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

**Screening** .......................................................................................................................................................... 5
  - Staff ............................................................................................................................................................. 6
  - Residents .................................................................................................................................................... 6

**Managing Visitors and Designated Family Caregivers** .......................................................................................... 6

**Pet Visitation** .................................................................................................................................................... 6

**Resident Care and Infection Prevention and Control Measures** ......................................................................... 7
  - Hand Hygiene .............................................................................................................................................. 7
  - Masking for all staff providing or participating in resident care, and any visitors/volunteers .................. 7
  - Droplet and Contact Precautions ................................................................................................................ 8
  - Aerosol-Generating Medical Procedures (AGMPs) ..................................................................................... 8

**Admissions/Re-Admissions** .................................................................................................................................. 9

**Considerations for Admissions during COVID-19 Outbreaks** .......................................................................... 10

**Testing** ........................................................................................................................................................... 12
  - Specimen Collection Process ..................................................................................................................... 13

**COVID-19 Vaccination** ....................................................................................................................................... 13

**Outbreak Management** ..................................................................................................................................... 15

**Handling Resident Care Equipment** .............................................................................................................. 16

**Environmental Cleaning and Disinfection** ....................................................................................................... 17

**Linen, Dishes and Cutlery** .................................................................................................................................... 17

**Waste Management** ......................................................................................................................................... 17

**Resident Transport Within Site** ....................................................................................................................... 17

**Discontinuing Additional Precautions** ........................................................................................................... 18

**Recovered Laboratory-Confirmed COVID-19 Cases** ......................................................................................... 18

**Handling of Deceased Bodies** .......................................................................................................................... 19

**Short-Stay Absences and Resident Activities** .................................................................................................. 19

**Transfer to and from Hospital** .......................................................................................................................... 20

**Limiting Work Locations** ................................................................................................................................... 20

**References/Adapted From** ................................................................................................................................... 20

**Change Log** .................................................................................................................................................... 21
Highlights

PCH operators must ensure:

1. Up to date awareness of data on the local and provincial spread of COVID-19.

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

3. 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. This includes proper cleaning, disinfection and disposal of PPE. Staff must support visitors/volunteers in appropriate use of PPE.

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

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

6. 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)
   - 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.

7. Procedures based on Shared Health recommendations to mitigate the introduction of COVID-19 into PCHs, and to prevent and control spread are in place. This includes procedures to:
   - Maintain appropriate physical distancing of residents and staff in common areas and staff or break rooms
     - Physical distancing measures (e.g. use of single rooms when available, maintaining 2 metres spatial separation between residents in hallways, all recreation, activity, dining or other communal areas) are utilized for all residents.
   - Support adequate space for donning and doffing of PPE
   - Limit access points and conducting entrance screening at all access points.
   - Ensure there is a process in place for staff to self-screen for symptoms prior to reporting to work or there is active screening at staff entrance point(s)
   - Restrict visitation according to the **Personal Care Home Resident Visitation Principles**

8. 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.

9. Active screening of residents and visitors/volunteers for signs or symptoms of COVID-19 occurs.
10. A plan for how to manage resident or staff exposures, symptoms, or confirmed COVID-19 is in place as per Shared Health Infection Prevention and Control (IP&C) and Occupational and Environmental Safety & Health (OESH) guidelines.

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

12. Residents, families, staff and visitors/volunteers are provided with printed or posted information and updates 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, including appropriate hand hygiene, placed inside and outside of resident rooms for easy visual cues.
   - Instructions on how and where to dispose of used supplies.

13. PPE is securely stored while not hindering staff’s access to PPE. 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.

14. Coordinated procurement of supplies to maximize access occurs.

15. 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.

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

17. Essential items (e.g., dentures, hearing aids) are appropriately cleaned and disinfected 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.

