COVID-19: Guidance for Long-Term Care Facilities (LTCF)

This document has been updated from the May 4, 2020 version. The following changes have been made:

p. 1. Wording changed in 1st paragraph.
p. 2. Resident assessment changed to 2 times per day from every 8 hours.
p. 2. Symptoms added.
p. 2. Incubation period updated.
p. 2. Change: Temperature
p. 3. updated wording in Reporting section; Appendix O referenced.
p. 4. Added staff may consult RMOH on rapid testing.
p. 4. Staff section added- contains bullets from control measures (p.6) and HCW section (p.11).
p. 4. Staff section: self screening instead of active screening.
p. 4. Travel outside Atlantic Canada.
p. 5. Active screening added; PCRA- reference to Appendix I; staff working between facilities updated.
p. 5. Change: Staff returning from travel (in accordance with Mandatory Order).
p. 6. Laboratory Testing section updated.
p. 6-7. Control measures edits made. Keep a list of employees added.
p. 7. Contact information on all. visitors.
p. 7. Uniform worn by staff.
p. 7. Change: Treatment
p. 9. Addition of visitor restrictions during an outbreak.
p. 9. To prevent spread…isolation precautions
p. 10. PPE Addition- mask for shift updated.
p. 11. Addition to recommendation for CPAP use.
p. 11. New recommendations for cohorting.
p. 12. Additional recommendation under new admissions, readmissions.
p. 13. Admissions, Readmissions and Transfers
p. 13. New recommendation under transfers regarding movement of residents.
p. 14. New recommendations under Communal and Social activities regarding bubbles.
p. 16. New section added: Declaring an outbreak over.
p. 17. Laundry: addition.
p. 17. HVAC, air conditioners, fans.
p. 18. Appendix A updates to #2 and #5.
p. 24. Appendix E updates to screening questionnaire.
p. 25. Appendix E: (from Mandatory Order)
p. 30. Appendix I PCRA section added.
p. 41. References added.
p. 36. Appendix L replaced with new form.
p. 39. Appendix N new List for staff, visitors, and others entering facility during an outbreak.

Coronaviruses are a large family of viruses. COVID-19 is a rapidly evolving new disease that has spread globally. As knowledge of the virus and its transmission has increased, there is now evidence that asymptomatic and pre-symptomatic transmission can occur and may be an important factor in closed settings such as long-term care facilities (LTCF). Residents of LTCF have been identified as a vulnerable population who are at very high risk for serious disease and have the potential to transmit the virus easily within their facility. (Long-term care facility in NB refers to a Nursing Home.) Health care workers, staff and volunteers in such facilities can also easily transmit and need to be extremely vigilant in self-monitoring in order to prevent introducing the virus into this setting.

Health care workers (HCW) in LTCF have a critical role to play in identifying, reporting and managing potential cases of COVID-19. Public health provides guidance to those who care for residents who might become ill with the virus and work to minimize the risk to those most likely to become severely ill if infected. Long-term care facilities care for some of our most vulnerable community members, as persons who are older or who have underlying health conditions have a higher risk of developing complications from this virus.

Nursing Home Operators or Administrators should ensure that their nursing homes have developed policies and procedures for the prevention and management of respiratory outbreaks such as COVID 19. Outbreak management planning is a provincial responsibility and will include a staffing contingency plan; an outbreak response plan and review process (including contact details for Public Health); and define areas of responsibility for coordination of an outbreak response. Implementation of outbreak measures is under the direction of the Regional Medical Officer of Health (RMOH) and Public Health

The guidance in this document has been developed specifically for implementation in LTCFs and will be updated as new information becomes available from Federal/Provincial/Territorial (F/P/T) authorities. Guidance has been adapted from ***Public Health Agency of Canada Infection Prevention and Control for COVID-19 Interim Guidance for Long Term Care Homes.***

For information regarding COVID-19, visit the Canada.ca and WHO Web site and the Government of New Brunswick (GNB) Coronavirus web site: www.gnb.ca/coronavirus.

Experience in other jurisdictions is that COVID-19 is introduced into these settings by mildly symptomatic workers or visitors. It is important for infection prevention and control strategies to prevent or limit transmission of COVID-19 in LTCFs to have prompt identification of all persons with signs and symptoms of possible COVID-19. The elderly does not always have clear clinical presentation. Staff should be vigilant completing assessments for any symptoms twice per day, and flag symptoms even if mild. Assessments are to be escalated as needed if increased risk has been identified. Testing should be done promptly for residents with one or more symptoms.

Signs or symptoms of COVID-19 can be very subtle early on, for the purposes of protecting this vulnerable group a sensitive definition is used and may include:

- Fever (temperature of greater than 38^0 C or greater), or chills
- Any new or worsening respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat or difficulty swallowing), OR
- Any new onset atypical symptoms including but not limited to muscle aches, diarrhea, malaise, fatigue, headache or loss of taste or smell.

Transmission

- Symptomatic cases of COVID-19, including mild cases, are causing the majority of transmission, although there is also evidence that asymptomatic and pre-symptomatic transmission can occur in LTCF settings.
- Person-to-person transmission is mostly occurring via infectious respiratory droplets.
- The virus enters a person's body either:
  - by large respiratory droplets containing the virus that adhere to mucous membranes of a person's eyes, nose or mouth, or
  - by touching a surface or an object contaminated with the virus and then proceeding to touching one's eyes, nose and mouth.
- A longer exposure time and a more severe illness with coughing likely increases the risk of exposure to the virus.
- Performing an aerosol-generating medical procedure (AGMP) can generate aerosols capable of being inhaled, and capable of spreading further in the air than respiratory droplets.
- Fecal-oral and body fluid transmission of the COVID-19 virus is uncertain at this time..

Incubation period

Current estimates of the incubation period range from one to -14 days with median estimates of 5-6 days between infection and the onset of clinical symptoms of the disease.

Period of communicability

The period of communicability is not well understood and varies by type of coronavirus. Detailed medical information from people infected is needed to determine the infectious period of COVID-19.

For contact tracing purposes, New Brunswick has adopted the period of communicability for COVID-19 is from two days prior to onset of symptoms up to 14 days after symptom onset.

Contamination of surfaces

COVID-19 viruses can survive on surfaces from several hours to days depending on several factors including relative temperature, humidity, and surface type.

NOTE: Information on transmission, incubation period, period of communicability and how long the virus can survive in the environment are assumptions. These assumptions are based on

currently available scientific evidence and expert opinion and are subject to change as new information on transmissibility and epidemiology becomes available. It is still to be determined how easily the virus spreads between people. See: Summary of Assumptions

If a resident is experiencing any symptom of COVID-19, or if RMOH recommends asymptomatic testing of residents (for example during outbreaks) follow the **Nursing Home Assessment and Testing Pathway Appendix A and D** and the control measures below.

To maintain the integrity of the health care system and prevent transmission in clinical and other vulnerable group settings, residents and staff of LTCFs that are symptomatic (even with mild symptoms) are considered as a priority group for testing for COVID-19.

