COVID-19

Infection Prevention and Control Guidance for Personal Care Homes

This document is informed by currently available scientific evidence and expert opinion and is subject to change as new information becomes available.

Please refer regularly to Manitoba's Provincial COVID-19 Resources for Health-Care Providers and Staff at https://sharedhealthmb.ca/covid19/.

Note: As this outbreak evolves, there will be continual review of emerging evidence to understand the most appropriate measures to take.

This document provides guidance specific to the COVID-19 pandemic in PCHs. Individuals responsible for implementation and oversight of infection prevention and control (IP&C) measures at specific PCHs should be familiar with relevant IP&C background documents on Routine Practices and Additional Precautions.

Individuals responsible for implementation and oversight of occupational and environmental health and safety measures should be aware of occupational health and safety legislation. The term "staff" is intended to include anyone working in PCHs, including but not limited to health care workers.

Table of Contents

Highlights 3
Background 4
Introduction 4
Symptoms of COVID-19 4
Infection Prevention and Control 5
Screening 8
Staff 8
Residents 9
Managing Visitors 9
Resident Care and Infection Control Measures 9
Hand Hygiene 9
Masking for all staff providing or participating in resident care, and any visitors/Volunteers 10
Droplet and contact precautions 11
Aerosol-Generating Medical Procedures (AGMPS) 11
Admissions/Re-Admissions 12
Testing 13
Specimen Collection Process 14
Outbreak Management 15
Handling Resident Care Equipment 16
Environmental Cleaning and Disinfection 16
Linen, Dishes and Cutlery 17
Waste Management 17
Resident Transport Within Site 17
Discontinuing Additional Precautions 17
Handling of Deceased Bodies 17
Short-Stay Absences and Resident Activities 17
Transfer to and from Hospital 18
Limiting Work Locations 18
Questions 19
References/Adapted From 19
Change Log 19

Highlights

Important measures to prevent the introduction and spread of COVID-19 in Personal Care Homes (PCHs):

All staff must work proactively to identify suspect or confirmed cases of COVID-19 in staff, residents, and any visitors/volunteers. Staff and residents with symptoms should be tested, staff self-screening must be conducted prior to every shift and all permitted visitors must be screened for symptoms, exposure and travel history prior to entry.

- All staff will use Droplet/Contact precautions with Airborne precautions for Aerosol Generating Medical Procedures (AGMPs) in addition to Routine Practices, for all care of residents with suspected or confirmed COVID-19.

- Training and monitoring of all staff and permitted visitors/volunteers for compliance with the Personal Protective Equipment (PPE) requirements for long term care, as well as appropriate donning and doffing protocols to minimize the risk of contamination. Staff must support visitors/volunteers in appropriate use of PPE.

- Training of all staff and visitors/volunteers permitted on other IP&C measures such as proper hand hygiene and the importance of maintaining a 2-metre spatial distance between residents, and other staff during breaks, etc.

- Environmental cleaning and disinfection practices are monitored for compliance
    - Frequent cleaning and disinfection of regularly used surfaces, recreation equipment, electronics and other personal belongings with a facility-approved disinfectant.

- Adherence to the "Single Site Restriction" for staff who work at licensed PCHs.

- Management of Visitors as per Shared Health guidance. Guidelines for Exceptions to Visitor Restrictions to Health Facilities should be followed.

- All permitted visitors must be screened prior to entry as per Shared Health recommendations for signs/symptoms of COVID-19 prior to entry.

- Signage must be posted at all entry locations to indicate visitor restrictions and screening requirements:
    - Shared Health LTC-Poster-Letter-Size
    - Shared Health COVID-19-Screening-Questions-Poster

- Exploration of alternate mechanisms for interactions between residents and other individuals (e.g., video call on cell phones or tablets).

Background

In December 2019, a cluster of cases of pneumonia of unknown origin was reported from Wuhan, Hubei Province in China. On January 10, 2020, a novel coronavirus, causing a disease now referred to as COVID-19 was identified as the cause of this cluster of pneumonia cases. A pandemic was declared on March 11, 2020.

Over the last few months, our understanding of COVID-19 has rapidly expanded, for example:

- Person-to-person transmission is occurring in Canadian communities.
- COVID-19 is most commonly spread from an infected person through respiratory droplets generated through cough or sneezing, close personal contact such as touching or shaking hands, or touching something with the virus on it and then touching your mouth, nose or eyes before washing your hands.
- COVID-19 can also be spread through the air during Aerosol Generating Medical Procedures.

PCH residents are vulnerable to infection with COVID-19 due to behavioral factors, shared spaces, and transit between other healthcare facilities. Older adults and those with pre-existing medical conditions are also at risk for more severe disease and have higher mortality when infected with COVID-19.