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

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

20. Staff are:
   - Self-monitoring for new signs or symptoms and immediately report any new symptoms, including not reporting to work if symptoms exist.
   - Reporting to PCH management, PRIOR to working every shift, if they have had potential exposure to a case of COVID-19, in order to determine whether restrictions are necessary. Staff should also contact Occupational Health and consult with their own healthcare provider for any needed follow-up.
o Receiving 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://sharedhealthmb.ca/files/routine-practices-protocol.pdf
  - Staff IP&C training, testing and monitoring for compliance and education must be in place, tracked, recorded, and kept up-to-date

o Only performing AGMPs if deemed medically necessary and according to Provincial guidance. An updated list of AGMPs is available at https://sharedhealthmb.ca/files/aerosol-generating-medical-procedures-AGMPs.pdf. If AGMPs are performed, N95s should be worn. Extend use for repeat encounters with multiple residents (except intubation). Remove if damaged, wet or soiled and at break,
  - There must be appropriate training and fit-testing for all staff who maybe required to participate in or who may be exposed to AGMPs

o Performing a Point of Care Risk Assessment (PCRA) based on their professional judgment (e.g. knowledge, skills, reasoning and education) prior to any interaction with every resident, regardless of COVID-19 status to assess 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

o Knowledgeable about
  - 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.
  - Current recommendations about utilization of PPE.

### Screening

All staff must work proactively to identify suspect or confirmed cases of COVID-19 in staff, residents, and any visitors/volunteers. Older people and those living with chronic health conditions appear to be more vulnerable to becoming severely ill.

PCHs shall minimize access points and ensure:
- Screening of all residents, designated family caregivers, visitors/volunteers and contractors or outside care providers is conducted at all PCH access points, with signage, and assessment for symptoms and travel 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.

- PPE, 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:

- Guiding principles for sustainable staff screening
- Staff screening tool – this must be conducted prior to every shift. Staff with symptoms should be tested.
- 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 and Designated Family Caregivers

All entrants to health facilities in Manitoba, including visitors and designated family caregivers, must be screened for COVID-19 risk factors upon entry each time they attend a facility. They must also follow appropriate Public Health recommendations such as hand hygiene, infection control practices including wearing of appropriate PPE and physical distancing. Sites are to keep a log of all visitors for at least 30 days to assist with contact tracing.

Refer to the COVID-19 Process for Managing Visitors to Long Term Care ORANGE/RED.

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

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 and Current Screening Requirements that align with the presence and transmission of the COVID-19 virus.

Pet Visitation

Pet visitation is not allowed for Orange or Red Zone residents. Pet visitation is allowed for Green Zone residents if the following are met:

- Ensure no one in the household where the pet lives is isolating for COVID-19
- Adhere to physical distancing recommendations; maintaining 2 metres/6 feet distance from anyone who is not the pet escort (including residents) at all times. Consult IPC to consider compassionate/palliative based exceptions
- Refer to the Regional IP&C guidance on Pet Visitation
Resident Care and Infection Prevention and Control Measures

All staff will immediately implement and use Droplet/Contact precautions with Airborne precautions for Aerosol Generating Medical Procedures (AGMPs) in addition to Routine Practices, for care of all residents with suspected or confirmed COVID-19. These residents, and high-risk contacts of a confirmed COVID-19 positive person, are cared for in a single room with a dedicated toilet and sink. 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.

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

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 hand hygiene according to the four moments of hand hygiene. Additional resources which can be used include:

- Hand rub posters in English and French
- Hand wash posters in English and French
- Clean Hands Save Lives brochure in English and French
- [Additional resources](#)

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**

Masking for the full duration of shifts or visits for all PCH staff and any /volunteers is required.
Staff must support/volunteers to ensure appropriate use of masks. Refer to Long Term Care Resident Visitation Principles for masking requirements for designated family caregivers and visitors.

Staff, visitors 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.

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

Procedure masks should be worn by residents that are able to tolerate them and are able to don and doff them independently, when they are outside of their room or are within 2 feet/6 metres of other individuals.

Droplet and Contact Precautions

Remove PPE (except mask and eye protection) 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.
- Half face shield.
- 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 resident is minimized.

