautions with all residents who are symptomatic, test positive and/or refuse testing for an RVI.
- Consider implementing UM for the duration of the OB. UM entails:
 - All residents should wear a mask while outside of their room or when they have other persons (besides roommates) in their room.
- Non-residents should mask at all times, including in residents' rooms.

- Non-essential visits should be postponed.
- Staff can remove their masks in the break room while eating.
- Ensure ABHR is readily available, particularly at entrances and exits to the facility.

8.5.2 Physical distancing during an OB

- In any LTCF common area, it is advised that residents, staff and non-residents physically distance. Staff, workers, and caregivers are exempt from physical distancing requirements when providing resident care.
- Staff should maintain physical distancing as much as possible from each other when unmasked in places like break rooms. Well-fitting medical masks may be removed when eating/drinking in designated staff break rooms or when on the grounds outside of the facility. Staff should not eat/drink in resident care areas.

8.5.3 Cohorting residents of non-affected units

- Cohorting residents can help prevent RVI transmission throughout the LTCF and should be considered during OBs.
- These guidelines should be followed:
 - Maintain consistent residents in a cohort.
 - A given cohort can participate in such activities as dining, recreation outings, and social activities.
 - With larger group activities in enclosed spaces (e.g., faith services), try to keep different cohorts physically distanced from each other as much as possible.

8.5.4 Environmental Management

- Enhanced environmental cleaning and disinfection regimens are important. This includes frequent (minimum twice daily) cleaning and disinfection of high touch surfaces.
- Hospital grade disinfectants with a DIN are effective in destroying respiratory viruses if used according to manufacturer's instructions, including appropriate wet contact/dwell time.
- Follow laundry and waste disposal protocols according to facility Routine Practices.
- Any equipment that is shared between residents must be cleaned and disinfected, as per facility Routine Practices, before use on or by another resident.
- Reach out to the facility's IPAC delegate with any questions or concerns.

8.5.5 Signage

Signs must be posted at all entrances and exits throughout the unit/facility advising staff and others that an OB has been declared.

Signage should include:

- Instruction for cleaning hands when entering and exiting the facility.

- Reminders that unwell non-residents must not enter the facility.
- Visitor restrictions are in effect (e.g., non-essential visits must be postponed).

8.5.6 Compassionate Exceptions

LTCF should allow visitation of any form and with any number of visitors, for compassionate reasons (e.g., palliative and end-of-life visits). The following measures should be in place for these visits:

- Visitors should passively screen themselves for symptoms and be asymptomatic to enter the LTCF.
- Visitation occurs only with the specific resident.
- Staff support visitors in selecting and appropriately using PPE.

8.5.7 Admissions, Re-admissions, and Transfers

Residents can be admitted/readmitted to a facility, or transferred to other facilities, unless otherwise indicated, during RVI outbreaks.

If a LTCF must transfer a potentially or confirmed infectious resident, ensure that receiving services are notified of the person's condition so that appropriate precautions can be taken.

Residents or SDMs must provide informed consent if a resident is being transferred to a facility experiencing an OB.

Please see [Appendix L](#) for Outbreak Management Quick Reference Guide).

9.0 Closing the Outbreak

9.1 Discontinuing Additional Precautions

The timing for discontinuation of Additional Precautions for a given resident does not change based on their vaccination status.

Table 12: Discontinuing Droplet and Contact Precautions	
Respiratory Virus	Recommended Duration of Precautions
Influenza	At least 5 days and clinically improving for 24 hours with no fever (off antipyretics) and not moderately – severely immunocompromised**
COVID-19	At least 7 days and clinically improving for 24 hours with no fever (off antipyretics) and not moderately – severely immunocompromised**
RSV	At least 7 days and clinically improving for 24 hours with no fever (off antipyretics) and not moderately – severely immunocompromised**
Unidentified or Other Respiratory Virus	Improving for 24 hours with no fever

**When determining the date to discontinue precautions, Day 0 is the date of onset of symptoms or the date of positive test. (Therefore, Day 1 begins 24 hours after the date of the onset of symptoms or a positive test).*

**** Droplet and Contact Precautions for moderately-severely immunocompromised individuals may extend for a longer timeframe and discontinuation for those individuals should be done after discussion with IPAC, OSHW and PH.**

For potentially relevant immunocompromising conditions, see link below:

[Definition for people who are immunocompromised | Nova Scotia Health](#)

9.2 Declaring the Outbreak Over

PH declares an RVI OB over, and the LTCF will receive a letter indicating the same.

Table 13: Closing a Viral Respiratory Outbreak	
Respiratory Virus	Declaring the OB Over*
Confirmed influenza	7 days

Confirmed COVID-19	10 days
Confirmed RSV	7 days
Outbreak: Unidentified /Other Respiratory Pathogen	7 days
Suspect OB	48 hours

**** From the period of communicability following the last known exposure to an infectious person in the affected unit/area.***

Glossary

Term	Definition
Active screening	A process whereby an individual is asked screening questions by facility staff to determine whether symptoms or established risk factors for an RVI are currently present.
Additional Precautions	Extra measures in addition to Routine Practices to be implemented when Routine Practices alone may not be sufficient to interrupt transmission of an infectious agent.
Contact	A person exposed (generally within 2 meters for at least 15 minutes and without respiratory protection) to an infected individual during the infectious period. For example, this could be a person sharing an eating space.
Designated Caregiver (DCG) / Essential Care Partner	Designated family members or support persons having an established pattern(s) of providing essential care or support for a resident.
Epidemiologically Linked Case	An RVI diagnosis in which the infected individual had contact with one or more people who have/had the disease, and from whom transmission of the infectious agent is plausible.
Essential Worker	Workers not employed by the LTCF, who provide services critical to the LTCF's day-to-day functioning. Examples include paramedics, physiotherapists, primary care providers and delivery services personnel.
Immunocompromise	Refers to having a weakened immune system, either from illness or medications. Individuals with significant immunocompromise are generally more susceptible to infections and may have more severe disease.
Incubation Period	The period between infection by a pathogen and the onset of symptoms/illness.
Infectious Period	The period during which an infected individual can transmit the infection to others.
National Advisory Committee on Immunization (NACI)	A national advisory committee of experts from various relevant fields that provides recommendations on how vaccines approved for use in humans in Canada should be used.
Passive Screening	Steps taken by an individual before entering a facility to assess that they do not have symptoms or established risk factors for an RVI.
Polymerase Chain Reaction (PCR) Testing	Diagnostic method that identifies the nucleic acid (DNA or RNA) of a pathogen. Because PCR testing detects nucleic acid and not the pathogen itself, it cannot differentiate between an active infection and left-over fragments of nucleic acid from a "dead" pathogen, e.g., resolved infection. Clinical interpretation is needed.

Personal Protective Equipment (PPE)	Equipment (e.g., gloves, gowns, masks, respirators, and/or eye/facial protection) worn by an individual to minimize exposure to infectious droplets, fluids and other biohazards.
Point of Care Risk Assessment (PCRA)	An evaluation by a healthcare worker (HCW) prior to an interaction with a resident to evaluate the likelihood of exposure to an infectious agent in order to determine the appropriate actions/PPE needed to minimize the risk of exposure for the specific resident, other residents, the HCW and others.
Point of Care Testing (POCT)	On-site, non-laboratory medical diagnostic testing that gives a rapid result. POCT tests may not be as sensitive as lab-based testing.
Routine Practices	A comprehensive set of IPAC measures to be used in every interaction with residents, to prevent transmission of infection.
Universal Masking (UM)	The wearing by all residents (as tolerated) and non-residents of a well-fitting medical mask within the LTCF, except when eating/drinking with physical distancing.