Reporting and Notification

Individual cases

An interim national case definition for COVID-19 has been developed, specifically for confirmed cases, probable cases and as well as associated surveillance reporting requirements.

Report any possible COVID-19 illness in residents and employees immediately to Regional Public Health (PH). It is critical for long term care staff to notify Regional Medical Officer of Health (MOH) or designate if any person (i.e. client or staff) has or may have COVID-19 **within 1 hour** as per amended legislation.

Regional Public Health staff can be reached during regular business hours as well as after hours as per established protocols (see **Appendix B**). Regional Public Health will work with the LTCF to provide overall coordination with health care providers and regional microbiology laboratories for the management of cases and to establish communication links with all involved health care providers for the full duration of illness. The LTCF may consult the Regional MOH or designate before testing. The Regional MOH will determine if Rapid or regular PCR test should be completed according to established criteria for the use of rapid testing.

The Regional MOH, through Regional Public Health Communicable Disease team, will provide direction on implementing the control measures outlined in this document.

Outbreak

Any suspected outbreak should be responded to immediately and reported to Regional Public Health. For any suspected outbreak, the LTCF will send Regional Public Health a line list for ill residents and staff with the specific elements. See **Appendix C.**

Definition of a COVID-19 outbreak in a LTCF: In the context of the COVID-19 pandemic, a single laboratory-confirmed case of COVID-19 in a resident or staff member.

Staff

- **Staff are required to self-screen just prior to entering the facility (as per Appendix E).**
- Staff should be reminded of their critical responsibility to self-monitor for COVID-19 symptoms twice daily and stay home when sick, even with mild or minor symptoms, and notify their supervisor.
- A dedicated telephone line has been set up for staff to call immediately to organize testing if they develop symptoms, whether at home or at work: 1-833-475-0724.
- Prior to working every shift, staff must report if they have had potential exposure to a case of COVID-19.
- If staff develop one or more symptoms of COVID-19 (as per the list outlined above) they should:
  - immediately exclude themselves from the resident environment.
  - not remove their mask if wearing one, or to don one immediately
  - clean their hands.
  - notify their supervisor who will report a possible case to Public Health.
  - call the dedicated line to arrange testing via the assessment centers
  - avoid further client contact and
  - leave the facility as soon as possible to self-isolate in own home; or self-isolate and stay off work if already at home.
- Staff should be isolated at home and not working if:
  - they are returning from an area outside of Atlantic Canada (New-Brunswick, Nova Scotia, Newfoundland and Labrador, Prince Edward Island and the following communities in Quebec: Temiscouata Regional County municipality, Avignon Regional County municipality and Listuguj First Nation, https://www2.gnb.ca/content/dam/gnb/Corporate/pdf/EmergencyUrgence19.pdf) or as outlined within the Mandatory Order that requires them to self-isolate as per the most current protocol of the GNB recovery phase. In this case, they should self-isolate for 14 days from their arrival to NB, unless they are exempt because live in or near an interprovincial border community and commute to and from work locally; and therefore must travel directly to and from work, self-monitor, avoid contact with vulnerable individuals outside work, and follow the guidance of the CMOH.
  - they have symptoms compatible with COVID-19. They should be tested and could consider returning to the work environment if result is negative and no other known exposures to COVID-19 are known.
  - they were a contact of a case of COVID-19, depending on the nature of the exposure and whether any PPE was worn. Consultation with Regional Public Health is warranted in such a situation.
  - they have been told to self-isolate by a Public Health authority.
- They must not enter the facility for at least 14 days from last exposure unless Regional Public Health provides other direction (based on an assessment of the proximity and duration of contact and level of personal protective equipment worn).
- Potential exposure of COVID 19 to a person during the 48 hours prior to symptom development is possible. When a resident is suspected to have COVID-19 and has been tested, a point of care risk assessment should be conducted to determine additional precautions for the health care workers who had direct contact with a resident during the

pre-symptomatic period. Discussion with the RMOH will help determine additional measures or restrictions; i.e. whether or not staff should be excluded from work, self- isolate and/ or self- monitor while waiting for resident test result.

- An asymptomatic HCW caring for this patient using appropriate PPE may still be able to work while self- monitoring for symptoms until the results of the test on the resident is back at the discretion/direction of the Regional MOH.
- Active screening of all staff may be requested by RMOH especially in outbreak situations.
- Ensure staff are aware how to conduct a point-of-care risk assessment prior to all interactions to determine what IPC measures are needed to protect residents and themselves from infection.(See Appendix I).
- Elements of the risk assessment should include but are not limited to:
  - Availability of test results within -72 hours
  - Presence of community transmission in an area
  - Type and length of contact
  - Presence of mask for all shift in place
  - Vulnerability of staff person
- Staff ill or with an unprotected exposure to someone with confirmed COVID-19 outside the LTCF or those otherwise determined to require self-isolation according to public health directives, must not enter the LTCF for at least 14 days from last exposure unless Regional Public Health provides other direction (based on an assessment of the proximity and duration of contact and level of PPE worn). Staff must notify their employer so Public Health can be advised.
- Ensure staff have access to information on COVID-19, infection prevention and control precautions and have an opportunity to practice donning and doffing protective equipment.
- Provide ongoing training and monitoring of compliance with Routine Practices, including hand hygiene, and implementation of additional precautions, including Droplet and Contact precautions, and use of an N95 respirator, in addition to Droplet and Contact precautions, if AGMPs are performed.
- HCW should have N95 fit testing done every two years.
- **Staff should avoid working in different facilities (including nursing homes, hospitals, and other vulnerable settings) when possible. In the case of an outbreak staff will not be allowed to work in different facilities unless otherwise allowed by RMOH.**
- Operators should:
  - plan for fluctuating staffing levels by identifying essential functions and creating plans for continuity of operations.
  - plan for what will be required to maintain critical operations.
  - cross-train personnel to perform essential functions so the workplace can operate even if key staff are absent.

Laboratory Testing

As per relevant laboratory guidance and identified protocols, ensure that appropriate specimens from a case are forwarded to the respective regional microbiology laboratory. Please follow the appropriate collection and transport procedure for the type of swab and transport media available to you.

Follow instructions as provided by the **COVID Assessment and Testing Pathway Appendix A and D**. The specimens (traditional PCR) will be tested at the Dr. Georges-L.-Dumont University Hospital Centre microbiology laboratory. Their assay is available 7 days a week and performed within 24 hours of receiving the specimens. Label as LTCF and provide the name of the LTCF on the requisition/assessment form.

The GeneXpert platform rapid testing for COVID-19 is now available in all regional laboratories. This platform allows for a result to be provided within 1-2 hours of sample processing. The inventory of testing cartridges required for this test is limited in the province. This is why, at the moment, its usage is to be approved by a medical officer of health or a medical microbiologist.

Treatment

The treating health care provider attached to the LTCF will provide individual clinical management of the case based on their condition and at the discretion of the health care provider. At this time, there is no specific treatment (e.g. antivirals) for cases of COVID-19.