**Admissions/Re-Admissions**

Screen new admissions/re-admissions for **signs or symptoms or potential exposure** to COVID-19, even if asymptomatic. Any stay in hospital longer than 24 hours is considered a re-admission. This includes any stay in an Emergency Department longer than 24 hours.

Give all new residents a level 1 medical 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.

Admissions to PCH will not be dependent on if the new resident has received their immunization. Vaccination should be arranged as soon as possible after admission.

**Test all new admissions and readmissions for COVID-19, except those residents who have tested positive for COVID-19 within the last 90 days.** Refusal of testing upon admission does not impact the ability of the resident to be admitted to the site.

Screen and isolate (Droplet/Contact and Airborne Precautions for AGMPs) all new admissions/readmissions for COVID-19 for 14 days. Monitor for signs and symptoms of COVID-19. Isolation of new admissions is not required only if **all** of the following criteria are met:

- The resident is fully vaccinated (received both doses)
- At least 14 days have lapsed since the second dose was administered
- The resident is asymptomatic
- The resident is not immune compromised (as defined by Public Health), and
- The resident has not been identified as a close contact of a positive or suspect case

NOTE: There are no restrictions to admitting COVID-19 recovered residents to either green units or ones with orange/red residents. This decision can be based on bed availability. Additionally, residents recovered from COVID-19 infection within the last 90 days do not require the 14-day isolation period.

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.

**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. Where an admission must be considered during an outbreak, refer to the section on considerations for admissions during COVID-19 outbreaks.
There is no concern admitting to a PCH units/sites with a suspected/confirmed outbreaks if the new resident is already confirmed COVID-19 positive or recently (within previous 90 days) deemed recovered. If positive, isolate for 10 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\(^1\) 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 10 days from symptom onset and/or until 72 hours after symptoms resolved, whichever is longer.

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. 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.

**Considerations for Admissions during COVID-19 Outbreaks**

**Principles/Approach to Admissions to a PCH in Outbreak Status:**
Creating capacity in the health care system during the COVID-19 pandemic requires, among other measures, that medically stable hospitalized patients positive for COVID-19 and still infectious, and asymptomatic patients not known to be positive, be transitioned safely to the environment that best matches their care needs.

Consistent decision-making methods should be used in determining whether to permit an admission and/or transfer to a facility experiencing an outbreak.

**Considerations:**
Responses to the following questions will assist in determining the appropriateness of a new admission/transfer to the outbreak site:

Review receiving site factors. Consider:

- **Size and physical layout/footprint including:**
  - Is there ability to isolate appropriately?
  - Are there shared spaces/hubs that are difficult to appropriately clean/disinfect, don’t have the ability to appropriately physically distance, etc. (e.g., nursing desk)?
  - Is the outbreak limited to one unit or multiple units? Is the outbreak proceeding in a consistent pattern or in an unexpected pattern with other units involved?
  - What is the proposed proximity\(^*\) of admission unit to outbreak unit/area (i.e., neighbouring unit/area) and the ability to maintain complete separation?
  - To access the outbreak area, is it necessary to go thru shared spaces that cannot be appropriately cleaned/disinfected?

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\(^1\)IP&C/designate: Person(s) with responsibility for providing IP&C guidance at the site. This may include, but is not limited to, IPC, unit manager, educator, director of care, IP&C physicians, or medical officer of health.
*Where there are frequently utilized or shared spaces close to the admission unit that are involved in the outbreak, admission during an outbreak should not occur. Re-evaluate once related risks have been minimized.

Where there is shared equipment, staff, or resident spaces between the outbreak unit and unit where admission is being considered, admission during an outbreak should not occur. Re-evaluate once related risks have been minimized.

Where there is proposed close proximity (i.e., neighbouring unit/area) of the admission unit to outbreak unit/area, admission during outbreak is delayed.