Appendix A: Comparison of Key Features of RVIs

	Influenza	COVID-19	RSV	Other Viruses
Virus	Influenza A & B	SARS-CoV-2	Respiratory syncytial virus	Adenovirus, Human metapneumovirus, Parainfluenza, Rhinovirus, etc.
Testing	PCR (NP swab)	POCT PCR (NP swab)	PCR (NP swab)	Not recommended (but rarely requested by PH)
Incubation Period	1-4 days	1-14 days, On average 5-6 days	2-8 days	Variable
Infectious Period (may be longer in immunocompromised individuals)	1 day before until about 5 days after symptom onset	2-3 days prior to about 8-10 days after symptom onset (may vary with variant of virus)	1-2 days before until 7 days after symptom onset. Infectivity can persist for weeks in infants and immune-compromised children	Variable – reasonable to assume infectious for a few days prior to symptom onset and while symptomatic
Vaccine Available	Yes	Yes	Yes	No
Antiviral Prophylaxis or Treatment	Prophylaxis and treatment	Treatment	Not routinely recommended	No

Appendix B: Antiviral use for both Treatment/Prophylaxis for Influenza FAQ

The rationale for influenza prophylaxis during an OB is to prevent spread of influenza throughout the facility. Antiviral prophylaxis should be given to appropriate residents whether vaccinated or not. Antiviral prophylaxis should continue until the OB is over. If residents develop ILI symptoms while on prophylaxis, they should be changed from the prophylaxis dose to the treatment dose, which is higher. The duration of the treatment course is typically 5 days.

- If influenza is suspected, appropriate testing should be done promptly (maximum 3 residents). Once an influenza OB has been confirmed, antiviral treatment can begin for LTCF residents who present clinically as having influenza, and antiviral prophylaxis can begin in asymptomatic residents.
- The MOH will make a recommendation to the Medical Director regarding the need for antiviral medication and which antiviral drug to use. It is the Medical Director's responsibility, or the responsibility of the attending clinician(s) in the LTCF, to prescribe antiviral medication. **NOTE: If there is just one resident with influenza and the LTCF physician has decided to treat this individual and no other residents have ILI symptoms, the MOH or local PH does not have to become involved.**

What antiviral medications are available for use against Influenza?

In Canada, two neuraminidase inhibitors (oseltamivir and zanamivir) are licensed for use as both treatment and prophylaxis against influenza. Oseltamivir is administered enterally and recommended as first-line therapy. Zanamivir is administered via inhalation through an inhaler device and may be preferred in those in whom enteral administration is not possible. Zanamivir is not recommended in those with cognitive or physical limitations due to challenges with administration and is also not recommended in those with underlying respiratory conditions due to concerns for bronchospasm. Oseltamivir is more readily available in pharmacies than zanamivir.

Baloxavir marboxil is a newer antiviral agent that became marketed in Canada in 2025. It works by inhibiting influenza virus cap-dependent endonuclease and is only approved for the treatment of uncomplicated influenza. It is not currently recommended for routine use in part due to its limited role in more severe illness, lack of indication for OB prophylaxis, concerns about treatment-emergent resistance, and cost/accessibility challenges (AMMI Canada, 2026).

Over the past few years, the predominant circulating strains of influenza have been sensitive to oseltamivir and zanamivir, but the potential for antiviral resistance emerging exists. The effectiveness of antivirals is determined each season, and recommendations may change as new information becomes available.

How are antiviral medications against influenza used in LTCFs?

Antiviral medications can be used for the prevention and control of influenza OBs among residents in the following ways:

- For the presumptive treatment of residents with ILI, while awaiting laboratory confirmation or for symptomatic residents epidemiologically linked to a confirmed influenza case in the context of an OB.
- For the treatment of residents with lab-confirmed influenza.
- For the prevention of influenza among residents once an OB has been declared. (e.g., prophylaxis).

LTCF residents do not need to have a high-risk condition for prophylaxis to be used.

Who decides when to use antiviral medication in the LTCF?

When an influenza OB has been declared, the MOH will make a recommendation for all non-affected individuals on the affected unit (or facility) to be placed on prophylactic doses of an antiviral (usually, oseltamivir). Those subsequently diagnosed with influenza illness should be placed on treatment doses of the antiviral for the appropriate duration.

If only a single individual has suspected or confirmed influenza, and there are no other affected individuals, the MOH will not typically recommend prophylaxis. Rarely, an MOH may recommend prophylaxis in other circumstances, e.g., in the context of very high and virulent influenza activity in the larger community.

While the MOH may recommend antiviral prophylaxis to the LTCF, it is ultimately up to the facility to implement/prescribe antiviral medication in consultation with the Medical Director/attending staff.

Antiviral medication use in an OB situation should begin as early as possible after the OB begins to be effective in interrupting transmission.

What can you do to prepare for the possible use of antiviral medication?

Each LTCF should have a plan in place that allows for the rapid administration of antiviral medication if an influenza OB occurs:

- For all LTC residents, prior to the influenza season, document an up-to-date serum creatinine, weight, height and age. Up-to-date means within at least the past 12 months for residents who are medically/renally stable. Those who are unstable and/or who have progressive renal disease should have more frequent renal function testing e.g. monthly. Using the appropriate data, please work with your pharmacist to calculate an oseltamivir dose for each resident.
- In the rare scenario where a recent serum creatinine is unavailable, initiation of antiviral treatment or prophylaxis should not be delayed. Medication may be initiated at full dose and adjusted once bloodwork is available and allows for accurate creatinine clearance calculation.
- Develop a mechanism to obtain physicians' orders on short notice (e.g., a pre-approved antiviral order).

- For adverse events and considerations on each antiviral drug, please see [NSH Firstline](#).

Which residents do you treat with antiviral medication in an OB situation?

While antiviral medication is most beneficial when symptoms have been present for less than 48 hours; it is still recommended for LTC residents after that time. Antivirals also make the individual less infectious. Antiviral treatment is usually continued for a maximum of 5 days but can occasionally be extended for an additional 5 days. Antiviral prophylaxis is continued until the OB is declared over.

In consultation with the Medical Director and MOH, presumptive treatment can be stopped if influenza is not identified as the cause of the ILI (e.g., laboratory test is negative for influenza).

Which residents do you put on antiviral prophylaxis in an OB situation?

Residents who do not have ILI and have no contraindications to antiviral medication, e.g., history of anaphylaxis, should be put on antiviral prophylaxis regardless of influenza vaccination status.

If large numbers of residents continue to become ill despite antiviral prophylaxis, the OB may be caused by another virus, or antiviral resistance may have emerged. Consult with PH for further recommendations.

Can the same antiviral medication be used for both treatment and prophylaxis?

Yes, but the treatment dose is higher than the prophylaxis dose.

Who pays for antiviral medications?