Clinical management of the case (whether in the home or in an acute care setting) is based on the case's condition and at the discretion of the primary health care provider. Canadian guidance on the clinical management of patients with moderate to severe COVID-19 is available. Reference 4

Guidance on the clinical management of severe acute respiratory infection (i.e. in a hospital) when a case of COVID-19 is suspected is available from the Public Health Agency of Canada (PHAC).

INFECTION PREVENTION AND CONTROL

CONTROL MEASURES

To prevent the introduction of COVID-19 into your facility, all the following measures should be currently in place until further notice:

- **Monitor entry to the facility, limit visitors** Those who need to enter into the facility need to buzz in, check in with operator or designate before entering. Limit access points to single entry to the facility.
- Post signs at the entrance of the building outlining visitor restrictions.
- Signage should be placed inside and outside the centre to advise no entry if any symptoms.
- Signage should be placed in foyer reminding staff and essential visitors that they must complete screening and put on a mask before entering.
- Active screening should be conducted on volunteers and visitors at entry of the facility. Refer to **Appendix E for sample screening**.
- Food and essential items should be delivered through a single access point. Every effort should be made to avoid unnecessary entry, and if entry is required delivery personnel must be screened.
- After active screening (see Appendix E), designated visitors and volunteers will be granted access, unless cases of COVID-19 within the facility. Refer to Social Development NH ARF Visitation Recovery Phase document.

- Keep a list of all regular employees and another for the other staff, other essential workers and visitors. Submit daily to public health during an outbreak. The list should include the person's name and phone number in case they need to be contacted. See Appendix N.
- Residents may be allowed to have a friend or family member visit where physical distancing can be accommodated and the number of visitors at one time is limited depending on the current recovery visitation guidelines. For palliative care patients, refer to the latest memo outlining criteria.
- Keep a log of all persons entering the building (including staff). Contact information on all visitors (name and phone number) should be obtained.
- Physical distancing measures (maintaining 2 metres spatial separation) are utilized for staff wherever feasible.
- Medical/procedure masks should be worn by all staff when carrying out direct client care.
- Non-medical community masks can be worn by staff involved in indirect care.
- Physical distancing measures must be maintained for staff during meal and break times. Consider rotating break times.
- Frequent hand and respiratory hygiene have to be encouraged for clients and staff.
- Resident screening should include assessments for symptoms of COVID-19 (at least 2 times per day, increased to more frequent if increased risk identified)
- Support hand and respiratory hygiene, as well as cough etiquette by residents, and employees.
- All staff, essential volunteers and essential visitors (as per the recovery guidance) must be trained with putting on and wearing a mask for the duration of their shift or visit, and ensuring it is appropriately discarded after use. This is to reduce the risk of transmission to residents, which may occur even when symptoms are not recognized.
- All staff wearing a uniform at work, once the shift is over, should change clothing when they arrive home and launder their uniform. The uniform once worn, should not be used to run errands or to go to an appointment. The coronavirus may remain detectable for hours to days on surfaces made from a variety of materials, including clothing.
- Residents with symptoms should be isolated to their room and put under droplet contact precautions. Minimize the number of HCW caring for them (i.e. reduce the number of possible exposures). Cluster the activities of staff going into their room so they do not need to enter the room as often. Keep a list of the staff going into their rooms.
- Physical distancing measures (maintaining 2 metres spatial separation) are utilized for staff wherever feasible, while providing safe care and while on lunch breaks, etc.
- Physical distancing measures (e.g. use of single rooms when available, dedicated bathrooms, maintaining 2 metres spatial separation between residents in hallways, all recreation, activity, activation or dining or other communal areas) are utilized for all residents that are not part of a determined bubble.
- Rooms for isolation of ill residents should be identified proactively before any suspect or confirmed cases in the facility if available.

To prevent the spread of COVID-19 within your facility:

- All residents with suspect COVID-19 are immediately placed into Droplet and Contact precautions (e.g., use of gloves, gown, mask and face or eye protection) for all staff who enter the resident room or who are within 2 metres of resident until COVID-19 or other respiratory infection is confirmed through testing.

- **In the event that residents who are under isolation precautions (e.g. contact and droplet), the Regional MOH will use specific triggers to determine specific actions.** Single rooms and dedicated bathrooms should be utilized. Roommates should be placed in a separate single room with same precautions, and concurrently tested. The resident must be restricted to their room or bed space.
- If positive test result (confirmed case), continue isolation as described above until resident is cleared, in consultation with the attending Physician/NP and the Regional Medical Officer of Health. Additional outbreak control measures based on a risk assessment may be required by Regional PH to be implemented in the facility (see outbreak management)
- For residents positive for COVID-19, post signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required personal protective equipment (PPE). Establish a 'cold' zone where PPE is available and donned. The patient room is deemed a 'hot zone' where PPE is worn at all times and access is restricted. A clearly defined (sign and taped off) 'warm zone' is the area where PPE is removed before leaving the room.
- Posters illustrating the current methods for putting on and removing required PPE placed inside and outside of resident rooms for easy visual cues.
- If a resident is a close contact of a case and tests negative, they should continue to monitor and isolate with droplet and contact precautions in place for 14 days. If symptoms worsen may need a second test.
- If a resident is tested because COVID-19 is suspected and the test is negative, the Primary Care provider should discuss when to discontinue isolation with the Regional MOH.
- The duration and discontinuation of Droplet and Contact precautions and isolation measures for an individual resident or unit on outbreak should be determined on a case-by-case basis, in consultation with Regional Public Health.
- If there is a case and during an **outbreak** in one of the facilities, **staff** will be RESTRICTED from working shifts in more than one facility.

Outbreak management strategies include:

- Regional PH will conduct contact tracing to determine whether a COVID-19-positive staff member or resident exposed other staff or residents during the period of communicability.
- LTCF should notify the transferring hospital and local public health authorities if a resident develops symptoms and/or is diagnosed with COVID-19 within 14 days of transfer from another facility.
- The Regional MOH and PH will provide guidance and directives on when to apply outbreak measures to the affected unit or the entire LTCF. This could include such measures as placing all residents on isolation precautions and/or wider testing within the facility, depending on the risk assessment.
- LTCF will need to implement further restrictions of movement of residents within the facility and discontinuation of all non-essential activities, including communal activities, if not already in place, as directed by the Regional MOH and PH.
- LTCF should arrange for the use of dedicated equipment to avoid unnecessary transmission between residents or ensure that all equipment is appropriately cleaned and disinfected between residents.
- There will be no new resident admissions permitted in the context of an outbreak of COVID-19.
- All visitations for residents will be prohibited in an outbreak, including palliative visitation,

Hand Hygiene:

Hand hygiene remains one of the most important means to prevent and control communicable disease, and should be performed frequently by residents, staff, visitors, and volunteers.

Hand washing is an effective way to reduce microbial contamination of hands and should be part of the routine of residents, staff and visitors. Soap and water should always be used if hands are visibly soiled and after personal toileting. Use of an alcohol-based hand rub between 60-90% ethyl alcohol is also appropriate and is the method of choice for health care settings.

