INFECTION PREVENTION AND CONTROL RECOMMENDATIONS FOR
RESIDENT IMMUNIZATION AND SCREENING
IN LONG TERM CARE HOMES

Purpose
The Long Term Care Homes Act includes legislation requiring Long Term Care Homes to screen residents upon admission and provide specific immunizations. The purpose of this document is to provide infection prevention and control guidance regarding resident immunization and screening upon admission to long term care homes.

Admission Screening

1. Assess resident on admission assessment for evidence of
   • fever, cough, shortness of breath
   • nausea, vomiting, diarrhea
   • undiagnosed rash, open wounds

2. Obtain a history of communicable diseases including
   • Clostridium difficile in the last 60 days
   • Antibiotic Resistant organisms (ARO) i.e. Methicillin Resistant Staphylococcus Aureus (MRSA) and Vancomycin Resistant Enterococcus (VRE)
   • Measles, mumps, rubella, diphtheria, chickenpox, tetanus, pneumococcal infections, hepatitis, polio
   • Tuberculosis
   • Sexually transmitted diseases.

3. Obtain a history of immunizations (Refer to Table 1) including adverse vaccine effects and egg allergies.

4. Screen for communicable diseases as per Table 2

5. Screen for Tuberculosis as per “Recommendations for Tuberculosis (TB)Screening in Long Term Care and Retirement Homes” on page 4 of this document

6. Document findings in resident’s file
Table 1.
RESIDENT ADMISSION - IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Vaccine or toxoid</th>
<th>Indication for immunization</th>
<th>Further doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>Adults ≥ 65 years; adults &lt; 65 years at high risk of influenza-related complications</td>
<td>Annual immunization is recommended using current vaccine formulation¹</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>Adults ≥ 65 years; conditions with increased risk of pneumococcal diseases.</td>
<td>Routine re-immunization is not recommended.</td>
</tr>
<tr>
<td></td>
<td>“Individuals with unknown immunization histories should receive the vaccine”</td>
<td>Re-immunization is considered for residents with:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• functional/anatomic asplenia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• sickle cell disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• hepatic cirrhosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• chronic renal failure/nephrotic syndrome</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• HIV infection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• immunosuppression related to disease/therapy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For these people, a single re-immunization is recommended after 5 years ⁴</td>
</tr>
<tr>
<td>Diphtheria (adult preparation)</td>
<td>All adults</td>
<td>Every 10 years, preferably given with tetanus toxoid (Td)⁴</td>
</tr>
<tr>
<td>Tetanus</td>
<td>All adults</td>
<td>Every 10 years, preferably given with diphtheria toxoid (Td)⁵</td>
</tr>
<tr>
<td>Measles</td>
<td>All adults born in 1970 or later who are susceptible to measles</td>
<td>Preferably given as MMR⁴</td>
</tr>
<tr>
<td>Rubella</td>
<td>Susceptible women of childbearing age and health care workers</td>
<td>None</td>
</tr>
<tr>
<td>Mumps</td>
<td>Adults born in 1970 or later with no history of mumps</td>
<td>None</td>
</tr>
</tbody>
</table>

Documentation of resident’s immunization
The resident’s immunization health record should reflect:
- Name of vaccine
- dosage
- amount
- route
- site
- lot number
- expiry date of vaccine.
<table>
<thead>
<tr>
<th>PATHOGEN</th>
<th>Recommended test/action</th>
<th>Rationale for recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Respiratory Illness such as influenza, and others</td>
<td>Acute respiratory illness (ARI) Screening Recommended on admission and readmission</td>
<td>For preventing the transmission of communicable diseases, reduce the risk of serious illnesses, hospitalization and deaths To quickly identify symptoms of ARI</td>
</tr>
<tr>
<td>Tuberculosis (TB)</td>
<td>Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the home. Retesting on readmission from hospital is not necessary Following are sample tools to assist in documentation: &quot;Region of Peel Positive TB Skin test reporting form&quot;, &quot;Resident Immunization Record, Unit Tuberculosis Record - Residents&quot;.</td>
<td>For the purpose of obtaining an accurate baseline for those who may have future testing Regular, ongoing testing for TB is not necessary. Public Health will work with any home with specific needs. For more information contact the TB Program through Health Line Peel at 905-779-7700.</td>
</tr>
<tr>
<td>Vancomycin Resistant Enterococcus (VRE)</td>
<td>Rectal swab (beyond/at the anal orifice) Screening recommended on admission and readmission</td>
<td>VRE is prevalent and incidence is increasing in acute care facilities in the region – epidemiological locally and in the Greater Toronto Area</td>
</tr>
<tr>
<td>Bloodborne pathogens: Hepatitis B, Hepatitis C, HIV</td>
<td>No recommendations for screening for the elderly population</td>
<td>Including travel history and country of origin would assist in ascertaining risk related to endemic diseases.</td>
</tr>
<tr>
<td>Syphilis, Gonorrhea, Chlamydia</td>
<td>No recommendations for the elderly population in recent Health Canada guidelines related to sexually transmitted infections. No screening recommended on admission or readmission</td>
<td>Including questions in the resident admission history related to sexual activity, travel or being relatively new to country from endemic area will assist in ascertaining risk.</td>
</tr>
</tbody>
</table>
Recommendations for Tuberculosis (TB) Screening in Long Term Care and Retirement Homes