If residents have private or Veterans' drug insurance plans, coverage should be preferentially billed to these plans. The Nova Scotia Pharmacare Program covers antiviral medications for influenza treatment or prophylaxis for LTCF residents who meet the clinical criteria (listed below) and are Pharmacare beneficiaries.

Note: Co-payments and/or deductibles may apply depending on what program the resident is enrolled in. For example, Seniors' Pharmacare has a 30% co-payment per prescription up to a co-payment maximum of \$424.00 annually.

Oseltamivir and zanamivir are Exception Status Benefits under the Nova Scotia Pharmacare Program. LTCF residents who are covered by one of the Pharmacare Programs and meet the exception status criteria will have access to oseltamivir and zanamivir. The Pharmacare Exception Status Benefit criteria are:

- For treatment of LTC residents with lab-confirmed influenza.
- For clinically suspected cases, it is covered for the treatment of residents with ILI where there is lab confirmed influenza circulating in the facility or community.
- For use as a prophylaxis of residents when the facility has an influenza OB.

Note: Oseltamivir and zanamivir are covered by the Pharmacare programs in LTCF based on the recommendation by an MOH. Veterans Affairs Canada will provide financial coverage for antiviral

This is an evergreen document. LTCFs should access [Public Health](#) to obtain the most up-to-date version. Last updated 2026/10/01

medications for Veterans residing in a LTCF when prophylaxis or treatment are recommended by PH due to an outbreak of flu-like illness or confirmed influenza.

In the event of an influenza OB, the facility must work closely with the pharmacy to advise them of the MOH recommendation and initiate therapy/prophylaxis. Pharmacare no longer requires a letter from PH indicating which pharmacy will be providing antivirals in order for payment to be received. Pharmacies have the code for antiviral therapy, and all Pharmacare requires is an invoice from the pharmacy with the code on it to issue payment.

How does a LTCF go about getting a supply of antivirals?

A prescription for antiviral medication written by the resident's physician is filled in the same way as for any other prescription. Nevertheless, antiviral medication supply in pharmacies may be limited. To ensure there is a sufficient supply within the community for confirmed cases and outbreaks, physicians are encouraged NOT to prescribe antiviral medications unless it is consistent with recommended guidelines.

Recommended doses of antiviral drugs:

For current drug dosing and adverse effects information please see the following:

NSH Firstline dosing recommendations:

- Oseltamivir: [Oseltamivir | Nova Scotia Health | Firstline](#)
- Zanamivir: [Zanamivir | Nova Scotia Health | Firstline](#)

Adverse reactions to antiviral therapy should be reported to Health Canada:

- By calling toll-free at 1-866-234-2345
- Online at www.healthcanada.gc.ca/medeffect
- By completing a Canada Vigilance Reporting Form which you can send by fax toll-free to 1-866-678-6789.

Appendix C: Non-Severe COVID-19 Treatment Team LTC Referral Information: COVID-19 Therapeutics for LTCF Residents

Referral Process:

1. **Obtain consent**

Obtain consent from the resident and/or their substitute decision maker (SDM) before the assessment is completed. The [Non-Severe COVID Treatment Team](#) **will not** contact residents and/or SDMs individually for consent. Patient information sheets are available to guide these discussions:

- [Nirmatrelvir/ritonavir \(Paxlovid\)](#)
- [Remdesivir](#)

2. **Report and Support**

This is the **preferred referral mechanism** for LTCF residents to be assessed for COVID medication including inhaled budesonide (Pulmicort), oral nirmatrelvir/ ritonavir (Paxlovid), and IV remdesivir (Veklury). Online form is to be completed by a family member or LTCF staff member. Complete online at: <https://c19hc.nshealth.ca/self-report> or by phone: 1-833-797-7772. Please also complete the shaded sections on the [Long Term Care Non-Severe COVID-19 Therapeutics Referral Form](#) (page 2) and provide a list of the resident's active medications or a copy of the medication administration record (MAR) and email to: CovidTreatment@nshealth.ca (preferred) or fax to: 902- 492-5604.

OR

Complete the entire table on page 2 of the [Long Term Care Non-Severe COVID-19 Therapeutics Referral Form](#). Also, please provide a list of the resident's active medications or a copy of the medication administration record (MAR) and email to: CovidTreatment@nshealth.ca (preferred) or fax: 902- 492-5604

Note: When Report and Support cannot be completed automated assessment triage will not occur.

Referral Criteria:

To assess resident(s) in a timely and efficient manner, **only refer resident(s) who meet ALL the following referral criteria:**

- They are currently symptomatic
- Symptom onset was within the last 7 days
- COVID treatment options are within goals of care for the resident and/or SDM
- They have not received a COVID-19 vaccine booster at any time during the period **from 2 weeks to 168 days ago nor had a COVID-19 infection in the previous 168 days****. Residents who

have received a COVID-19 vaccine in the previous 2 weeks or greater than 168 days ago are eligible for therapeutics consideration (if they fulfill the other criteria).

*****Please refer profoundly immunocompromised patients regardless of vaccination history as they are not expected to mount an adequate immune response to COVID-19 immunization, regardless of vaccine status (e.g., post-HSCT, or primary immunodeficiency disorders with B-cell depletion, or anti-B cell therapy (monoclonal antibodies targeting B-cell antigens such as CD19, CD20, CD22, CD30, CD38 or BAFF [e.g., ocrelizumab, rituximab, ofatumumab, alemtuzumab, obinutuzumab, blinatumomab, daratumumab, basiliximab, brentuximab, belimumab])).***

IV Administration:

Please note: remdesivir infusions are administered at the closest infusion centre when residents are able to ambulate. Otherwise, they are coordinated through Continuing Care with the goal of IV administration onsite facilitated by VON. The resident does not need to be an existing client of VON.

Appendix D: Ordering Process for PCR/POCT Swabs

Process for ordering PCR Swabs
1. Go to the Health Association of Nova Scotia (HANS) GPO (Group Purchasing Organization) Viral Collection Kit page: • Direct link: https://hansgpo.ca/collections/swabs • Or via the website: Site Name > PPE > Viral Collection Kits
2. Sign in using your existing account • If you do not have an account, contact: group.purchasing@healthassociation.ns.ca
3. Add Viral Collection Kits to your cart
4. Click Checkout and enter: • Facility name • Billing & shipping address • Contact info • On-site delivery contact: specify who should receive the order to ensure it doesn't get misplaced
5. Submit your order. You'll receive an order confirmation email. • Distribution: orders are shipped directly from HANS • Turnaround time: orders are typically processed and shipped within 1–2 business days
For questions, support or to arrange priority delivery, please contact: group.purchasing@healthassociation.ns.ca
Process for ordering POCT swabs
NSH continues to offer COVID-19 rapid testing to LTCFs. Orders for these tests can be placed Continuing Care Rapid Testing Ordering Page .