Admissions to a PCH in COVID Outbreak MAY be considered IF the:
1. Individual being considered for new admission/transfer is a recently recovered COVID-19 case within 90 days of positive test. This person can be admitted to any unit (including outbreak unit).
2. Individual being considered for new admission/transfer is COVID-19 positive. This person can only be admitted to an outbreak unit.
3. Individual is asymptomatic and not known to have COVID-19. Admission may be considered to a non-outbreak unit of a facility experiencing an outbreak where the outbreak is limited/restricted to a specific unit(s), if residents of the possible admission unit have had no exposure to the unit under outbreak and direct care staff as well as housekeeping & dietary staff on the outbreak unit, have not been exposed and are cohorted only to that unit (i.e., exposure risk to residents and staff on that unit are limited); AND/OR
4. Outbreak at PCH involved only 2 cases (staff, resident, or visitor), AND appropriate resident prevalence testing (i.e., outbreak testing of the unit upon declaration of an outbreak) did not identify new cases, AND at least one incubation period (14 days) had passed with no new cases or newly symptomatic individuals requiring testing; AND/OR
5. There is high prevalence/transmission noted in the local community, and following required discussion with acute and PCH leadership, the subsequent impact to acute care capacity of not transferring these residents may result in increased harm. Consideration must also be given to the staffing capacity of the PCH in outbreak, to ensure they can appropriately care for admissions of additional residents. Triggers to be considered prior to determine impact on acute care capacity are hospital bed pressure due to acute care high positive admission rates and/or outbreaks, current public health measures, positivity rates in the local community, and number of cases of variants of concern.

Admissions to a PCH in COVID Outbreak are NOT allowed IF:
1. Newly declared outbreak (within one incubation period, 14 days). The site must first investigate scope of the outbreak, and determine possible source(s), transmission, and impact.
2. Uncontrolled outbreak. This includes if SDO lead or Red Cross are on site at the PCH to help (considered uncontained)*.
3. Outbreak is not confined to one unit/wing/floor*.
4. There is less than one incubation period (14 days) since the last known case was diagnosed...
(or if a staff member, since they were at the site)*.

5. When the outbreak investigation has any individuals with pending test (symptomatic or asymptomatic) results or any newly symptomatic individuals that need to be tested for COVID-19*.

6. Multiple residents (i.e., more than one) on the unit in outbreak are confused or unable to follow IP&C direction and there is no plan or ability to address, and transmission at the site may have already occurred related to this risk*.

7. Staffing level is not adequate, sufficient support staff not available or staff cannot be cohorted to provide care only for isolated residents.

*Unless the individual being considered for new admission/transfer is a recently recovered COVID-19 case within 90 days of date of positive test, or is currently COVID-19 positive, where the positive individual is only admitted to an outbreak unit.

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 IP&C/designate. 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 influenza-like illness (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. If the site is in outbreak, include the outbreak code on the requisition

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

- See Infection Prevention and Control Guidance COVID-19 (Red) Recovered Patients/Residents/ Clients for testing guidance of recovered residents

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.

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 will collect a nasopharyngeal swab (NP). An asymptomatic resident may refuse this 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 10 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.

COVID-19 testing of a new admission or readmission is not recommended and is strongly discouraged, for any asymptomatic COVID-19 recovered person within 90 days of their date of diagnosis.


**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 resident.
  - 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.

**COVID-19 Vaccination**

All PCH residents meet the eligibility criteria to be offered the COVID-19 vaccine. Residents who have tested positive for COVID-19 and have recovered may still benefit from receiving the vaccine. Residents and families should be provided with the current version of the COVID-19 Vaccine Public Health Factsheet.

For residents newly admitted to the PCH, verification of vaccination status from one of the sources outlined below is required prior to providing any vaccination:

- Copy of immunization record from Public Health Information Management System (PHIMS), eChart, or the Shared Health COVID-19 Online Immunization Display
- Copy of the COVID-19 Standard Immunization Consent Form sent with transfer paperwork with either 1 or 2 vaccine doses documented

Vaccination of PCH residents will be completed either by trained immunizers within the PCH or by focused immunization teams (FITs) which have been created to administer first and second vaccinations at sites throughout the province. In both instances, vaccination of PCH residents
will require the consent form to be completed. PCH staff are also encouraged to get the COVID-19 vaccination.