Introduction

Coronaviruses can cause illness in humans and in animals. Sometimes an animal coronavirus can cause illness in a human. Common coronaviruses that infect humans usually cause mild symptoms similar to the common cold. COVID-19 is a new strain of the virus that has not been previously identified in humans.

On March 22, 2020, the Manitoba government declared a province-wide state of emergency to elevate Manitoba's response to this pandemic. The invocation of a state of emergency was made to equip the Manitoba government with the full range of resources needed to mitigate the impact of COVID-19.

Symptoms of COVID-19

Prompt identification of all persons with signs and symptoms of possible COVID-19 is required. Refer to the Screening Tool for Public Health and Health Links Staff or the COVID-19 Online Screening Tool.

Older people and those living with chronic health conditions appear to be more vulnerable to becoming severely ill.

At this time, there is no vaccine to prevent the spread of COVID-19. There are no specific treatments for coronavirus illnesses.

Most people with COVID-19 will have mild symptoms and get better on their own. Some individuals, however, may require medical treatment and supportive care (e.g. supplementary oxygen).

Infection Prevention and Control

PCH operators must ensure:

1. Up to date awareness of data on the local and provincial spread of COVID- 19. https://www.gov.mb.ca/covid19/updates/index.html.

2. Awareness of and adherence to Manitoba's Provincial Personal Protective Equipment Requirements.

3. Staff receive ongoing training and monitoring of compliance with Routine Practices, including hand hygiene, and implementation of additional precautions, including Droplet/Contact precautions with Airborne precautions for AGMPs. Refer to: https://www.gov.mb.ca/health/publichealth/cdc/docs/ipc/rpap.pdf.
    - Staff IP&C training, testing and monitoring for compliance and education must be in place, tracked, recorded, and kept up-to-date.

4. AGMPs are only performed if deemed medically necessary and according to Provincial guidance: https://sharedhealthmb.ca/files/agmps-and-long-term-care.pdf.

5. An updated list of AGMPs is available at https://sharedhealthmb.ca/files/aerosol-generating-medical-procedures-AGMPs.pdf. If AGMPs are performed, please note the following:
    - There is to be appropriate training and N95 respirator fit-testing for all staff who may be required to participate in or who may be exposed to these procedures.
    - The fewest staff necessary to perform the procedure should be present.
    - These procedures should be performed in an Airborne Infection Isolation Room where available, or a single room with the door closed.

6. Procedures are in place to prevent the introduction of COVID-19 into PCHs, and to prevent and control the spread of infection if identified and informed by regional and/or provincial recommendations. This includes procedures to:
    - Communicate with staff, residents and families on COVID-19 updates.
    - Limit access points and conducting entrance screening at all access points.
    - Restrict visitors.

7. A Point of Care Risk Assessment (PCRA) is conducted by all staff prior to any interaction with a resident:
    - Prior to any resident interaction, all staff have a responsibility to assess the infectious risks posed to themselves, other staff, other residents and essential visitors/volunteers from a resident, situation or procedure.

      The PCRA should be applied before every clinical encounter regardless of COVID-19 status and is based on staff's professional judgment (e.g. knowledge, skills, reasoning

and education) regarding the likelihood of exposing themselves and/or others to infectious agents (e.g. COVID-19), for a specific interaction, a specific task, with a specific resident, and in a specific environment, under available conditions.
    - The PCRA helps staff select the appropriate actions and/or PPE to minimize the risk of exposure to known and unknown infections (e.g. asking oneself, "Will I be in contact with body fluids?").

8. Routine scheduled and additional environmental cleaning occurs with attention paid to high touch, high risk surfaces (e.g. bed rails, bed headboard and footboard, chair arms, light switches, hand and support rails, toilets, sinks and grab rails, shower chairs, call bell cords and buttons, telephones, white boards).

9. Responsibility for cleaning and disinfection of resident care equipment is identified.

10. Proper cleaning, disinfection, and disposal of PPE occurs.

11. Review of scheduling and restriction of staff work assignments to specific units or areas occurs wherever feasible and safe. This is intended to limit potential spread within facilities, even before COVID-19 is detected in a PCH, with capacity to acquire necessary staffing.

12. Active screening of residents and visitors/volunteers for signs or symptoms of COVID-19 occurs.

13. A plan for how to manage resident or staff exposures, symptoms, or confirmed COVID-19 is in place as per Infection Prevention and Control (IP&C) and Occupational and Environmental Safety & Health (OESH) guidelines.