Appendix E: Volume Considerations for Ordering PCR Swabs

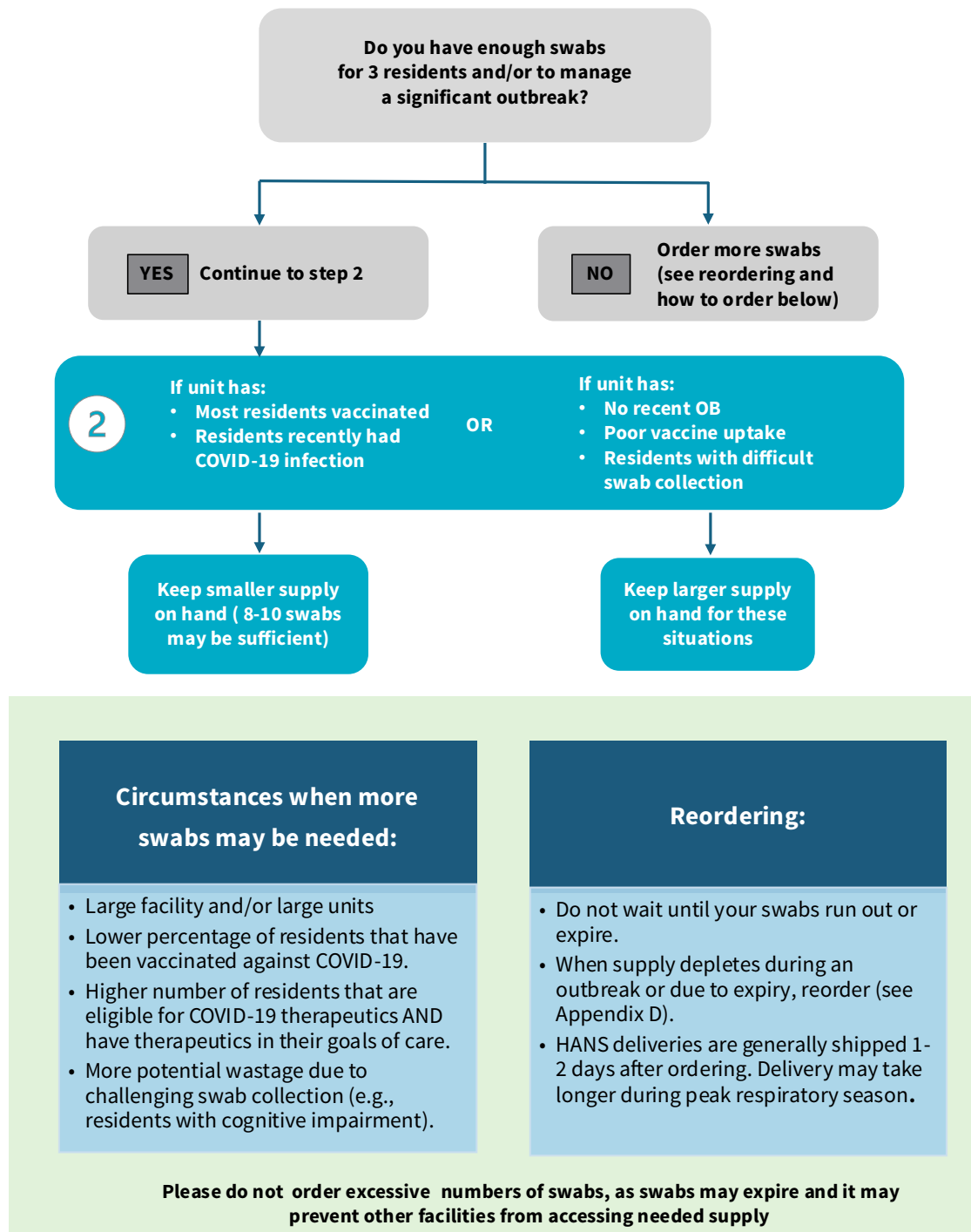


Figure 4: Volume Considerations for Ordering PCR Swabs

Appendix F: Public Health Office Contact Information

If calling outside Monday – Friday, 8:30am-4:30pm, or on holidays, please call the QEII switchboard at 902-473-2222 and ask to speak to the PHN for the appropriate zone.			
Central Zone	Eastern Zone	Northern Zone	Western Zone
Dartmouth Phone: 902-481-5800 1-800-430-9557 Fax: 902-481-5803	Antigonish Phone: 902-867-4500 x 4800 Fax: 902-863-7476	Amherst Phone: 902-667-3319 1-800-767-3319 Fax: 902-667-2273	Bridgewater Phone: 902-543-0850 Fax: 902-543-8024
	Neil's Harbour Phone: 902-336-2295 Fax: 902-336-2202	Truro Phone: 902-893-5820 Fax: 902-893-5839	Chester Phone: 902-543-0850 Fax: 902-543-8024
	Glace Bay Phone: 902-842-4050 Fax: 902-842-4004	Elmsdale Phone: 902-883-3500 Fax: 902-883-3400	Clare Phone: 902-742-7141 Fax: 902-742-6062
	Inverness Phone: 902-258-1920 Fax: 902-258-2721	Guysborough Phone: 902-533-3502 Fax: 902-533-2167	Digby Phone: 902-742-7141 Fax: 902-742-6062
	New Waterford Phone: 902-862-2204 Fax: 862-3155	New Glasgow Phone: 902-752-5151 Fax: 902-755-7175	Wolfville Phone: 902-542-6310 Fax: 902-542-6333
	North Sydney Phone: 902-794-2009 Fax: 902-794-8029		Lunenburg Phone: 902-543-0850 Fax: 902-543-8024
	Port Hawkesbury Phone: 902-625-1693 Fax: 902-625-4091		Liverpool Phone: 902-543-0850 Fax: 902-543-8024
	Cheticamp Phone: 902-224-2410 Fax: 902-224-2903		Shelburne Phone: 902-742-7141 Fax: 902-742-6062
	Sydney Phone: 902-563-2400 Fax: 902-563-0508		Middleton Phone: 902-542-6310 Fax: 902-542-6333
	Baddeck Phone: 902-295-2178 Fax: 902-295-3432		Berwick Phone: 902-542-6310 Fax: 902-542-6333
			Yarmouth Phone: 902-742-7141 Fax: 902-742-3083

Appendix G: Staff Testing and Return to Work

Staff working in an LTCF, not under the DSLTC, should follow the LTCF's internal policies and procedures to mitigate RVIs.

Symptomatic Staff

Staff should **not** report to work if feeling unwell. The option of coming to work and wearing a mask when sick is **not** acceptable. If staff become symptomatic while in the LTCF, they should immediately perform hand hygiene, ensure they are wearing a well-fitting medical mask, inform their supervisor or manager, avoid further resident and staff contact, and leave the workplace. Staff should notify all LTCF and other congregate settings where they have worked during their infectious period of their RVI.

Staff Testing for COVID-19

Staff with symptoms of RVI will be directed to choose a COVID-19 testing stream, either PCR (preferred) or POCT. The first test must be conducted **at least 48 hours following initial symptom onset to be considered valid**. If using a POCT, ensure it has not expired before carrying out the test. If a PCR test is chosen/required, staff can follow the [Nova Scotia Health link COVID-19 Appointment Testing](#). Switching from PCR to POCT or vice versa is not recommended and does not change guidance based on initial test results.

Staff who are **symptomatic and test positive for COVID-19 using a POCT test do not require further testing** and are considered a positive case of COVID-19 for case counting and OB management purposes. Please contact OHSW if you have any questions about the testing process.

