LIST OF DISEASES REQUIRING WORK RESTRICTIONS

Disease	Off Work – Resident Care	Off Work – Non-Resident Care	Duration / Restriction
Adenovirus Conjunctivitis	Yes	No	From time of onset of conjunctivitis in an eye for a period of 14 days after onset. If a second eye becomes infected – for a period of 14 days after onset of conjunctivitis in the second eye. Must be cleared for work by the IPCC before returning to resident care.
Cytomegalovirus	No	No	Careful hand hygiene and caution to prevent body fluids from contacting others.
Diarrhea or Vomiting	Yes	Yes	Until symptom free for at least 48 hours after symptoms have resolved. Once a specific causative agent is known, disease-specific exclusions apply.
Diarrhea or Vomiting as result of Salmonella Typhi and paratyphi	Yes	Yes – Food handler and resident care	Until Carrier State is eradicated and until 3 consecutive stool specimens collected at least 1 week apart and at least 24 hours after cessation of symptoms. If treated, specimens must be collected at least 2 weeks after completion of antibiotic treatment. Return to work is conditional on good personal hygiene.
Diarrhea Outbreaks	Yes	Yes	IPCC must notify the Medical Officer of Health. Food handlers & epidemiologically-linked resident care workers may be asked to submit stools for examination. Symptomatic persons must remain off work until at least 48 hours after symptoms have resolved. Once a specific causative agent is known, disease-specific exclusions apply. Prior to return to work, affected team members must be assessed and instructed in personal hygiene, high-risk food preparation, and proper hand hygiene, either by IPCC or PH staff. In outbreak situations, other measures may be dictated by Public Health.
Group A Streptococcal (GAS) Disease, including	Yes	Yes	Excluded from work until 24 hours after the start of effective antibiotic therapy.

Disease	Off Work – Resident Care	Off Work – Non-Resident Care	Duration / Restriction
streptococcal pharyngitis (strep throat)			
Hepatitis A	Yes	Yes	14 days after onset of symptoms, or 7 days after onset of jaundice.
Hepatitis B	No	No	Gloves will be worn by all personnel performing procedures that involve trauma to tissues, contact with mucous membranes, or non-intact skin. Note: Follow regulatory college requirements.
Hepatitis C	No	No	Same as Hepatitis B
Herpes Simplex (HSV) Acute primary oro-pharyngeal infection	Yes	No	Until symptoms resolved
Herpes Simplex (HSV) Oral and orofacial infection	Yes if working with immune-compromised residents	No	Hand hygiene, gloving when touching residents, covering lesions (e.g. wearing a surgical mask or dressing) as an additional barrier to discourage hand-to-mucous membrane contact until lesion healed.
Herpes Simplex Hands (herpetic whitlow)	Yes	No	Until lesions are healed.
Herpes Simplex – Genital infection and herpes corpis	No	No	
HIV Infection (Aids)	No*	No*	*See Hepatitis B
Measles – post exposure (susceptible personnel)	Yes	Yes	Must be excluded from any work in the care community from 5 days after first exposure until 21 days after last exposure.
Measles (rubeola) acute disease	Yes	Yes	Until 4 days after rash appeared.
Meningococcal Disease	Yes	Yes	Those who develop meningococcal disease must be excluded from work until 24 hours after the start of effective therapy.
Norovirus (Norwalk-like Disease)	Yes	Yes	Until symptom free for 48 hours. In outbreaks of Norovirus, resident-team members cohorting should be implemented; persons working in the affected unit should not work in other units or facilities until outbreak is over. Refer to Guide to the Control of Gastroenteric Outbreaks in Long-Term Care Homes, October 2013.