According to the National Advisory Committee on Immunization (NACI), individuals that are immunosuppressed, due to disease, treatment or who have an autoimmune disorder should consult with their primary care provider about the risks and benefits of receiving this vaccine.

If a risk assessment deems that the benefits of the vaccine outweigh the risk, and if informed consent from the resident/substitute decision maker includes discussion about the insufficient evidence with this population, then the COVID-19 vaccination series may be administered.

If a resident develops symptoms of COVID-19 following vaccination, isolate resident immediately and test for COVID-19 after 24-hours if symptoms persist. If recovered within the past 90 days, consult with IP&C/designate prior to testing.

Admissions to PCH will not be dependent on if the new resident has received their immunization.

Residents admitted between the two (2) scheduled doses may be able to receive their first dose when the team arrives to administer the second dose. It is preferred that the site arrange for the second dose to be administered however, if this is not possible, there is benefit to the resident if they are only able to receive a single dose of the vaccine as some immunity will be present.

Families of residents paneled and waiting PCH placement may choose to take the resident to a super-centre for immunization prior to admission if that age cohort is eligible to receive the vaccine. The same brand of vaccine is required for both the first and second doses, therefore, the new resident must also attend the super-centre for the second dose as well.

All Public Health and Infection Prevention and Control guidance must continue to be followed regardless of the vaccination status of the resident.

**Faith-Based Gatherings**

Faith-based gatherings have demonstrated to be a higher risk setting thus adherence to public health guidance is important. If families chose to take the resident to a faith-based gathering outside of the PCH, guidance and practice related to leaves/passes from healthcare facilities must align with the current Public Health orders and pandemic response level.


- Maintain spatial separation between each person (2 metres/6 feet)
- Hand hygiene upon entrance, frequent hand hygiene, no hand shaking or hand holding – ensure ABHR is available
- All high-touch and frequently used items must be cleaned with a facility-approved disinfectant wipe between each resident
- Clean/disinfect shared equipment and objects (e.g. microphones, speakers, ceremonial objects, books, etc.) after each use
  - If shared books cannot be cleaned, it must be removed and stored at least overnight in a clean, dry and secure space without being handled. All hands must be cleaned with ABHR prior to handling each time
  - If it is required for religious/spiritual reasons, touching of ceremonial objects (e.g.
statues, religious symbols, rings) may occur if residents perform hand hygiene before and after touching the object, and the objects are cleaned/disinfected before and after use.

- Keep group sizes small and do not allow residents from different floors/units to attend the same service
- Alter ceremonial traditions that involve close contact to maintain the 2 metre/6 feet separation between all residents (e.g. nod head rather than shake hands)
- Do not use instruments that require blowing (woodwind or brass). Consider using pre-prepared audio or video recordings rather than live instrumentalists.
- Singing is discouraged – encourage pre-recorded vocalists. However, 14 days, or more, after the majority of the residents in the site have received the second dose of the COVID-19 vaccine, and if the community prevalence of the virus is low, then singing may be permitted as long as all public health orders are followed
- The IP&C guidance document for spring celebrations provides direction to sites for safely allowing faith based celebrations in health care facilities.

### Outbreak Management

For COVID-19, an outbreak is defined and declared with a total of two cases (staff, resident, visitor), epi-linked within 14 days of each other, and where at least one could have been acquired in the LTC site.

If a result comes back as COVID-19 positive, the resident(s) should be isolated in their room for 10 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. If there is only a single positive case (staff, resident, visitor), isolate the positive individual, investigate and implement measures to prevent any further spread.