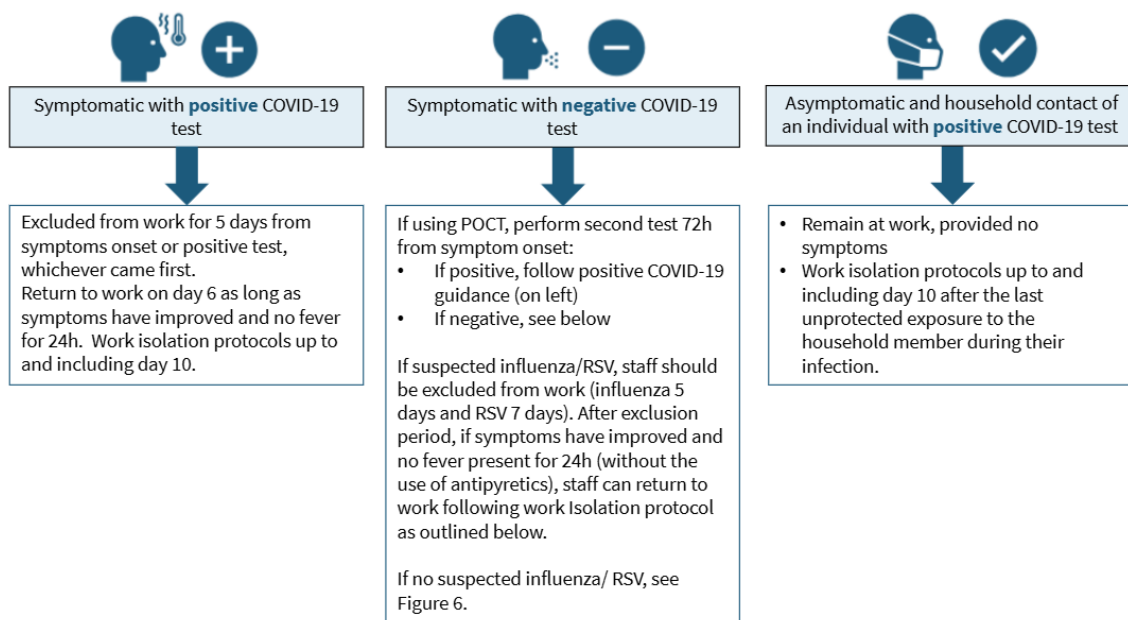


Figure 5: Work Isolation Protocols

Appendix H: Work Isolation Protocol

Work isolation protocol includes:

- Zero unprotected interactions with others (no eating or drinking in shared spaces)
- Masks **MUST** be worn at all times unless alone in a room
- Self-monitor for symptoms of RVI
- Additional PPE while in the workplace, such as gloves and eye protection based on the resident PCRA
- Frequent hand hygiene

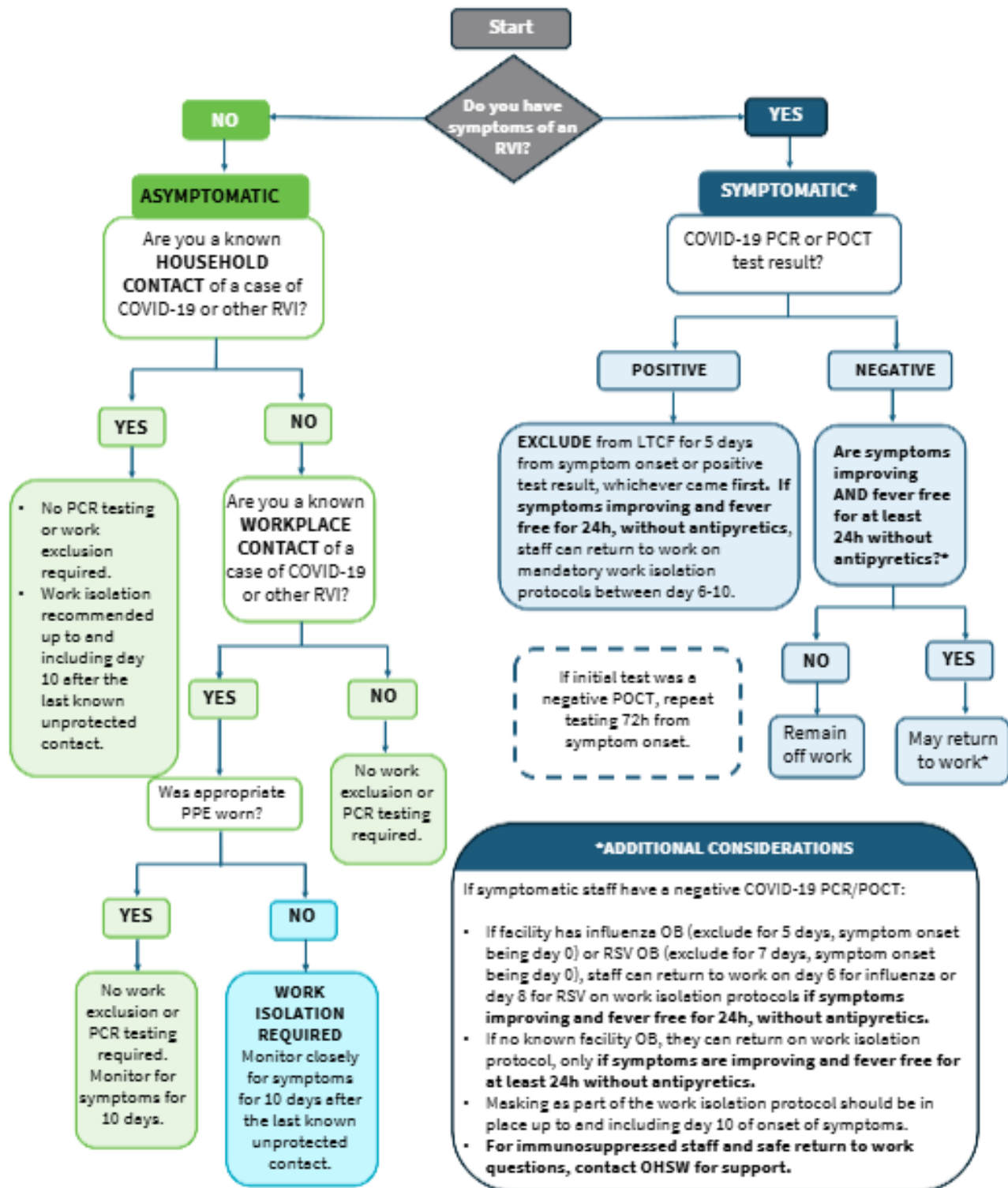
Refer to **Figure 5** for further staff guidance on when above work isolation protocols would be required.

Influenza/RSV

Symptomatic staff will not be routinely tested for Influenza/RSV except if they are tested by primary care or an ED. It can be assumed that any staff member has contracted influenza or RSV (unless testing confirms a different virus) if they have similar symptoms to residents in an LTCF with an influenza or RSV OB and should follow staff guidance below.

