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.
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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 and/or Designated Family Caregivers as per Shared Health guidance. Guidelines for Exceptions to Visitor Restrictions to Health Facilities should be followed.

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

- 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.

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. Variant strains are now being detected in Manitoba and Public Health officials are monitoring them and providing direction.

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 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.


3. Staff receive ongoing training and monitoring of compliance with [Routine Practices](https://sharedhealthmb.ca/files/routine-practices-protocol.pdf), including hand hygiene, and implementation of additional precautions, including Droplet/Contact precautions with Airborne precautions for AGMPs. Refer to:
   - 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.

5. An updated list of AGMPs is available at [https://sharedhealthmb.ca/files/aerosol-generating-medical-procedures-AGMPs.pdf](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.
     - Where required, N95s for performing AGMPs may be worn across zones (Green, Orange, Red). Extend use of N95s for repeat encounters with multiple residents (except intubation). Remove if damaged, wet, or soiled, and at breaks.
   - The fewest staff necessary to perform the procedure should be present.

6. Procedures based on Shared Health recommendations to mitigate the introduction of COVID-19 into PCHs, and to prevent and control the spread of infection are in place. This includes procedures to:
   - Ensure appropriate physical distancing of residents and staff in common areas and staff or break rooms.
   - Ensure there is adequate space for donning and doffing of PPE.
   - Communicate with staff, residents and families on COVID-19 updates.
   - 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).

   - Prior to any resident interaction, all staff have a responsibility to assess the infectious risks posed to themselves, other staff, other residents and visitors/volunteers from a resident, situation or procedure.
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:

   o The importance of hand hygiene and how to wash hands and how to use alcohol-based hand rub (ABHR).
   o Instructions on appropriate respiratory hygiene (e.g. covering their cough with a tissue or coughing into their elbow followed by performing hand hygiene).
   o 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.
   o 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 everyone who enters 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 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. Strategies are developed to manage a high volume of residents with COVID-19 (e.g. cohorting staff to work only with suspect or confirmed).

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

PCH operators shall ensure staff are:

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

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

32. 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 contact Occupational Health and consult with their own healthcare provider for any needed follow-up.

33. 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.
- Current recommendations about utilization of PPE.

**Screening**

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 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:

- [https://sharedhealthmb.ca/covid19/providers/](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 such as hand hygiene, infection control practices including wearing of appropriate PPE and physical distancing.


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 Prevention and 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, visitors and volunteers is to reduce the risk of transmitting COVID-19 infection from staff, visitors 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 designated family caregivers and visitors: [https://sharedhealthmb.ca/files/covid-19-pch-visitation-principles.pdf](https://sharedhealthmb.ca/files/covid-19-pch-visitation-principles.pdf).

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/or at breaks. Inform staff how to access additional masks if needed.

Procedure masks should be strongly considered for 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, especially during an outbreak.

### 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 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 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. The quarantine requirements upon admission are the same regardless of whether or not the new resident has been immunized.

Testing is recommended for all new admissions and readmissions, except those residents who have tested positive for COVID-19 within the last 90 days. Refusal of asymptomatic testing upon admission does not impact the ability of the resident to be admitted to the site. Isolation of asymptomatic new admissions/re-admissions from Green Zones of Health Care facilities is not required after arrival in the facility.

New admissions/re-admission 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 (i.e. quarantine). They should not participate in any group activities or meals during this period.

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.

- Green Zone PPE is indicated; testing an asymptomatic individual does not indicate additional PPE is required

- Orange/Red Zone Precautions are not required for asymptomatic new admissions/readmissions unless exposure criteria have been met. If a new admission/readmission becomes symptomatic, implement Droplet/Contact and Airborne Precautions for AGMPs and manage as a COVID-19 suspect (Orange Zone); and re-collect specimen.

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 quarantine (or isolation) period.

In Pandemic Response System Level RED (CRITICAL)

All new admissions/re-admissions from health care facilities and community require 14 day quarantine after arrival in the facility, with the exception of newly admitted residents which have recovered from COVID-19 infection within the last 90 days. All other individuals are to remain in their room as much as possible for the full 14 days. During this time frame, individuals who are in quarantine should not participate in any group activities, including meals. Meals should be eaten in their room.
NOTE: The calculation of the 14 day time frame may include days spent in isolation in another facility/setting prior to transfer.

Green Zone PPE is indicated; testing an asymptomatic individual does not indicate additional PPE is required.

Orange/Red Zone Precautions are not required for asymptomatic new admissions/readmissions unless exposure criteria have been met. If a new admission/readmission becomes symptomatic, implement Droplet/Contact and Airborne Precautions for AGMPs and manage as a COVID-19 suspect (Orange Zone); and re-collect specimen.

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 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/designate1 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.

- 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 and/or quarantined. Consider use of one-on-one programs, as well as technology, to allow resident contact with family and friends.

Testing

Testing of Symptomatic Residents

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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.
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.


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 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 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.

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


**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 (https://manitoba.ca/asset_library/en/covid/covid19_vaccine_factsheet.pdf)

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. The quarantine requirements upon admission are the same regardless of whether or not the new resident has been immunized.

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 panelled and waiting PCH placement may chose 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. https://manitoba.ca/asset_library/en/restartmb/pandemic_response_system.pdf#page=28

- Maintain spatial separation between each person (2 metres/6 feet)
- Hand hygiene upon entrance, frequent hand hygiene, no handshaking 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
- Outside spiritual advisors are not permitted for faith-based gatherings in sites, when in Pandemic Response Level Orange or Red
• 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)
• Provision of food and beverages (e.g. communion) before, during or after the faith-based activity is not allowed.
• 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

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 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.

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 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, 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.

• 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 https://sharedhealthmb.ca/files/covid-19-ltc-cohorting-guidelines.pdf

• 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 after 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, it may be declared over after two incubation periods following the last positive staff person’s last day at work while infectious

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. 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 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) 

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


Change Log

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