- Ensure that residents have easy access to appropriate hand hygiene facilities following toileting and before meals or food preparation.
- Include education and assistance of residents with hand hygiene as part of care plan.
- Ensure alcohol base hand rub is available and maintained at the point of care, ideally both inside and outside of resident room.
- Ensure alcohol base hand rub is located and maintained at entrances to the facility.
- Soap and water are required if hands are visibly soiled and after personal toileting.
- Make sure tissues are available and any sink is well-stocked with soap and paper towels for hand washing.
- Post signage directing all persons entering the building to clean their hands.
- Educate HCWs on the 4 critical moments for hand hygiene and review on a regular basis.
- See **Appendix F** for directions for HCWs and **Appendix G** for residents regarding hand hygiene.

Respiratory Hygiene:

- Respiratory hygiene products (e.g. masks, tissues, alcohol- based hand rinse (ABHR), no-touch waste receptacles) are available and easily accessible to staff and residents.
- Refer to **Appendix H.**
- Respiratory hygiene should be actively encouraged for all residents and staff.
- Contain respiratory secretions by using tissues to cover the mouth and nose during coughing/sneezing, with prompt disposal into a no touch waste receptacle.
- Cover the mouth and nose during coughing/sneezing against a sleeve/shoulder if tissues are not available.
- Turn the head away from others when coughing/sneezing.
- Provide tissues and masks for respiratory hygiene as well as instructions on how and where to dispose of them and the importance of hand hygiene after handling this material.

Personal Protective Equipment:

- The facility should ensure that they have on hand an adequate supply of PPE, including gloves, gowns, masks (including N95), goggles.
- The NB Pandemic Task Force is now recommending that Mask-for-all-shift guidance be implemented across the health care system. All HCWs working in all resident care areas who have any face-to-face (direct) with patients must wear a surgical/procedure mask

continuously, at all times and in all areas of their workplace when a physical distance of two metres cannot be maintained and a physical barrier (ie: plexiglass) is not in place to prevent transmission of droplets. It is recommended that HCWs minimize their mask use to two masks per shift where possible to preserve supplies while protecting employees and patients. Masking for the full duration of shift for staff working in **non-direct** patient care settings is using a non-medical face mask when unable to ensure two meters of physical distancing.

- Appropriate practice should be followed for donning and doffing of the masks as well as continue to use routine infection prevention and control guidance. (see **Appendix I and J**).
- Staff should receive ongoing training and monitoring of compliance with Routine Practices, including hand hygiene, and implementation of additional precautions, including Droplet and Contact precautions, and use of an N95 respirator, in addition to Droplet and Contact precautions, if Aerosol Generating Medical Procedures are performed.
- A Point of Care Risk Assessment (PCRA) should be applied before every clinical encounter regardless of COVID-19 status and all staff have a responsibility to assess the infectious risks posed to themselves, other staff, other residents and visitors from a resident, situation or procedure (See Appendix I)
- For patients that have symptoms or confirmed for COVID 19:
  - Post signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE.
  - Make PPE, including facemasks, eye protection, gowns, and gloves, available immediately outside of the resident room if required.
  - Position a trash can near the exit inside any resident room to make it easy for employees to discard PPE.

Aerosol Generating Medical Procedures (AGMP):

- AGMPs are rarely performed in LTCF, though potential examples in this setting may include open suctioning in patients with a tracheostomy, use of non-invasive positive pressure ventilation (CPAP) machines, or nebulized therapy.
- Oral suctioning and oxygen therapy are not considered an AGMP.
- An N95 respirator (plus eye protection) gown and gloves should be used when performing aerosol-generating medical procedures (AGMP): intubation and related procedures, nebulizing therapy, non-invasive positive pressure ventilation (CPAP, BiPAP), manual ventilation, open endotracheal suctioning on a suspect case.
- Where possible switch to metre dose inhaler (MDI) from nebulized treatment.
- Any AGMPs performed on patients with suspect or confirmed COVID- 19 require additional precautions including use of N95 respirator.
- AGMPs on a resident suspected or confirmed to have COVID-19 should only be performed if:
  - The AGMP 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.
  - These procedures are performed in a single room with hard walls with the door closed.
  - Entry into a room of a patient undergoing CPAP is minimized. In case of an outbreak discuss with treating health care provider attached to the LTFC if CPAP can be

discontinued temporarily.

- It is recommended to discontinue CPAP use if a resident is suspected to have COVID 19 and awaiting test results or is diagnosed with COVID-19. There is no short-term risk of discontinuing CPAP when diagnosed and recovering from COVID-19.
- If a resident currently uses CPAP machine there is no need to discontinue use provided the patient is not infected with COVID-19.
- Moving residents from room to room who are on CPAP or BiPAP within a LTCF should be avoided.

Communication:

- Prepare and practice calm, reassuring and accurate communication with residents, their families and other stakeholders. Acknowledge the seriousness of the situation and the feelings of fear and anxiety that might produce. Share only the facts from trusted sources.
- Keep residents and employees informed if a case of COVID-19 is identified in the LTCF.
- Describe what actions the facility is taking to protect them, including answering their questions and explaining what they can do to protect themselves and their fellow staff and residents.
- HCW should monitor Public Health information to understand COVID-19 activity in their community to help inform their evaluation of individuals with unknown respiratory illness. If there is transmission of COVID-19 in the community, in addition to implementing the precautions described above for residents with acute respiratory infection, facilities may also consult with public health authorities for additional guidance if required.

Cohorting:

- Plan for and actively identify dedicated employees to care for COVID-19 patients and provide infection control training.
- Actively cohort staff, so one group cares for the ill residents and a second cohort cares for the non-ill residents on the affected unit/wing.
- During an outbreak, establish dedicated teams of staff specific to residents with suspected or confirmed COVID-19, to reduce the risk of further transmitting infection in the LTCF.
- Staff and residents should not move from one area or unit to another but remain within their units to prevent possible spread of illness.
- In cases where physical distancing is very challenging (as with those with cognitive difficulties), every effort should still be made to limit the resident's interaction and close contact with other residents and staff outside their unit. This may require having dedicated staff control movements of the resident if necessary.
- Residents suspected or confirmed to have COVID-19 should be cared for in single rooms with a dedicated bathroom.
- Roommates of symptomatic residents should not be moved to new shared rooms, and instead should be moved to a new single room for isolation and monitoring for symptoms
- Public Health will provide direction regarding use of masks for residents.
- Perform a risk assessment to determine resident placement and/ or suitability for cohorting when single rooms are limited.
- When cohorting each resident must be isolated separately. Hand hygiene and a change of gown and gloves is required between contact with each resident and/or a resident's environment.