STAFF GUIDANCE

Work Exclusion/Isolation protocols



OHSW email: OHSW.ContCareID@nshealth.ca

Figure 6: Staff Guidance Work Exclusion and Isolation Protocols

Appendix I: Collection of Nasopharyngeal (NP) Swabs



COLLECTION INSTRUCTIONS OF NASOPHARYNGEAL SWABS
FOR RESPIRATORY VIRUSES Date: 2025-09-24

INSTRUCTIONS FOR THE COLLECTION OF NASOPHARYNGEAL SWABS FOR RESPIRATORY VIRUSES			
Container		Store Before Collection	Store After Collection
Nasopharyngeal Swab Collection kit		Room Temperature	*Refrigerate

HOW TO COLLECT THE SAMPLE

Follow the 4Ds to obtain a quality swab [The 4Ds of NPS collection](#) or view online [Nasopharyngeal swabbing for respiratory viruses – the 4 D's \(vimeo.com\)](#)

1. Use the flexible swab supplied with the viral transport media.
2. Explain the procedure to the patient.
3. When collecting the specimens, wear eye protection, gloves, gown and a mask. Change gloves and wash your hands between each patient.
4. If the patient has a lot of mucus in the nose, this can interfere with the collection of cells. Either ask the patient to use a tissue to gently clean out visible nasal mucus or clean the nostril yourself with a cotton swab (e.g. Q-Tip).
5. How to estimate the distance to the nasopharynx: prior to insertion, measure the distance from the corner of the nose to the front of the ear and insert the shaft approximately 2/3 of this length (*Depth*).
6. Seat the patient comfortably. Tilt the patient's head back slightly to straighten the passage from the front of the nose to the nasopharynx to make insertion of the swab easier.
7. Insert the swab provided along the medial part of the septum, along the floor of the nose, until it reaches the posterior nares; gentle rotation of the swab may be helpful. (If resistance is encountered, try the other nostril; the patient may have a deviated septum.) The Swab is directed toward the ear never upwards (*Direction*)
8. Allow the swab to sit in place for 5-10 seconds. (*Duration*)
9. Rotate the swab several times to dislodge the columnar epithelial cells. *Note: Insertion of the swab usually induces a cough. (Dialing)*
10. Withdraw the swab and place it in the collection tube.
11. Place specimen in the refrigerator (4°C).
12. Remove gloves.
13. Wash hands.
14. Attach completed requisition.
15. Transport to the laboratory.



The 4 Ds:
Depth
Direction
Duration
Dialing

A sterile swab is passed gently through the nostril and into the nasopharynx

Image obtained from <http://www.nlm.nih.gov/medlineplus/ency/imagepages/9687.htm>

MAKE SURE TO LABEL THE SPECIMEN

Use the barcoded label if using the web registration form OR If using a standard requisition make sure the label includes:

- Patient's legal name and date of birth
- Patient's Health Card Number or another unique identifier (as determined by healthcare provider)

USING STANDARD REQUISITION, MAKE SURE THE REQUISITION FORM INCLUDES

- Patient's legal name
- Patient's Health Card Number or another unique identifier (as determined by healthcare provider)
- Date and time of collection
- Patient's date of birth
- Physicians full name, address and physician registration number

Note: If the specimen and requisition are not labelled correctly, the specimen will not be processed.

DELIVER THE SPECIMEN

Delivery of sample(s) to the regional laboratory should occur within 4 hours from time of collection. *If transportation is delayed beyond 4 hours, the specimens should be refrigerated and transported to the laboratory using a cooler with ice packs. Transport logistics needs to be maximized to ensure that specimens are received by the QEII laboratory within 24 hours if so referred.

Appendix J: Collection of Throat and Nares Swabs

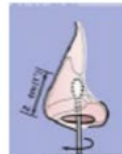


COLLECTION INSTRUCTIONS FOR THE ALTERNATE COLLECTION OF THROAT AND NARES SWABS FOR COVID-19
V7; Date: 2024-10-02

INSTRUCTIONS FOR THE ALTERNATE COLLECTION OF THROAT AND NARES SWABS FOR COVID-19				
Container			Store Before Collection	Store After Collection
Viral Swab Collection kit		Use the larger caliber swab with the rigid shaft in the kit for throat and nares collection. The smaller more flexible swab is used for Nasopharyngeal collection.	Room Temperature	*Refrigerate

HOW TO COLLECT THE SAMPLE (see [video link](#))

1. Explain the procedure to the patient.
2. When collecting the specimen, wear eye protection, gown, gloves, and a mask. Change gloves and wash your hands between each patient. Partially open the swab package and remove the swab. Do not touch the soft tip or lay the swab down. Have the patient tilt their head backwards, open their mouth, and stick out their tongue. Use a tongue depressor to hold the tongue in place.
3. Hold the swab, placing the thumb and forefinger in the middle of the shaft covering the black score line. Do not hold the shaft below the score line.
4. Without touching the sides of the mouth or tongue, use the swab to swab the posterior oropharynx. Using the same swab ask the patient to tilt his/her head back. Insert the swab approximately 1-2 cm into each nostril. Rotate the swab inside of the nostril for 3 seconds, covering all surfaces.
5. Withdraw the swab and place in the collection tube.
6. Refrigerate immediately.
7. Remove gloves and wash hands.
8. Attach completed requisition and transport to the laboratory.



MAKE SURE TO LABEL THE SPECIMEN

Use the barcoded label if using the web registration form OR If using a standard requisition make sure the label includes:

- Patient's legal name and date of birth
- Patient's Health Card Number or another unique identifier (as determined by healthcare provider)



USING STANDARD REQUISITION, MAKE SURE THE REQUISITION FORM INCLUDES

- Patient's legal name
- Patient's Health Card Number or another unique identifier (as determined by healthcare provider)
- Date and time of collection
- Patient's date of birth
- Physicians full name, address and physician registration number

Note: If the specimen and requisition are not labelled correctly, the specimen will not be processed.

DELIVER THE SPECIMEN

Delivery of sample(s) to the regional laboratory should occur within 4 hours from time of collection. *If transportation is delayed beyond 4 hours, the specimens should be refrigerated and transported to the laboratory using a cooler with ice packs. Transport logistics needs to be maximized to ensure that specimens are received by the QEII laboratory within 24 hours.

Appendix K: Lab Testing

1. Completing the Requisition

Complete ALL required sections on paper requisitions or webform submissions:

- Ensure each specimen and requisition label indicates **the name of the facility involved and the OB number from PH**. If an OB number is not available, clearly indicate **‘Suspect OB’** on the requisition.
- Ensure that each specimen label and requisition contain the same **exactly matching** two unique identifiers for the individual being tested.
- One identifier **MUST** be the individual’s legal name AND date of birth.
- The other identifier can be the individual’s provincial health card number/registered health care equivalent, hospital medical record number (MRN), passport number, or private insurance policy number.
- **Specimens lacking a second unique identifier or with identifiers not exactly matching the requisition will NOT be processed.**
- Ensure the specimen label includes the collection date and time.
- The ordering provider for the RVI swab is the facility Medical Director or the primary care provider (PCP) responsible for the resident’s care at the LTCF.
- Results should be copied to the facility Medical Director and the individual’s PCP.