Disease	Off Work – Resident Care	Off Work – Non-Resident Care	Duration / Restriction
Mumps	Yes	Yes	If clinical mumps develops, the team member must remain off work until 5 days after the onset of parotid swelling.
Orofacial Herpes (cold sore)	No*	No	*Those caring for high-risk residents: Hand hygiene, gloving when touching residents, covering lesions (e.g. wearing a surgical mask or dressing as an additional barrier) to discourage hand to mucous membrane contact until lesions heal.
Pertussis (7) active	Yes	Yes	Team members with symptoms of pertussis must be excluded from work anywhere in the care community for at least the first 5 days of antimicrobial treatment. Team members with symptoms of pertussis who cannot or refuse to take antimicrobial therapy must be excluded from work for 21 days from onset of cough. The use of a surgical/procedure mask by a team member is not sufficient protection for residents and other team members during this time.
Post exposure to Shingles (personnel susceptible to varicella)	Yes	Yes	From the 10th day of first exposure to the 21st day of last exposure. If varicella occurs: until all lesions are dry and crusted.
Post exposure of Pertussis (susceptible personnel)	No*	Yes	*Erythromycin treatment may be indicated. Observe for symptoms for 14 days from exposure.
Post Exposure to Rubella (susceptible personnel)	Yes	Yes	From the 7th day after first exposure through the 21st day of the last exposure
Rubella (German Measles) Acute disease	Yes	Yes	Until 7 days after the rash appears.
Scabies	Yes	Yes	Those who have completed prophylactic treatment may continue to work.
Shigella	Yes	Yes	If Shigella is cultured, the team member must be excluded from food handling and resident care activities until two negative stools have been obtained, 24 hours apart, beginning at least 24 hours after diarrhea ends. If treated with antibiotics, the first stool must be

Disease	Off Work – Resident Care	Off Work – Non-Resident Care	Duration / Restriction
			submitted at least 48 hours after the last dose.
Shingles (herpes Zoster) active	Yes	No*	*Lesions should be covered. Team members with shingles should not care for high-risk residents until all lesions are dry and crusted. Thorough hand washing shall be enforced.
Tuberculosis Active	Yes	Yes	A team member with smear positive TB can discontinue isolation after: a) At least two weeks of effective multi-drug therapy based on individual's drug sensitivity pattern; AND Three spontaneous sputum samples over a 1hr-24 hour period are all negative AFB, with one sputum specimen being an early morning specimen; or bronchial washings or induced sputum. c) Evidence of clinical improvement.
Varicella/Zoster (Chickenpox/Shingles) post exposure susceptible personnel	Yes	Yes	From 10th day of the first exposure through 21st day (if pregnant, 28th day) of the last exposure.
Varicella/Zoster (Chickenpox/Shingles) Acute Disease	Yes	Yes	Team members with acute chickenpox or disseminated zoster must be excluded from work anywhere in the care community until lesions are dried and crusted. Team members with localized zoster may work in most cases if appropriate barriers are used (i.e. all lesions covered and good hand hygiene is used before resident contact). Team members with zoster may not work with high-risk residents until lesions are dried and crusted.
Viral Respiratory Infections (Acute)	Yes*	Yes*	*Should not have contact with high-risk residents until acute symptoms resolve (5 days or symptoms fully resolved, whichever is shorter). Thorough hand washing and masking must be enforced if contact is unavoidable.
Monkeypox Infection	Yes	Yes	Self-isolation is maintained until all scabs have fallen off and new skin is present **and** they have been cleared by

Disease	Off Work – Resident Care	Off Work – Non-Resident Care	Duration / Restriction
			their PHU (no longer considered infectious).
COVID-19	Yes	Yes	For general community isolation to follow ministry current guidance. For high risk areas, such as, LTC home, isolate away for 10 full days from symptom onset or from swab collection date (if asymptomatic). IPAC lead to guide return to work.

References

OHA Communicable Disease Surveillance Protocols for Ontario Hospitals revision dates: 2012 – 2014 [Online] Available at: https://www.oha.com/labour-relations-and-human-resources/health-and-safety/communicable-diseases-surveillance-protocols

Public Health Agency of Canada: Canadian Tuberculosis Standards 7th edition, February 2014. [Online} Available at: https://www.canada.ca/en/public-health/services/infectious-diseases/canadian-tuberculosis-standards-7th-edition.html

Provincial Infectious Diseases Advisory Committee (PIDAC): *Best Practices for Infection Prevention and Control Programs in All Health Care Settings*, (3rd Edn.) (May 2012). [Online] Available at: http://www.publichealthontario.ca/en/eRepository/BP_IPAC_Ontario_HCSettings_2012.pdf.

Infection Prevention and Control (IPAC) Recommendations for Monkeypox in Health Care Settings 2nd Revision: June 2022 [online] available at: https://www.publichealthontario.ca/-/media/Documents/M/2020/monkeypox-ipac-recommendations-healthcare-settings.pdf?sc_lang=en