All new residents must undergo a history and physical examination by a physician/nurse practitioner within 90 days prior to admission or within 14 days after admission. It is recommended that this assessment include:

1. A symptom review for active pulmonary TB disease.
2. A chest x-ray (posterior-anterior and lateral) taken within 90 days prior to admission to the facility.
3. If signs and symptoms and/or chest x-ray indicate potential active pulmonary TB disease, the resident should not be admitted until three sputum samples taken at least eight hours apart are submitted to the Public Health Lab for testing (Acid Fast Bacilli and Culture) and the results are negative. **Note: It can take up to 8 weeks for a culture report.**
4. In addition to the above, for residents < 65 years of age who are previously skin test negative or unknown, a 2-step tuberculin skin test (TST) is recommended. If the TST is positive, treatment of latent TB infection (LTBI) should be considered. A TST is not recommended for residents with a previous positive TST.

Tuberculin skin tests are not recommended to be done upon admission for residents 65 years of age or older. If a TST was previously done, record the date and result of the most recent TST.

Recommendations for Residents admitted to Short Term Care of less than 3 months (e.g. Respite care)

Residents in facilities for short term care should receive an assessment and symptom review by a physician/nurse practitioner to rule out active pulmonary TB, within 90 days prior to admission or within 14 days after admission. If the symptom review indicates potential active pulmonary TB disease, a chest x-ray must be obtained and active TB disease ruled out (see #3 above). A TST for residents in short term care is not recommended.

Management of Residents with Suspected Active TB Disease

If at any time, active pulmonary TB disease is suspected in a resident, the individual should be isolated immediately. This involves placing the resident in a single room, keeping the door closed, limiting interactions with staff and visitors and ensuring appropriate personal respiratory protection (i.e. have resident wear a surgical mask, if tolerated while others are in the room; N95 masks are recommended for staff and visitors). Immediate steps should be taken to ensure appropriate medical care, investigation and follow-up according to facility policies and procedures. The local Public Health Unit should be notified and consulted regarding next steps.

Reporting Requirements for Tuberculosis

Under the Health Protection and Promotion Act, R.S.O. 1990, c. H.7, diagnoses of TB infection and cases of suspect and confirmed active TB disease are reportable to Public Health. For information on how to report or to ask for advice related to TB infection or TB disease, please contact your local Public Health Unit.
Legislation

The Ontario Regulation 79/10 made under the Long-Term Care Homes Act, 2007- Section 229 –Infection Prevention and Control Program states that:

a) Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
b) Residents must be offered immunization against influenza at the appropriate time each year and
c) Residents must be offered immunization against pneumococcus, tetanus, and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.


Additional Screening

Further to legislation, evidence-based literature (or consensus based expert opinion) supports additional screening for MRSA and VRE for the following reasons:

a) Development and transmission of AROs has the potential to negatively impact resident morbidity and mortality
b) Early identification of colonized residents through screening prevents transmission, reduces prevalence, improves resident outcomes and reduces health care costs
c) The long term care population is more susceptible to infection than the average, healthy population because:
   i. residents are elderly and their immune systems are less able to combat infection
   ii. residents have chronic underlying illnesses
   iii. many of our residents are cognitively impaired and have poor hygiene habits (similar to the paediatric population)
   iv. many residents live closely together in one home, thus exposing them to multiple flora that is foreign to their own
   v. Antibiotic resistant organisms and other organisms (e.g. C. difficile) are present in our LTCHs (but baseline rates are unknown)
   vi. Visitors and staff may bring communicable diseases into the residents’ home

For these reasons, it is essential to implement preventive measures and in particular, identify resident’s immunization status and susceptibility to communicable diseases.
**Additional Resources:**


Ontario Ministry of Health and Long-Term Care Long Term Care Homes Act. 2007 [http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_07l08_e.htm](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_07l08_e.htm)