2. Shipping RVI PCR Specimens

- Specimens must be collected and transported to the QEII laboratory or to the local/regional hospital laboratory as soon as possible and within 24 hours.
- Specimens must always remain at 4°C.
- To facilitate priority testing at the laboratory, rack/batch samples as described in the [Off-Site COVID-19 Specimen Transport Policy](#). The LTCF name must be indicated on the outer bag surrounded by the rack/batch.
- The samples in the batch should be clearly labelled with the LTCF’s name, the OB number, and resident identifiers.
- **Regularly check the expiry dates on viral collection kits and set up a replacement plan well before they expire. Specimens using expired swabs will not be processed. Please note that the swab and transport media might have a different expiry (even if they come from the same kit). Please check both.**

Appendix L: Outbreak Quick Reference Guide

RESPIRATORY VIRAL OUTBREAK MANAGEMENT IN LONG TERM CARE

QUICK REFERENCE GUIDE for 2026-2027 Respiratory Season

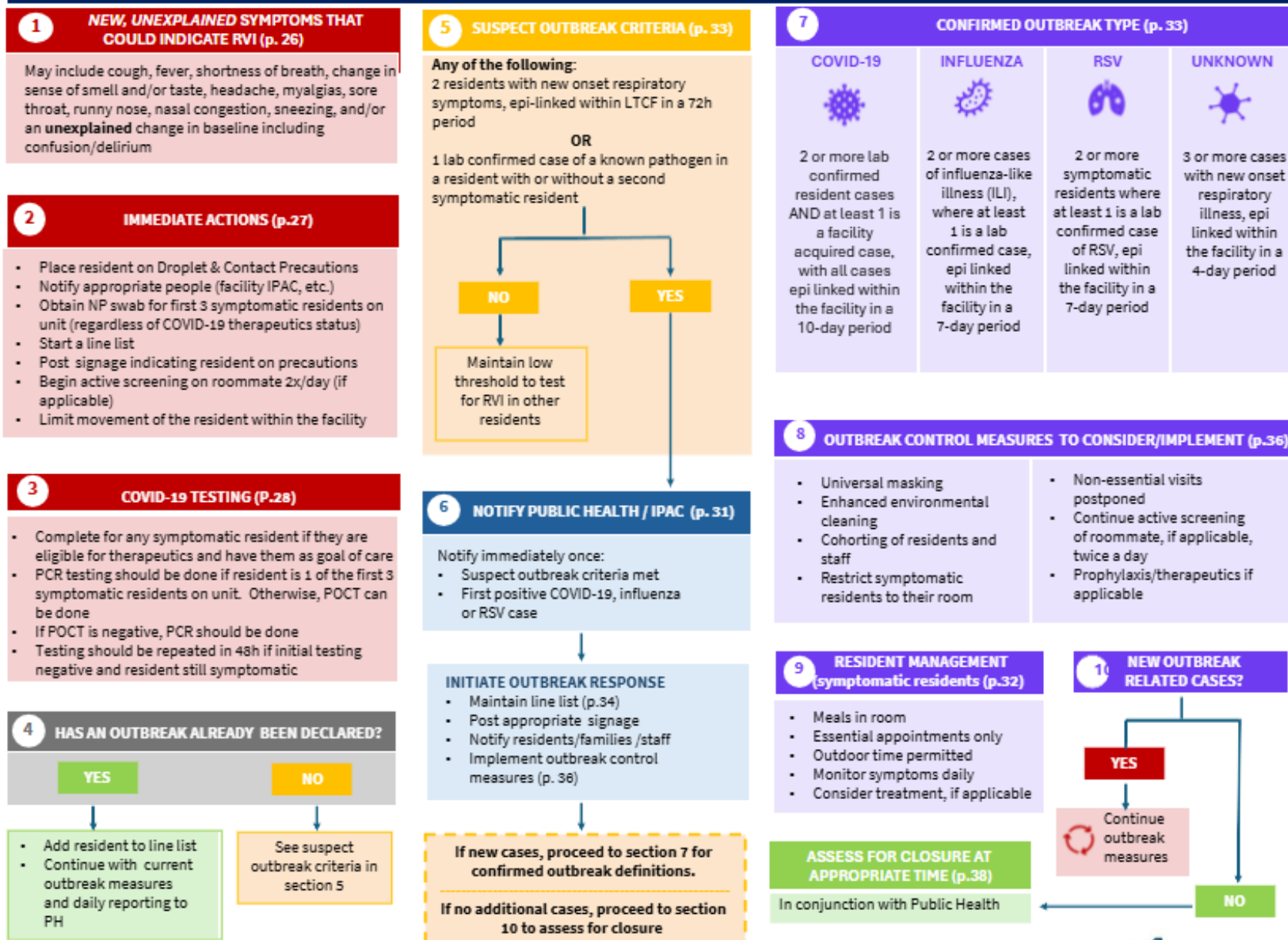


Figure 7:
Outbreak
Quick
Reference
Guide

Appendix M: Ordering Supplies

Ordering Supplies from Nova Scotia COVID-19 PPE Portal (Shopify)

From time to time, limited quantities of PPE and vaccine administration supplies may be made available through the Shopify portal to help minimize wastage from Nova Scotia's Provincial Stockpile. These offers apply only to the items listed in Shopify and will be available while quantities last. Providers are encouraged to plan accordingly for both anticipated use and storage space within their practice settings. The Stockpile Warehouse will not accept returns. Please allow up to seven business days for delivery.

Orders of the available items can be placed without limit via the online shopping site: <https://www.novascotiappe.ca/> (password is **eafoo**). Please ensure you are logged in with your vaccine account to gain access to the supplies. To ensure visibility for available supplies, please ensure you 'Shop For' within the 'Community Vaccine Clinics' category.

For reference, a document on how to access the portal can be found [here](#). Should you require support, please contact:

- NSPPECustSupport@nshealth.ca
- Tim.Matthews@nshealth.ca
- Gustavo.ferrer@nshealth.ca

Appendix N: Additional Resources

Canadian Immunization Guide:

- <https://www.canada.ca/en/public-health/services/canadian-immunization-guide.html>

COVID-19 and Influenza Report and Support:

- <https://www.nshealth.ca/reportandsupport>

Healthcare providers supporting immunization in Nova Scotia:

- [Immunization in Nova Scotia - Immunizer Education - LibGuides at Nova Scotia Health](#)

Immunization Resource page:

- [CDPC- Information for Professionals | novascotia.ca](#) – click on Immunization tab.