Admissions, Readmissions, Transfers:

- **New admissions and readmissions:**
  - Admission of an actively ill resident diagnosed with COVID is not recommended. The Regional Health Authorities (RHA) will apply screening tool on patients before considering transfer to Nursing Home.
  - For other new admissions or readmissions of asymptomatic residents who are not suspected or confirmed cases of COVID-19, access points should allow for rapid placement of residents being admitted from the community or returning from another facility, and they should be given a mask during transfer.
    - Residents entering LTC facilities no longer require isolation in the yellow phase, whether they are transferring from another facility or entering from community. Restrictions would be implemented once again in an orange or red phase. It was recognized that a clear communications strategy is required, and facilities will need to clearly understand how restrictions will scale up/scale down in the phases. Standard screening of residents will continue, twice a day.
  - In cases where isolating new admissions is very challenging (as with those with cognitive difficulties), every effort should still be made to limit the resident's interaction and close contact with other residents and staff. This may require having dedicated staff control movements of the resident if necessary.
  - If suspect COVID-19 then activate Droplet and contact precautions.
  - New admissions should be preferentially admitted to a single room if available or semi-private with curtains drawn between beds, maintaining at least 2 metres between residents.
  - Should avoid readmitting residents who have not had COVID-19 into a facility where there is a case of COVID-19. Consult with the RMOH.

- **Transfer:**

  - Movement/ transport of residents with suspected or confirmed COVID- 1 9 should be restricted to essential medical reasons.
  - If a resident has to be transferred to an acute care facility for a medically necessary, test/procedure they will not be subject to 14 days of self isolation upon return.
  - It is more important than ever that an evaluation be conducted prior to each decision to transfer a resident from a nursing home to a hospital.
  - All efforts should be explored to provide care to residents in the LTCF that complement their individualized care plan.
  - Transfers to hospital only should be considered after all options to place the additional resources required to enhance care in place have been explored and the transfer to the hospital has to occur to meet the resident's goals of care.
  - Transfers to the hospital should be limited to the provision of acute care services that may not be delivered in the nursing home setting even with supplementary resources.
  - Examples may include, but are not limited to, mechanical ventilation requiring admission to an Intensive Care Unit, acute cardiac or cerebrovascular events requiring critical care treatments and other acute care services requiring specialized interventions.
  - Notify facilities and Ambulance NB prior to transferring a resident with an acute respiratory illness, including suspected or confirmed COVID-19, to a higher level of care

and advise of the required precautions for the resident being transported.
- Residents with confirmed or suspected COVID-19 infection should stay in their room unless there is essential need for movement and/or transport, and until they are considered non-infectious by the RMOH.
- If residents with confirmed or suspected COVID-19 must leave their room for medically necessary care or treatment:
  - They should be provided with clean attire, be accompanied by staff, wear a mask.
  - They should be instructed to perform hand hygiene (with assistance as necessary) and avoid touching surfaces or items outside of the room.
  - Wheelchairs or transport stretchers should be cleaned and disinfected prior to exiting the resident's room.
  - Attention should be paid to cleaning and disinfection of any surfaces that may be touched by the resident while out of the room.
  - Droplet and Contact precautions should be maintained by staff during resident transport, and the need for Droplet and Contact precautions should be communicated to the transferring service and receiving unit ahead of transfer.

Communal / Social Activities:

- Cancel or re-schedule all social/group activities during an outbreak.
- If there are suspected or confirmed cases of COVID-19 in the LTCF:
  - Serve residents individual meals in their rooms while ensuring adequate monitoring and supervision for all residents.
- Non-essential outings should be carefully planned and may occur in non-outbreak situations.
- The Regional Medical Officers of Health recommends that the gold standard is to maintain a physical distance of 2 metres between all residents and staff but consider not imposing the 2 metre physical distancing (based on the current recovery phase) if the bubble concept can be applied by keeping the same group of residents (maximum 10) together for social activities and dining with dedicated staff (cohorting of staff).
  - In non- outbreak situations, restrict group activities to 10 or less people where physical distancing does not need to be maintained.
  - Residents and staff should separate into groups, ideally of ten or less when coming together for meals or in common areas.
  - Physical distancing (at least 2 metres) should be maintained between residents that are not part of a determined bubble.
- Ensure that when isolating residents that consideration is given to the potential impact this may have on resident physical, social and emotional well-being. Consider use of one-on-one programs and use of technology to allow resident contact with family or friends.
- Any resident activities in the LTCF should ensure that any materials (e.g. electronic tablets or other devices, craft supplies, bingo cards, magazines, books, cooking utensils, linens, tools) are not shared among residents unless they are cleaned and disinfected between uses for each resident. If the items cannot be easily cleaned and disinfected, they should not be shared among residents.

Care of Deceased Bodies:

- Routine Practices should be used properly and consistently when handling deceased bodies or preparing bodies for autopsy or transfer to mortuary services. Communicable disease regulations should be followed.
- Droplet and Contact precautions should be used for known cases of COVID-19.

Environmental Cleaning and Disinfection:

- Refer to Appendix K.
- Clean and disinfect residents' rooms twice a day with special attention to all horizontal and frequently touched surfaces for the duration of illness.
- Ensure all staff responsible for environmental cleaning adhere to required cleaning and disinfection practices.
- 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.
- Environmental disinfectants should be classed as a hospital grade disinfectant and registered in Canada with a Drug Identification Number (DIN) and labelled as effective for both enveloped and non-enveloped viruses. In the event that commercially-prepared hospital disinfectants are not available, LTCF may use a diluted bleach solution to disinfect the environment. When using bleach, cleaning must precede disinfection. See Appendix K.
- All resident room and central area surfaces, that are considered "high touch" (e.g. telephone, bedside table, overbed 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) should be cleaned and disinfected at a minimum of twice daily and when soiled. Hospital grade disinfectant (e.g., disinfectant wipes) using the recommended contact time should be used to disinfect smaller resident care equipment (e.g., BP cuffs, electronic thermometers, oximeters, stethoscope) after each use.
- In addition, room cleaning and disinfection should be performed at least once per day on all low touch surfaces (e.g., shelves, bedside chairs or benches, windowsills, headwall units, overbed light fixtures, message or white boards, outside of sharps containers). Floors and walls should be kept visibly clean and free of spills, dust and debris.
- All reusable equipment should be dedicated to the use of the resident with suspect or confirmed COVID-19 infection. If this is not feasible, equipment should be cleaned and disinfected with a hospital grade disinfectant before each use on another resident. Single-use disposable equipment and supplies should be discarded into a no-touch waste receptacle after each use.
- Ensure terminal cleaning and disinfecting of resident's room following discharge, transfer, or discontinuation of the Droplet Contact Precautions.
- Toilet brushes, unused toilet paper and other disposable supplies should be discarded. Privacy curtains should be removed and laundered upon a resident's discharge or transfer.
- At discharge, room transfer or death of a resident any resident-owned items (e.g. clothing, photos, televisions, furniture, cards and ornaments) should be removed, any items with hard surfaces cleaned, and placed in a bag for family or representative. While risk of transmission of COVID-19 via these 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 LTCH or another resident, they must first be thoroughly cleaned and disinfected.
- 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) should be cleaned and disinfected at least daily and when soiled. Staff should ensure that hands are cleaned before touching the above-mentioned equipment.

Resident care equipment:

- Ensure all staff responsible for utilizing resident care equipment is adhering to required cleaning and disinfection practices. All reusable equipment and supplies, electronics, personal belongings, etc., should be dedicated to the use of the resident with suspect or confirmed COVID-19 infection.
- All care equipment (e.g., thermometers, blood pressure cuff, commodes, etc.) used with an ill resident should be dedicated to that resident. If use with other residents is necessary, the equipment and supplies should be cleaned and disinfected with a hospital disinfectant before reuse.
- Items that cannot be appropriately cleaned and disinfected should be discarded upon resident transfer or discharge.
- Single person/resident devices are discarded after use with one resident (may be more than one use).
- Single use devices are discarded in a waste receptacle after a single use on one resident.