14. A plan for how to safely transport residents within and outside of PCH when necessary exists.

15. Residents, staff and visitors/volunteers should be provided with printed or posted information about COVID-19, how the virus causes infection, and how to protect themselves and others, including:
    - The importance of hand hygiene and how to wash hands and how to use alcohol-based hand rub (ABHR).
    - Instructions on appropriate respiratory hygiene (e.g. covering their cough with a tissue or coughing into their elbow followed by performing hand hygiene).
    - Posters illustrating the current methods for putting on and removing required PPE placed inside and outside of resident rooms for easy visual cues.
    - Instructions on how and where to dispose of used supplies.

16. There should be regular assessment to determine stock of necessary PPE (e.g. gloves, gowns, masks, face or eye protection) and clinical supplies including nasopharyngeal swab kits.

17. PPE must be securely stored while not hindering staff's access to PPE.

18. Coordinated procurement of supplies to maximize access occurs.

19. Appropriate number and placement of ABHR dispensers should be in place, in hallways, at the entry to each resident room, in communal areas and at point of care for each resident.

20. Respiratory hygiene products (e.g. masks, tissues, ABHR, no-touch waste receptacles) are to be available and easily accessible to staff and residents.

21. Environmental cleaning and disinfection practices are to be monitored for compliance.

22. Appropriately clean and disinfect essential items (e.g., dentures, hearing aids) upon arrival. Personal/Other Items (e.g. food, plants, flowers, newspapers, cards, and books) are permitted but must be dedicated to the intended resident only and not shared amongst residents. Staff must ensure hand hygiene before and after interaction with items and maintain physical distancing (maintaining 2 meters spatial separation) at the hand off.

23. Physical distancing measures are utilized for staff wherever feasible, and while providing safe care.

24. Physical distancing measures (e.g. use of single rooms when available, maintaining 2 meters spatial separation between residents in hallways, all recreation, activity, dining or other communal areas) are utilized for all residents.

25. All residents with suspect or confirmed COVID-19 are immediately placed into Droplet/Contact precautions with Airborne precautions for AGMPs for all staff or visitors/volunteers who enter the resident room or who are within 2 metres of resident until COVID-19 or other respiratory infection is ruled out.

26. All residents with suspect or confirmed COVID-19 infection, or high-risk contacts[1] of a confirmed COVID-19 positive person, are cared for in a single room with a dedicated toilet and sink dedicated to their use. Where this is not possible, a 2-metre separation **must** be maintained between the bed spaces of the affected residents and all roommates with privacy curtains drawn.

27. Signage indicating Droplet/Contact precautions with Airborne precautions for AGMPs is placed on the outside of rooms or areas where resident(s) with suspected or confirmed COVID-19 are located.

28. Where required, N95s for performing AGMPs (according to https://sharedhealthmb.ca/files/agmps-and-long-term-care.pdf), may be worn across zones (Green, Orange, Red). Extend use of N95s for repeat encounters with multiple residents (except intubation).

29. Strategies are developed to manage a high volume of residents with COVID- 19 (e.g. cohorting staff to work only with suspect or confirmed).

[1] Any person, such as a health-care provider, family member/caregiver, or anyone else who had prolonged contact with or provided care to a probable or confirmed COVID-19 person.

30. Waste, soiled linen and the care environment are managed and/or adequately cleaned and disinfected according to PCH policies and procedures.

PCH operators should ensure staff are:

31. Adhering to PCH IP&C policies and procedures and public health guidance.

32. Self-monitoring for new signs or symptoms and immediately report any new symptoms, including not reporting to work if symptoms exist.

33. Prior to working every shift, staff must report to PCH management if they have had potential exposure to a case of COVID-19 in order to determine whether restrictions are necessary. Staff should also consult with their own healthcare provider for any needed follow-up.

34. Staff must be knowledgeable about:

- How to conduct a PCRA prior to all interactions to determine what IP&C measures are needed to protect residents and themselves from infection.
- Where to get tested if they become symptomatic or if requested by local public health authorities or the PCH.
- Routine Practices followed for all resident interactions, e.g. hand hygiene.
- The use and limitations of the specific PPE available for their use.
- Programs to conserve PPE.

Screening

PCHs shall minimize access points and ensure:

- Screening of all residents, visitors/volunteers and contractors or outside care providers is conducted at all PCH access points, with signage, and assessment for symptoms or known exposure to COVID-19 prior to entry.

- Signage (multilingual as required) is available on Shared Health Website and is posted at access points instructing staff, essential visitors/volunteers regarding screening and visitor restriction: Shared Health COVID-19-Staff Screening-Questions-Poster.