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 residents who have symptoms compatible with COVID-19. In some cases, testing of asymptomatic residents may be recommended. Regional IP&C/designate 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 high-risk exposures to COVID-19 on Droplet/Contact precautions plus Airborne precautions for AGMPs.
- Quarantining low risk contacts (as defined in the Interim Guidance Public Health Measures) for one incubation period (i.e. 14 days). Quarantine refers to time spent in a facility where the following are in place:
  - staff are wearing universal PPE at all times; and
- no exposures occurred (e.g. no new staff positive and unprotected exposure, no new patients/residents/clients and unprotected exposure); and
- individual did not have a roommate/was in a private room; and
- individual was restricted to their room with the exception of departure for medically necessary procedures/appointments.

- 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, in discussion with IP&C/designate, 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 except for those that are COVID-19 positive or have recovered within the past 90 days. However, if there are capacity issues in the local health system due to the COVID-19 pandemic, admissions to PCH can be considered during an outbreak. Please refer to the admission section for the principles to guide this decision making.
- 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 as per the COVID-19 Long Term Care/Transitional Care Cohorting Guidelines
  - 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, including housekeeping, specific to residents with suspected or confirmed COVID-19, where feasible, to reduce the risk of further transmitting infection in the PCH.
- An outbreak may be declared over after two incubation periods without any new cases following the isolation of the last case (i.e., 28 days with no new COVID-19 healthcare associated infection [HAI] cases after last case isolated).
  - Where the outbreak involves only staff cases, if the staff persons are isolating at home, the outbreak can be declared over after one incubation period (i.e. 14 days) from the last shift worked during the period of communicability if high risk contacts are tested at the end of the isolation period before taking off precautions and before declaring the outbreak over.
  - If a resident refuses testing, as long as they have been successfully isolated for the 14 days, the outbreak can still be declared over if there are no new cases. The resident who refuses testing must remain isolated for an additional 10 days (i.e. 24 days in total)

**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 an asymptomatic COVID-19 suspect resident with known exposure history consult IP&C/designate*. Precautions may be discontinued 14 days from last exposure. If symptoms develop, collect specimen. In this situation, precautions may be discontinued 10 days from symptom onset and 72 hours while asymptomatic must have passed, whichever is longer.

To discontinue precautions for a resident who is COVID-19 positive, consult IP&C/designate. 10 days from symptom onset and 72 hours while asymptomatic must have passed, whichever is longer. Where residents with confirmed COVID-19 infection have been cohorted and one has recovered, the recovered resident may be moved into the Green Zone as required.

COVID19 positive residents may be discharged home positive; they do not have to stay in a facility.

Where there are negative COVID-19 test results in a resident that does not meet the ‘exposure’ criteria OR exposure to a confirmed case of COVID-19 OR in a laboratory working directly with biological specimens that contain COVID-19) in residents with respiratory symptoms:

- Consult IP&C. Resident management maybe adjusted to follow seasonal viral respiratory management protocols (i.e., Droplet/Contact precautions and discontinuation of precautions when symptom resolve)
- Decisions are based on relevant epidemiological data (i.e., known COVID-19 case(s) in a 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.

**Recovered Laboratory-Confirmed COVID-19 Cases**

There is not enough evidence to ensure lasting immunity from previous COVID-19 infection. For persons previously identified as COVID-19 positive (within 90 days of initial infection)

- Do not re-test unless there is a known exposure or outbreak. Before retesting, consult IP&C/designate
  - **Asymptomatic person**: Further testing is not recommended, including asymptomatic admission screening
    - Comprehensive clinical assessment
  - **Symptomatic person**: Investigation according to clinical presentation (example: testing for influenza or other respiratory viruses for acute respiratory syndrome)
    - Clinician must perform a diligent and in-depth clinical evaluation to verify whether the symptoms can be explained by an alternative diagnosis (e.g., bacterial pneumonia, pulmonary embolism, heart failure, etc.) and document the epidemiological context of the new episode
    - Isolate case during the investigation. In the absence of an alternative diagnosis, manage as COVID-19 suspect.
- Residents may have chronic respiratory symptoms and/or a post-viral cough, which do not require maintenance of enhanced precautions for COVID-19
- If re-testing, place on Droplet/Contact precautions plus Airborne precautions for AGMPs. Evaluate results in cooperation with IP&C/designate, for interpretation to determine if
case is considered communicable and any contact tracing necessary
- There are no restrictions to admitting COVID-19 recovered residents to either green units or ones with orange/red residents within 90 days of date of diagnosis. This decision can be based on bed availability; private room is not required.