Linen, dishes and cutlery:

No special precautions are recommended. Routine Practices are used.

If laundry of a confirmed case is done within the home:

- Contaminated laundry should be placed into a laundry bag or basket with a plastic liner and should not be shaken.
- Gloves and a medical/procedure mask should be worn when in direct contact with contaminated laundry.
- Clothing and linens belonging to the ill person can be washed together with other laundry, using regular laundry soap and hot water (60-90°C).
- Laundry should be thoroughly dried.
- Hand hygiene should be performed after handling contaminated laundry and after removing gloves.
- If the laundry container comes in contact with contaminated laundry, it should be disinfected.

Waste management:

No special precautions are recommended; Routine Practices are used.

HVAC, air conditioners, fans:

- If a change in airflow is required, consult with facility maintenance and operations.
- Increasing air circulation (exchanges) and ventilation in patient areas, such as opening windows in non-restricted areas only and using well-maintained heating, ventilating and air conditioning (HVAC) systems to circulate air, can help improve air quality. Refer to CSA Standards (Z8000, Z317.13-17) and CSA HVAC Standard (Z317.2-19) for information on infection control during construction, renovation, and maintenance of health care facilities.
- Depending on the environment, propping doors and opening windows can cause positive airflow pressure and may cause imbalances in mechanical airflow throughout healthcare facilities (similar to those of portable fans).
- The use of portable fans can promote the spread of dust, debris and microorganisms through the air and can pose a risk to patients, staff, and visitors. They can also disturb the normal air flow within a room or patient care area, altering the expected air flow pattern.
    - It is highly recommended that portable fan use is not be permitted in: Patient Isolation Room where any transmission -based precautions are in place, whether single or multi-bed room, or Airborne Infection Isolation Room
    - If the patient is in a private/single room; or in a curtained bed space and not on any additional precautions, then the use of a portable fan is acceptable. Alternative cooling methods should be attempted first, the use of the fan is determined to be of benefit to the patient's clinical condition or well-being, and is approved for use by facilities maintenance and operations,
- Alternate cooling methods to portable fans, or opening doors or windows include: cleanable window coverings, cool washcloths, ice packs, or portable patient cooling blankets (where available).

Declaring an outbreak over:

The Regional Medical Officer of Health will declare the end of the outbreak at the appropriate time. Different jurisdictions adopt different definitions to declare an outbreak over. A prudent approach is recommended.

Declare end of outbreak after two incubation periods after resolution of the last case in the facility or 28 days with no new cases after resolution of the last case (usually 14 days after the onset of symptoms). De-escalation of COVID-19 outbreak control measures can be initiated towards the end of the outbreak as described in the reference guide *De-escalation of COVID-19 Outbreak Control measures in Long-Term Care and retirement Homes*. Prevention and control measures can start to soften 14 days (maximum incubation period) from the last of:

- end of isolation (resolution) date of the last resident case; or
- date of the last shift for the last staff case

Each situation should be managed on a case by case basis by the outbreak team and the RMOH can declare the outbreak over after a shorter or longer period. Repetition of PCR (massive testing or testing selected asymptomatic staff and residents) makes it possible to clarify when the outbreak can be declared complete.

Appendix A: A Nursing Home Assessment and Testing COVID Pathway

Assessment and Testing (See Appendix D: Nursing Home COVID-19 Assessment and Testing Flowchart)

If a patient meets the signs and symptom as per this guideline from the Office of the Chief Medical Officer of Health (OCMOH) or if RMOH recommends massive testing or other asymptomatic testing :

1. Apply isolation procedures on resident and follow all instructions in *Coronavirus (COVID-19) Guidance for Long Term Care Facilities* issued by Public Health (hereafter referred to as G*uidance*)
2. Follow procedures with the resident's primary care provider to obtain an order for testing.
3. May consult MOH to determine if rapid testing is indicated. Report to the Regional Medical Officer of Health (within 1 hour) and follow instruction.
4. Notify the Major Incident Line (within 24 hours) as per Nursing Home Standard.
5. Swab resident using appropriate technique for the type of swab available to you using personal protective equipment as per the G*uidance*. A video on the technique is available at the link below. Note that some of the transport media available needs to be kept refrigerated at all times.
   https://www.paho.org/hq/index.php?option=com_content&view=article&id=7918:2012-videos-sample-collection&Itemid=40295&lang=pt
6. Complete *COVID 19 Combined Referral and Lab Requisition Form,* last version *(Appendix L)* in its entirety (including ordering physician). Send a copy to the lab and to regional public health.
7. Follow the instructions in *COVID 19 Specimen Collection and Transportation,* latest version *(Appendix M)* procedure for packaging and transfer of specimens.

Note: Nursing home staff are expected to complete the specimen collection. If unable to do so:

- In **Vitalité Health Network (VHN) regions and self-identifying francophone Nursing Homes in Moncton**, complete *COVID 19 Screening Tool General Referral Form*, latest version, 2020 (Appendix L) and fax to clinic closest to nursing home (see form)
- In **Horizon Health Network (HHN) regions and self-identifying anglophone nursing homes in Moncton**, complete the *COVID 19 Combined Referral and Lab Requisition Form latest version (*Appendix L*)* in its entirety (including ordering physician and fax to dispatch centre (number on bottom of form) and identify that this is a nursing home request requiring mobile testing for the resident. The dispatch centre will promptly forward the request to the appropriate assessment centre for mobile dispatch.
- **For Appendix L ensure identification of specific nursing home.**

Test Results and Care

1. Test results will be given by the RMOH or designate although individuals can also obtain their own results in the COVID tracker.
2. If the test result is positive, continue isolation until the resident is cleared.
3. If the test result is negative but the resident is a ***contact of someone*** with the coronavirus, continue isolation for 14 days (timed from the first day of onset of symptoms for the person with symptoms) or as recommended by RMOH. If the resident's condition gets worse, they may need to be retested.

4. If the test result is negative but COVID-19 is suspected (but the resident is not a contact of someone with coronavirus), discuss with the Regional Medical Officer of Health to determine when to discontinue isolation.
5. Care is to be given on site at the Nursing Home unless the physician determines that resident's condition requires acute care. Physician's order will be required prior to arranging such transfer. In this event, ensure there is communication that this is a probable or confirmed case to ambulance services and the hospital emergency department.

Obtaining Test Kits

Test/Collection Kits are available at the regional labs (see table below). The regional labs will allow each nursing home to have one test kit as stock. When used for a resident and specimen taken to the closest regional laboratory, the laboratory will give the nursing home a new kit in exchange.