- Masks, tissues, alcohol-based hand rub and a no-touch waste receptacle are available for staff, resident, and essential/compassionate visitors at screening at each entrance.

Staff

Refer to Shared Health guidelines for staff screening:

- https://sharedhealthmb.ca/covid19/providers/
- Guiding principles for sustainable staff screening
- Staff screening tool
- Staff screening FAQs
- Self-isolation letter

Residents

Resident screening must begin prior to admission. Following admission, it should include daily assessment for symptoms of COVID-19. Residents with signs or symptoms or potential exposures to COVID-19 should be immediately isolated, and if symptomatic tested for COVID-19. Symptoms in elderly residents may be subtle or atypical, and screening staff should be sensitive to detection of changes from resident baseline.

Managing Visitors

All entrants to health facilities in Manitoba, including visitors, must be screened for COVID-19 risk factors upon entry each time they attend a facility. They must also follow appropriate Public Health recommendations including hand washing, infection control practices and social distancing.

Refer to the **Screening Tool**, https://sharedhealthmb.ca/files/covid-19-visitor-triage-process-for-long-term.pdf.

Visitor restrictions are designed to reduce the number of individuals that enter facilities in order to limit the risk of exposure to COVID-19 to staff and to residents.

In collaboration with Public Health, Operators of Health Facilities throughout Manitoba will adhere to the **Long Term Care Resident Visitation Principles** https://sharedhealthmb.ca/files/covid-19-pch-visitation-principles.pdf and Current Screening Requirements that align with the presence and transmission of the COVID-19 virus.

Resident Care and Infection Control Measures

Routine Practices apply to all staff and residents, at all times, in all PCHs and include but are not limited to:

- Conducting a PCRA.
- Hand hygiene.
- Appropriate use of PPE.
- Adhering to respiratory hygiene (i.e., covering a cough with a tissue or coughing into elbow followed by performing hand hygiene).

Hand Hygiene

Staff are required to perform the following hand hygiene:

- On entry to and exit from the PCH.
- Before and after contact with a resident, regardless of whether gloves are worn.
- After removing gloves.

- Before and after contact with the resident's environment (e.g. medical equipment, bed, table, door handle) regardless of whether gloves are worn.
- Any other time hands are potentially contaminated (e.g. after handling blood, body fluids, bedpans, urinals, or wound dressings).
- Before preparing or administering all medications or food.
- Before performing aseptic procedures.
- Before donning on PPE and doffing of PPE according to the facility procedure for donning or doffing PPE.
- After other personal hygiene practices (e.g. blowing nose, using toilet facilities, etc.).

Train visitors/volunteers to perform hand hygiene; they are expected to perform hand hygiene under the same circumstances outlined above for staff.

Train residents to perform hand hygiene and assist with this if they are physically or cognitively unable. **Residents should perform the following hand hygiene**:

- Upon entering or leaving their room.
- Prior to eating, oral care, or handling of oral medications.
- After using toileting facilities.
- Any other time hands are potentially contaminated (e.g. after handling blood, body fluids, bedpans, urinals, wound dressings, or tissue, use of bathroom, etc.).

Hands may be cleaned using alcohol based hand rub (ABHR) containing 60-90% alcohol, or soap and water. Washing with soap and water is preferable immediately after using toilet facilities, if hands are visibly soiled, when caring for a resident with norovirus or *Clostridioides difficile* infection, or during an outbreak of norovirus or *Clostridioides difficile*.

Masking for all staff providing or participating in resident care, and any visitors/Volunteers

Given the rapid increase in community spread of COVID-19 within Canada and increasing evidence transmission may occur from those who have few or no symptoms, masking for the full duration of shifts or visits for all PCH staff and any /volunteers is required.

The rationale for full-shift masking of PCH staff and volunteers is to reduce the risk of transmitting COVID-19 infection from staff or /volunteers to residents or other PCH staff, at a time when no symptoms of illness are recognized, but the virus can be transmitted. Staff must support/volunteers to ensure appropriate use of masks. Refer to **Long Term Care Resident**

Visitation Principles for masking requirements for the visitors:
https://sharedhealthmb.ca/files/covid-19-pch-visitation-principles.pdf

Staff and volunteers will perform hand hygiene before they don a mask, after doffing, and prior to putting on a new mask. They shall not touch the front of mask while wearing it, nor allow it to dangle under the chin, off the ear, under the nose, or place on top of the head. Wear masks as outlined in the provincial guidelines for long term care.

Generally, it is a foundational concept in IP&C practice that masks should not be re-worn. However, in the context of the COVID-19 pandemic and PPE supply chain management conservation follow the provincial guidance with regard mask use, reuse, and reprocessing.