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. Guidance and practice related to leaves/passes from healthcare facilities must align with current Public Health orders and pandemic level (https://manitoba.ca/asset_library/en/restartmb/pandemic_response_system.pdf#page=28). 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 the driver/escort enters the site, provide them with a level 1 procedure mask for the purpose of the outing. 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. Physical 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.

Adhere to the Adherence to the “Single Site Restriction” for staff who work at licensed PCHs.

- Exemptions to the Single Site Staffing Order are available for immunized staff upon receipt of proper documentation.

**References/Adapted From**


Change Log

May 7, 2021
- Added Pet Visitation information (pg. 6)
- Added information for exemptions to single site staffing requirements (pg. 20)
- General clean-up of document

April 19, 2021
- Added information about single site staffing exemptions (pg. 3)
- Updated requirement to maintain visitor log for 30 days for the purposes of contact tracing (pg. 8)
- Updated protocol for admission/readmission, including consideration for vaccine status (pg. 12)
- Updated protocol for outbreak management, including updated definition for OUTBREAK. Definition changed to refer to: Two cases (staff, resident or visitor), epi-linked within 14 days and where at least one case may have been acquired at the LTC site (pg. 18)

April 9, 2021
- Added that procedure masks should be strongly considered for residents able to tolerate them (pg. 10)
- Testing is now required (not recommended) for all new admissions and readmissions, except those who tested positive for COVID-19 in the last 90 days. (pg. 6)
- Added "Considerations for admissions during COVID-19 outbreaks section (pgs. 13 – 15)
- Link to safely celebrating spring celebrations added (pg. 19)

March 15, 2021
- Removed reference to mask reuse (pg. 10)

March 12, 2021
1. Changed visitors to visitors and/or designated family caregivers to provide clarification (throughout document)
2. New information about variant strains (pg. 4)
3. Updated information for N95s while performing AGMPs (Pg. 5)
4. Updated procedures in bullet 6 (Pg. 5)
5. Guidance regarding procedure masks for residents (Pg. 10)
6. Updated admissions/re-admission guidance (pg. 12 & 13)
7. Updated testing information regarding fevers (Pg. 14)
8. Added information for testing asymptomatic COVID-19 recovered persons (Pg. 14)
9. Updated vaccination information (Pg. 15 & 16)
10. Added Faith-based Gatherings section (Pg. 16 & 17)
January 11, 2021
1. Added Vaccination Protocols (pg. 15).
2. Updated Outbreak Management protocols for PCHs where cases are solely identified in staff. (pg. 17).

December 9, 2020
1. Added “There are no restrictions to admitting COVID-19 recovered patients to either green units or ones with orange/red residents. This decision can be based on bed availability. Additionally, residents recovered from COVID-19 infection do not require the 14 day quarantine (or isolation) period.” (pg. 12)

November 26, 2020
1. Changed period of time a COVID-19 positive or symptomatic resident must be isolated from 14 days to 10 days from symptom onset (pgs. 13 & 15)
2. Changed period of time an asymptomatic resident who tests positive for COVID-19 must be isolated from 14 days to 10 days from specimen collection date (pg. 14)
3. Changed period of time for discontinuing additional precautions for a symptomatic resident from 14 days to 10 days from symptom onset (pg. 18)

November 23, 2020
1. Added information for Recovered Laboratory-Confirmed Cases of COVID-19 (pg. 18)

October 22, 2020
1. Updates to Admission/Readmission when in Pandemic Response System Level RED (pg. 12/13).
2. Update to Discontinuing Precautions guidance (pg. 18).

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