Vitalité Health Network Labs	Horizon Health Network Labs
Dr. Georges L.-Dumont University Hospital Center (Moncton)	The Moncton Hospital
Hôpital Régional d'Edmundston	Saint John Regional Hospital
Hopital Régionl de Campbellton	Dr. Everett Chalmers Hospital (Fredericton)
Hôpital Régional de Chaleur (Bathurst)	Miramichi Hospital

Appendix B: Public Health Communicable Disease Team Contact List

Contact information for the RHA Public Health Offices is listed below and is also available on the Office of the Chief Medical Officer of Health's website: https://www2.gnb.ca/content/gnb/en/departments/ocmoh/healthy_people/content/public_health_clinics.html

Department of Public Safety Public Health Inspectors	Regional Health Authority Public Health Nurses
Central Region Fredericton (Regular hours): Main office (506) 453-2830 Communicable Disease Line (506) 444-5905	**Zone 3** Fredericton (Regular hours): Main office (506) 453-5200 Communicable Disease Line (506) 444-5905
Central Region After Hours Emergency Number 1-506-453-8128	
South Region Saint John (Regular hours): Main office (506) 658-3022 Communicable Disease Line (506) 658-5188	**Zone 2** Saint John (Regular hours): Main office (506) 658-2454 Communicable Disease Line (506) 658-5188
South Region After Hours Emergency Number 1-506-658-2764	
East Region Moncton (Regular hours): Main office (506) 856-2814 Communicable Disease Line (506) 856-3220	**Zone 1** Moncton (Regular hours): Main office (506) 856-2401 Communicable Disease Line (506) 856-3220 **Zone 7** Miramichi (Regular hours): Main office (506) 778-6756 Communicable Disease Line (506) 778-6104
East Region After Hours Emergency Number 1-506-856-2004	
North Region Edmundston (Regular hours): Main office (506) 737-4400 Campbellton (Regular hours): Main office (506) 789-2549 Bathurst (Regular hours): Main office (506) 549-5550	**Zone 4** Edmundston (Regular hours): Main office: (506) 735-2065 Communicable Disease Line: (506) 735-2626 **Zone 5** Campbellton (Regular hours): Main office phone number: (506) 789-2266 Communicable Disease Line (506) 790-4769 **Zone 6** Bathurst (Regular hours): Main office phone number: (506) 547-2062 Communicable Disease Line (506) 547-2062
North Region After Hours Emergency Number 1-506-789-2428	

Note: Regular hours are 8:15 am - 4:30 pm Monday-Friday.

The after-hours emergency number is to report notifiable diseases after 4:30 pm on weekdays and on the weekends and holidays. The pager is intended for emergency reporting only – operators are asked to keep the after-hours pager number confidential within the facility (only for operators and staff).

Appendix C: Sample COVID-19 Investigation Line Lists

A strong line listing of COVID-19 cases is very helpful in both identifying an outbreak and then monitoring and managing that outbreak.

Line list – Respiratory Outbreaks in Long-Term Care Facility

Date of initial report: _____ **Facility name:** _____

Person responsible: _____ **# wings in facility**: _____ **# residents /wing**: _____

*****Check appropriate box for this line list:** **Employees**† **Residents**† N**ame of wing** _____

Case Identification									Symptoms																		Complications				Diagnostic Tests				Treated / Prophyl			
Case No.	Resident's initials and room number / wing	Sex F/M	Age	Co-Morbidities	Health care plan	Consent provided for testing (Yes/No)	Date of onset of first symptoms (d/m)	Date of resolution of symptoms (d/m)	Fever or signs of fever	Shortness of breath	New or worsening cough	Dry cough (new)	Productive cough (new)	Nasal congestion	Runny nose / sneezing	Hoarseness/diff. swallowing	Shivers	Myalgia (new onset)	Fatigue (new onset)	Diarrhea	Nausea/Vomiting	Loss of taste or smell	Sore throat	Headache	Anorexia	Other – see legend	Bronchitis – date (d/m)	Pneumonia – date (d/m)	Hospitalization – date (d/m)	Death – date (d/m)	Swab done: Nasopharyngeal -NP/ Throat / GeneXpert	Result – date (d/m)		Other test - result		Flu vaccine – date (d/m)	Pneumovax 23 – Y / N	Antibiotic – date (d/m)

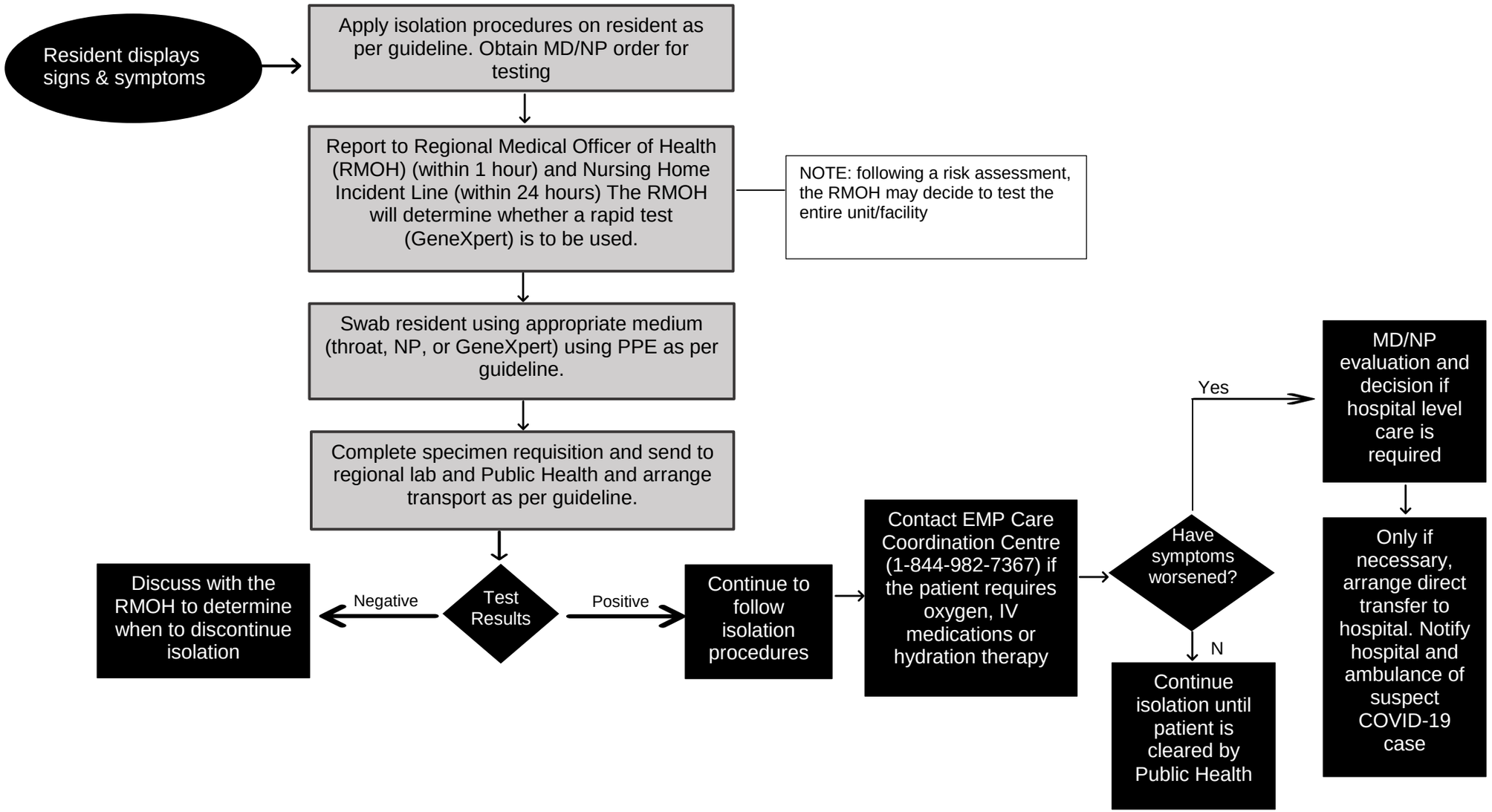
Case Identification									Symptoms																			Complications				Diagnostic Tests				Treated / Prophyl			
Case No.	Resident's initials and room number / wing	Sex F/M	Age	Co-Morbidities	Health care plan	Consent provided for testing (Yes/No)	Date of onset of first symptoms (d/m)	Date of resolution of symptoms (d/m)	Fever or signs of fever	Shortness of breath	New or worsening cough	Dry cough (new)	Productive cough (new)	Nasal congestion	Runny nose / sneezing	Hoarseness/diff. swallowing	Shivers	Myalgia (new onset)	Fatigue (new onset)	Diarrhea	Nausea/Vomiting	Loss of taste or smell	Sore throat	Headache	Anorexia	Other – see legend	Bronchitis – date (d/m)	Pneumonia – date (d/m)	Hospitalization – date (d/m)	Death – date (d/m)	Swab done: Nasopharyngeal -NP/ Throat / GeneXpert	Result – date (d/m)		Other test - result		Flu vaccine – date (d/m)	Pneumovax 23 – Y / N	Antibiotic – date (d/m)
Comments																																						