Mask reuse shall follow the provincial guidance for the removal, storage and extended wear of face masks.

Dispose of masks and replace when they become wet, damp, or soiled (from the wearer's breathing or external splash). Inform staff how to access additional masks if needed.

Droplet and contact precautions

Remove PPE (except mask and eye protection when extended use during all shifts is practiced) in the correct order and discard prior to exiting the resident's room or entering the anteroom in the nearest no-touch waste receptacle.

Implement Droplet/Contact precautions for all residents presenting with new signs or symptoms of possible COVID-19.

Hand hygiene should occur according to Routine Practices and as required for donning and doffing PPE.

Gloves, long-sleeved cuffed gown (covering front of body from neck to mid-thigh), mask and face or eye protection (which should already be worn due to PPE framework) should be worn upon entering the resident's room or when within 2 meters of the resident on Droplet/Contact precautions.

Examples of face or eye protection (in addition to mask) include:

- Full face shield.
- Mask with attached visor.
- Safety glasses or goggles (regular eyeglasses are not sufficient).

Ensure the area where PPE is put on is separated as much as possible from the area where it is removed and discarded.

Aerosol-Generating Medical Procedures (AGMPS)

An AGMP is any medical procedure that can induce production of aerosols of various sizes, including droplet nuclei. AGMPs are rarely performed in PCH, though a potential example in this setting may include use of non-invasive positive pressure ventilation (CPAP) machines.

Follow the provincial guidance on AGMPs in LTC or other procedures that require the use of Airborne in addition to Droplet/Contact precautions.

Only perform AGMPs on a resident suspected or confirmed to have COVID-19 if:

- It is medically necessary and performed by the most experienced person.
- The minimum number of persons required to safely perform the procedure are present.

- All persons in the room are wearing a fit-tested, seal-checked N95 respirator, gloves, gown and face or eye protection.
- The door of the room is closed.
- Entry into a room of a patient is minimized.

Admissions/Re-Admissions

Screen new admissions/re-admissions for signs or symptoms or potential exposure to COVID-19, even if asymptomatic. A re-admission is considered to be any stay in hospital longer than 24 hours. This includes any stay in an Emergency Department longer than 24 hours. Give all new residents a mask during transfer and preferentially admit to a single room if available or semi-private with curtains drawn between beds, maintaining at least 2 metres between residents.

To better understand how COVID-19 is spreading in Manitoba, Public Health officials are conducting surveillance testing of people without symptoms of COVID-19 (asymptomatic people). Expanding the testing criteria to monitor the spread in people without symptoms will help officials monitor transmission of COVID-19 in Manitoba, particularly as social (physical) distancing measures are lifted. New evidence on the spread of COVID-19 suggests that infected people may spread the virus without experiencing symptoms (*asymptomatic transmission)* or just before they develop symptoms *(presymptomatic* transmission). To further enhance early detection of cases in PCH's, testing is recommended for all new admissions and readmissions.

Asymptomatic new admissions/re-admissions from Green Zones of Health Care facilities do not require isolation after arrival in the facility. However, those admitted/readmitted from community should remain in their room for 14 days after arrival in the facility as much as possible, including eating their meals in their room. They should not participate in any group activities or meals during this period.

Green Zone PPE is indicated and testing an asymptomatic individual does not indicate additional PPE is required. Droplet/Contact and Airborne precautions are not required for asymptomatic new admissions/readmissions unless exposure criteria have been met. If a new admission/readmission becomes symptomatic they will need to be re-tested and at that time would be treated as a suspect case and would require Droplet/Contact precautions.

For all new admissions follow these guidelines:

- Continue admissions to PCH units/sites with no suspected/confirmed outbreak per the usual regional process considering screening/testing/isolation requirements, regardless of new resident COVID-19 status.
- Do not admit to PCH units/sites with suspected/confirmed outbreaks unless the new resident is already confirmed COVID-19 positive. If positive, isolate for 14 days from symptom onset and/or until 72 hours after symptoms resolved, whichever is longer.

Droplet/Contact precautions plus Airborne precautions for AGMPs must be implemented. Consult with IP&C/designate prior to discontinuation of the precautions.

- If a resident is transferred from a unit with a known outbreak of COVID-19 or is a known contact of a COVID-19 case, Droplet/Contact precautions plus Airborne precautions for

  AGMPs must be implemented for 14 days. If the resident becomes symptomatic, isolate for 14 days from symptom onset and/or until 72 hours after symptoms resolved, whichever is longer.

- These residents should be met by a health care worker wearing PPE and immediately escorted to a single room or a space where at least 2 metres between residents can be ensured.