Infection Prevention and Control:

- Nova Scotia Health Long-Term Care IPAC Resource Website: <https://library.nshealth.ca/IPAC-LTC>

Non-Severe COVID-19 Treatment Team Long-Term Care Referral Information

- [COVID-19 Non-Severe Therapy Pharmacist Consult Service](#)
- [Long Term Care Non-Severe COVID-19 Therapeutics Referral Package](#)

Nova Scotia Vaccine/Immunoglobulin Eligibility policy

- [Nova Scotia Vaccine Immunoglobulin eligibility.pdf](#)

Occupational Health Safety & Wellness: Continuing Care:

- [Occupational Health Safety & Wellness](#)

Order Set:

- https://policy.nshealth.ca/Site_Published/covid19/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=90889%20

Publicly Funded Respiratory Virus Immunizations:

- https://policy.nshealth.ca/Site_Published/covid19/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=110406

Appendix O: Important Contact Information

Contact	Information
COVID-19 Lab Results	Available 7 days a week from 7:30 a.m. to 3:30 p.m. https://c19results.nshealth.ca/ Note: If unable to obtain results, LTCF can access results by contacting Public Health in their zone.
COVID-19 Report and Support	https://www.nshealth.ca/reportandsupport Available 7 days a week from 7:30 a.m. to 3:30 p.m. (if unable to complete online form, call 1-877-797-7772 for assistance)
COVID-19 Testing for Staff	COVID-19 and Flu Testing Nova Scotia Health If unable to book using the link above, call 1-877-979-7772 for assistance. Answered 7 days a week from 7:30 a.m. to 3:30 p.m.
COVID-19 Therapeutics	Available 7 days a week from 8 a.m. to 4 p.m. The Non-Severe COVID-19 Treatment Team 1-833-714-2784 to assess residents for COVID-19 medication
DSLTC	LTC@novascotia.ca
Group Purchasing	group.purchasing@healthassociation.ns.ca .
Health Association of Nova Scotia (HANS) Group Purchasing Organization (GPO) <u>Viral</u> Collection Kit page	https://hansgpo.ca/collections/swabs
NSH-IPAC	Monday to Friday 8 a.m. to 4 p.m. 1-833-736-0880 or IPAC.longtermcare@nshealth.ca
NSH-PH	Monday to Friday: 8:30 a.m. to 4:30 p.m. Zonal Nova Scotia Public Health Offices After hours and holidays: Contact Public Health Nurse on-call through Central Zone Locating 1-902-473-2222. Please specify the appropriate zone nurse to be contacted.
OHSW	Monday to Friday 8 a.m. to 4 p.m. OHSW.ContCareID@nshealth.ca

References

Andrew, M. K., MacDonald, S., Godin, J., McElhaney, J. E., LeBlanc, J., Hatchette, T. F., Bowie, W., Katz, K., McGeer, A., Semret, M., & McNeil, S. A. (2021). Persistent functional decline following hospitalization with influenza or acute respiratory illness. *Journal of the American Geriatrics Society*, 69(3), 696–703. <https://doi.org/10.1111/jgs.16950>

Bosco, E., van Aalst, R., McConeghy, K. W., Silva, J., Moyo, P., Eliot, M. N., Chit, A., Gravenstein, S., & Zullo, A. R. (2021). Estimated cardiorespiratory hospitalizations attributable to influenza and respiratory syncytial virus among long-term care facility residents. *JAMA Network Open*, 4(6), e2111806. <https://doi.org/10.1001/jamanetworkopen.2021.1180>

Breznick, J.A., Miller, M.S. & Bowdish, D.M.E. (2025) Rationalizing recommendations for influenza and COVID-19 vaccines. *Vaccine*, 65. <https://www.sciencedirect.com/science/article/pii/S0264410X25010722#ec0005>

Department of Health and Wellness. (2025, August). *COVID-19*. In *Nova Scotia communicable disease manual*. <https://novascotia.ca/dhw/cdpc/cdc/document/s/covid-19.pdf>

Department of Health and Wellness. (2025, September). *Respiratory syncytial virus (RSV)*. In *Nova Scotia communicable disease manual*. <https://novascotia.ca/dhw/cdpc/cdc/documents/respiratory-syncytial-virus.pdf>

Falsey, A. R., & Walsh, E. E. (2006). Viral pneumonia in older adults. *Clinical Infectious Diseases*, 42(4), 518–524. <https://doi.org/10.1086/499955>

Government of Canada. (2026, April 15). *Respiratory syncytial virus (RSV): For health professionals*. <https://www.canada.ca/en/public-health/services/diseases/respiratory-syncytial-virus-rsv/health-professionals.html>

Government of Canada. (2016). *Routine practices and additional precautions for preventing the transmission of infection in healthcare settings*. <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/routine-practices-precautions-healthcare-associated-infections/part-a.html>

Harrison, R., Reid, E. K., Allen, U. D., Papenburg, J., Skowronski, D. M., Mubareka, S., Hatchette, T., & Evans, G. A. (2026). AMMI Canada seasonal influenza guideline update 2025–26: Some questions answered. *Journal of the Association of Medical Microbiology and Infectious Disease Canada*, 11(1), 1–8.

Ison, M. G., Nam, H., Ramirez, J., & Mitty, J. (2026, April 24). *Respiratory syncytial virus infection in adults*. In *UpToDate*. Retrieved June 17, 2026, from <https://www.uptodate.com>

Kilkelly, A, Siu, W, Abrams, E.M. & Salvadori, M. (2024). Respiratory syncytial virus vaccination in older adults, *Canadian Medical Association Journal*, 196, (29) E1011; DOI: <https://www.cmaj.ca/content/196/29/E1011>

Lansbury, L. E., Brown, C. S., & Nguyen-Van-Tam, J. S. (2017). Influenza in long-term care facilities. *Influenza and Other Respiratory Viruses*, 11(5), 356–366. <https://doi.org/10.1111/irv.12464>

National Advisory Committee on Immunization. (2026, May). *Statement on seasonal influenza vaccines for 2026–2027*. Public Health Agency of Canada. <https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-statement-seasonal-influenza-vaccines-2026-2027.html>

Public Health Agency of Canada. (2025, September). *Canadian immunization guide*. Government of Canada. <https://www.canada.ca/en/public-health/services/canadian-immunization-guide.html>

Public Health Agency of Canada. (2026, March 4). *COVID-19: For health professionals*. Government of Canada. <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals.html>

Public Health Agency of Canada. (2026, January 9). *Flu (seasonal influenza): For health professionals*. Government of Canada. <https://www.canada.ca/en/public-health/services/diseases/flu-influenza/health-professionals.html>

Public Health Agency of Canada. (2026, June). *Guidance on the use of COVID-19 vaccines starting fall 2026*. <https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-summary-guidance-covid-19-vaccines-starting-fall-2026.html>

Prendki, V., Tiseo, G., & Falcone, M. (2022). Caring for older adults during the COVID-19 pandemic. *Clinical Microbiology and Infection*, 28(6), 785–791. <https://doi.org/10.1016/j.cmi.2022.02.040>.

Schleihauf, E., Fathima, S., Pettipas, J., LeBlanc, J. J., Hatchette, T. F., Drews, S. J., et al. (2015). Respiratory outbreak investigations: How many specimens should be tested? *Infection Control & Hospital Epidemiology*, 36(11), 1344–1347. <https://doi.org/10.1017/ice.2015.171>

Su, K., & Jin, K. (2023). Aging during the pandemic: Untangling the complexities of COVID-19 and geriatric care. *Aging and Disease*, 14(3), 572–576. <https://doi.org/10.14336/AD.2023.0405>

Trombetta, C. M., Kistner, O., Montomoli, E., Viviani, S., & Marchi, S. (2022). Influenza viruses and vaccines: The role of vaccine effectiveness studies for evaluation of the benefits of influenza vaccines. *Vaccines*, 10(5), Article 714. <https://doi.org/10.3390/vaccines10050714>

Watson, A., & Wilkinson, T. M. A. (2021). Respiratory viral infections in the elderly. *Therapeutic Advances in Respiratory Disease*, 15, Article 1753466621995050. <https://doi.org/10.1177/1753466621995050>