- In PCHs where it is not possible to maintain physical distancing of staff or residents from each other, manage all residents or staff as if they are potentially infected, and use Droplet/Contact precautions with Airborne precautions for AGMPs when in an area affected by COVID-19.

- Support resident physical, social and emotional well-being when isolated. Consider use of one-on-one programs, as well as technology, to allow resident contact with family and friends.

Testing

Testing of Symptomatic Residents

Immediately collect a nasopharyngeal (NP) specimen from any symptomatic resident for COVID-19 testing. Decisions regarding how many residents would be tested in an outbreak should be made in consultation with the Medical Officer of Health (MOH) and IP&C. Consideration will be made if other respiratory viruses are prevalent in the community and require testing.

- In addition to routine investigations relevant to the resident's symptoms and care, testing for COVID-19 requires a nasopharyngeal (NP) swab placed in viral transport medium or NP aspirate. If such a specimen is being collected for ILI or presumed viral respiratory tract infection, a second swab is not required.

- Clearly identify on the Cadham Laboratory General Requisition: contact of a case or other relevant screening criteria (e.g. resident lives in a PCH), relevant symptoms, and request for COVID-19.

- Additional laboratory testing for other respiratory viruses may also be done. Positive results will be reported to Public Health and IP&C.

Testing of Asymptomatic Residents

Any person who is admitted or readmitted to a PCH who is asymptomatic will receive COVID-19 testing. A health care provider at the PCH will collect a nasopharyngeal swab (NP). Clearly

mark the lab requisition with “Asymptomatic Surveillance” and send it to the laboratory for testing. A resident may refuse this asymptomatic testing and still be admitted into the PCH.

If the new admission’s test comes back as COVID-19 positive, they should be isolated for 14 days from the specimen collection date. These individuals will be treated as a COVID-19 case, and Droplet/Contact precautions plus Airborne precautions for AGMPs must be implemented. Please see the Outbreak Management section for more information.

Please note, criteria for testing will continue to change as Manitoba’s response to COVID-19 evolves. Check Shared Health for updates.

For PCH residents, fever = temperature 37.8°C or greater; some resources suggest that repeated oral temperatures >37.2°C or rectal temperatures >37.5°C or an increase in temperature of >1.1°C over baseline represent fever in older adults.

Specimen Collection Process

Follow Routine Practices as well as Droplet/Contact precautions with Airborne Precautions for AGMPs at all times when handling specimens.

Process includes:

- Assemble all supplies outside of the isolation space:
  - Dedicate specimen collection equipment to the specific patient.
  - Do not take phlebotomy trays/carts into the room/space.
  - Plan and take all required equipment into the room at the start of the procedure after donning PPE.
- Perform hand hygiene.
- Don personal protective equipment.
- Collect one nasopharyngeal (NP) swab placed in viral transport medium in addition to routine investigations. Refer to Video.
- Doff gloves and gown.
- Perform Hand Hygiene.
- Exit room/space.
- Deposit specimen(s) into an impervious, sealable bag immediately following removal from the resident room. Each site might vary in the process of how to achieve this step, with the goal to ensure the outside of the bag does not become contaminated.
- Perform hand hygiene.

Outbreak Management

For COVID-19, a single case in resident or staff is considered an outbreak. A single suspected case of COVID-19 is justification to apply outbreak measures to a unit or facility. Please refer to Manitoba Coronavirus/Interim Guidance for specific definitions.

If a result comes back as COVID-19 positive, the resident should be isolated in their room for 14 days from symptom onset and/or until 72 hours after symptoms resolve, whichever is longer. Droplet/Contact precautions plus Airborne precautions for AGMPs must be implemented. Consult with IP&C/designate prior to discontinuation of the precautions.

Contact tracing of individuals (staff and residents) with potential exposure to the case will be immediately undertaken in consultation with regional IP&C staff and/or public health. For staff testing and return-to-work policies for staff with suspected or confirmed COVID-19 whose symptoms have resolved, refer to the Occupational and Environmental Safety and Health (OESH) guidance.

To identify additional cases of COVID-19, PCHs must test all individuals who have symptoms compatible with COVID-19. In some cases, testing of asymptomatic residents may be recommended. Regional IP&C staff in consultation with Medical Officer of Health can provide guidance on this, as well as on documentation and communication protocols related to the outbreak. Staff should initiate and maintain a line list listing of residents with suspected or confirmed COVID-19.

Outbreak management strategies include:

- Immediate isolation of residents with signs or symptoms or potential exposures to COVID-19 on Droplet/Contact precautions plus Airborne precautions for AGMPs.
- Notification of the transferring hospital and local public health authorities if a resident develops symptoms and/or is diagnosed with COVID-19 within 14 days of admission from the community or transfer from another facility.
- Determination of applying outbreak precautions to the affected unit or entire PCH based on knowledge of the PCH and staffing, and in accordance with provincial public health guidance and directives.
- Increased frequency of cleaning and disinfecting with a focus on high-touch surfaces.
- Further restriction of movement of residents within the PCH, with discontinuation of all non-essential activities, including communal activities.
- Arranging for the use of portable equipment to help avoid unnecessary resident transfers (e.g. portable x-rays), while ensuring it is cleaned and disinfected between residents.

- New resident admissions are generally not recommended in the context of an outbreak of COVID-19.
- Increased frequency of active screening for COVID-19 symptoms in residents.
- Reviewing and reinforcing visitor restrictions.
- Consultation with their regional IPC staff regarding resident and staff cohorting, including the following:
    - Resident cohorting of the well (together) and unwell (together):
        - Utilizing respite and palliative care beds and rooms, or utilizing other rooms as appropriate.

- Staff cohorting:
  - Designating staff to work with either ill residents or well residents.
  - Staff assignment between multiple units should be limited.
- When the number of confirmed or suspected COVID-19 cases in a PCH is high, consideration should be given to having dedicated teams of staff specific to residents with suspected or confirmed COVID-19, where feasible, to reduce the risk of further transmitting infection in the PCH.

Handling Resident Care Equipment

Dedicate all reusable equipment and supplies, electronics, personal belongings, etc., to the use of the resident with suspect or confirmed COVID-19 infection. If use with other residents is necessary, clean and disinfect equipment and supplies with a Facility-Approved-Disinfectant before reuse. Discard items that cannot be appropriately cleaned and disinfected upon resident transfer or discharge, into a no-touch waste receptacle after use.

Environmental Cleaning and Disinfection

Increased frequency of cleaning high-touch surfaces in resident rooms and any central areas is important for controlling the spread of microorganisms during a respiratory infection outbreak; only use a Facility-Approved-Disinfectant.

Clean and disinfect all resident room and central area surfaces, that are considered "high touch" (e.g. telephone, bedside table, over-bed table, chair arms, call bell cords or buttons, door handles, light switches, bedrails, handwashing sink, bathroom sink, toilet and toilet handles and shower handles, faucets or shower chairs, grab bars, outside of paper towel dispenser) **at a minimum of twice daily and when soiled**. Use facility approved disinfectant with the recommended wet contact time to disinfect resident care equipment (e.g. BP cuffs, electronic thermometers, oximeters, stethoscope) after each use.

In addition, perform room cleaning and disinfection at least once daily on all low touch surfaces (e.g. shelves, bedside chairs or benches, windowsills, headwall units, over-bed light fixtures, message or white boards, outside of sharps containers). Keep floors and walls visibly clean and free of spills, dust and debris. Environmental services/Housekeeping staff are to wear PPE as outlined in https://sharedhealthmb.ca/files/ppe-provincial-requirements-inpatient-and-outpatient-settings-cleaning.pdf when cleaning and disinfecting the resident room.

Follow the PCH protocol for cleaning and disinfection of the resident's room after discharge, transfer, or discontinuation of Droplet/Contact precautions. Discard toilet brushes, unused toilet paper and other disposable supplies. Remove and launder privacy curtains upon a resident's discharge or transfer.

At discharge, room transfer or death of a resident, remove any resident-owned items (e.g. clothing, photos, televisions, furniture, cards and ornaments). All items with hard surfaces are to be cleaned and disinfected and placed in a bag for family or representative. While the risk of transmission of COVID-19 via items is likely low, at this time best practice may be for families to store for 5 days prior to handling. If the family wishes to donate any of the resident's items to the

PCH or another resident they must first be thoroughly cleaned and disinfected and meet established regional processes.

Clean and disinfect all surfaces or items outside of the resident room that are touched by, or in contact with staff (e.g. computer carts and/or screens, medication carts, charting desks or tables, computer screens, telephones, touch screens, chair arms) at least daily and when soiled. Staff should ensure that hands are cleaned before touching the above-mentioned equipment.

Linen, Dishes and Cutlery

No special precautions are recommended; Routine Practices are used.

Waste Management

No special precautions are recommended; Routine Practices are used.

Resident Transport Within Site

Only transport residents out of isolation rooms for medically essential purposes.

Notify Transport Services and receiving department in advance of transport regarding Droplet/Contact Precautions with Airborne precautions for AGMPs.

Assist resident to apply a mask and to perform hand hygiene.

Discontinuing Additional Precautions

To discontinue precautions for a COVID-19 positive resident consult IP&C/designate. Fourteen (14) days from symptom onset and/or until 72 hours after symptoms resolved, whichever is longer.

Where there are negative COVID-19 test results in symptomatic residents, consult IP&C. Resident management maybe adjusted to follow seasonal viral respiratory management protocols (e.g. Droplet/Contact precautions and discontinuation of precautions when symptom resolve). Decisions are based on relevant epidemiological data (e.g known COVID19 case(s) in the facility, community or congregated/work setting, or outbreaks). Those with known exposure history (contact, travel, or lab exposure) would not change additional precautions, regardless of swab results.

Handling of Deceased Bodies

Routine Practices and additional precautions should be used properly and consistently when handling deceased bodies or preparing bodies for autopsy or transfer to mortuary services. Funeral Homes should be notified in advance of the demise of the resident due to COVID-19.

Short-Stay Absences and Resident Activities

Short-stay absences are those off-site visits or leaves of any duration that are not required for essential health care services Absences from the facility that are not required for essential

health services are discouraged. However, if the family caregiver/ resident requests social pass, that should only be considered for Green Zone residents.

If a resident/family elect to leave a facility on a pass, due to the inability to maintain consistent physical distancing during social passes/leave (i.e. personal vehicles), all Green Zone residents must wear a medical/procedure mask. Drivers/escort(s) must also be masked (non-medical is acceptable). If either the escort/driver and/or the resident are unable or unwilling to wear a mask, pass is not permitted. During transport, If possible, travel with car windows open. Hand hygiene should be practiced often.

Drivers/escorts must be designated, up to a maximum of 2. The number of people in the vehicle should be minimized to those considered necessary. Passes are to be kept to a minimum; recommended up to 2 times weekly for up to 2 hours each.

All drivers/escorts that will be in the vehicle must be screened before entry to facility.

There should be direct travel to the destination for the pass and back to facility, with no stops in between. Escort(s) should be informed on how to put on and remove a mask, and the importance of maintaining physical distancing from others.

The destination could be a personal home, an outdoor venue or an indoor public venue such as a hairdresser, a church, synagogue or mosque, a restaurant or a store/shop. Social distancing and masks are required other than for purposes of eating/drinking. Perform hand hygiene and replace masks after removal i.e. eating/drinking

If all elements are not adhered to, passes will revert to essential purposes only.

Reassess all group activities for their potential to unnecessarily bring residents in close proximity to each other. During group activities, space residents to maintain a minimum distance of 2 meters between them.

Recommended restrict group activities to a single unit and floor. Ensure materials used for any resident activities (e.g. electronic tablets or other devices, craft supplies, bingo cards, magazines, books, cooking utensils, linens, tools) are not shared among residents unless appropriately cleaned and disinfected between uses for each resident. If the items cannot be easily cleaned and disinfected, do not share.

Maintain residents with confirmed or suspected COVID-19 infection in their rooms unless there is essential need for movement and/or transport. Only transfer within and between facilities if medically indicated.

Transfer to and from Hospital

Care for residents in-place to preserve hospital capacity as much as possible. Only send residents to hospital if they cannot be managed in PCH.

Every resident requiring transfer to hospital must be triaged by a physician/nurse practitioner. Refer to: COVID-19 Guiding Document on Long-Term Care Communication & Symptom Guidelines.

Limiting Work Locations

PCHs should limit the number of physical visits from clinicians (physician or nurse practitioner). Refer to: COVID-19 Guiding Document on Communication & Symptom.

All staff at licensed PCHs are restricted to working at one specified licensed PCH (the "Single Site Restriction"). Refer to: COVID-19-Single-Site-Staffing-Model-For-Licensed-PCHs.

Questions

Personal Care Homes may contact their local Regional Health Authority Representative.

References/Adapted From

- Ontario, Province: *COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 (*March 30, 2020). http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/directives/LTCH_HPPA.pdf
- Public Health Agency of Canada: *Infection Prevention and Control for COVID-19. Interim Guidance for Long Term Care Homes (*April, 2020). https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevent-control-covid-19-long-term-care-homes.html

Change Log

July 9, 2020:

1. Changes to admission/readmission section (pg. 13). Asymptomatic admissions/readmissions from Green Zones do not require isolation after arrival in facility.
2. Changes to Managing Visitors (pg. 9). Changed visitor restrictions to match current Public Health orders.

July 14, 2020

1. Updated to link to PCH Visitation Principles document.

July 24, 2020

1. Updated short-stay absences and visitor guidelines

Sept. 11, 2020

1. Updated information on what constitutes a fever (pg. 14)

Sept. 16, 2020

1. Updated staff screening information