***Please indicate the month and circle the day of the month you are sending the report to us MONTH_____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

(Legend) other symptoms: Breathlessness (B)– Confusion (C) – Drowsiness (DR) – Cutaneous eruption (CE) – Abdominal pain (AP)

Appendix D: Nursing Home COVID Assessment and Testing Flowchart



Appendix E: Self Screening Questions for essential workers / visitors / volunteers for entry to facility

PLEASE DO NOT ENTER THE BUILDING WITHOUT ANSWERING THE FOLLOWING QUESTIONS

1. **Do you have** two or more of the following symptoms:

- Fever above **38°C** or signs of fever (such as chills)
- new cough or worsening chronic cough
- runny nose
- headache
- sore throat
- new onset of fatigue
- new onset of muscle pain
- diarrhea
- loss of taste or smell

2. **Are you under the age of 18 and experiencing purple fingers or toes?**

3. **Have you returned from travel outside of Atlantic Canada (New Brunswick, PEI, Nova Scotia, Newfoundland and Labrador** and the following communities in Quebec: Temiscouata Regional County municipality, Avignon Regional County municipality and Listuguj First Nation, https://www2.gnb.ca/content/dam/gnb/Corporate/pdf/EmergencyUrgence19.pdf**) within the last 14 days?**

You may be exempt if live in or near an interprovincial border community and commute to and from work locally.

4. **Have you had close contact within the last 14 days with a confirmed case of COVID-19 while outside the facility and without consistent and appropriate PPE?**

If you answered YES to question 1,2, 3, or 4 self-isolate at home. If you have or develop symptoms, call 811 or for staff 1-833-475-0724.

5. **Have you been diagnosed with COVID-19 in the last 14 days?**

If you answered YES to question 5, you should be self-isolating for 14 days.

6. Have **you** had contact within the last 14 days with a person being tested for COVID-19?

If you answered YES to question 6 you may enter the building however you must self-monitor for symptoms. If symptoms develop, self-isolate and call for testing.

For staff during an outbreak:

7. Have **you** had close contact **while wearing appropriate PPE** within the last 14 days with a person being tested for COVID-19?

If you answered YES to question 7, you may enter the building however you must self-monitor for symptoms. If symptoms develop, self-isolate and call for testing.

8. Have you had close contact within the last 14 days **without consistent and appropriate PPE** with a person being tested for COVID-19?

If you answered YES to question 8, you may not enter the building, you should self- monitor at home until COVID-19 is ruled out or confirmed.

Appendix F: Hand Hygiene for Health Care Workers (HCWs)

Hand hygiene is the single most effective measure to prevent the transmission of Health Care Associated Infections (HCAI). It has been documented that HCAIs kill 8,000-12,000 Canadians every year. Good hand hygiene saves lives and reduces the strain on our healthcare system.

Hands must be cleaned at the point of care and it is crucial that hand hygiene is performed at these 4 critical times:

- Before initial resident/resident environment contact.
- Before aseptic procedure.
- After body fluid exposure risk.
- After resident/resident environment contact.
- Personal hand hygiene should also be performed:
- Before assisting residents with feeding
- Before and after preparing food
- After using the toilet
- After blowing your nose, coughing or sneezing
- If there is visible soiling, hands should be washed with soap and water.

Follow these simple instructions when washing your hands with soap and water:

- Wet hands with warm water.
- Apply soap and rub for 15 - 20 seconds – all surfaces including front and back of hands, between fingers, around nails (especially cuticles), thumbs and wrists.
- Rinse well.
- Dry with a paper towel.
- Turn off faucet without re-contaminating hands, for example, use towel to turn off taps.

Follow these simple instructions when using an alcohol-based hand rub:

- Apply a measured pump of the product (enough of the product to cover all surfaces of the hand) into your open palm.
- Rub into hands covering all surfaces including front and back of hands, between fingers, around nails (especially cuticles), thumbs and wrists.
- Rub until dry.

Hands must be fully dry before touching the resident or the environment/equipment for the alcohol-based hand rub to be effective and to eliminate the extremely rare risk of flammability in the presence of an oxygen- enriched environment.

Appendix G: Hand Hygiene for Residents

Hand washing is the single best way to prevent spread of infection. It is estimated that 80% of common infections such as the cold and flu are spread by unwashed hands. Good hand washing technique is easy to learn.

If there is visible soiling, hands should be washed with soap and water.

Follow these simple instructions when washing your hands with plain soap and water:

- Wet hands with warm water.
- Apply soap and rub for 15 - 20 seconds – all surfaces including front and back of hands, between fingers, around nails (especially cuticles), thumbs and wrists.
- Rinse well.
- Dry with a paper towel.
- Turn off faucet without re contaminating hands, for example, use towel to turn off taps.

Follow these simple instructions when using an alcohol-based hand rub:

- Apply a measured pump of the product (enough of the product to cover all surfaces of the hand) into your open palm.
- Rub into hands covering all surfaces including front and back of hands, between fingers, around nails (especially cuticles), thumbs and wrists.
- Rub until dry.
- If using an alcohol-based hand rub, remember alcohol is flammable.

When to clean your hands:

- Before meals
- Before and after preparing food
- Before and after visiting our residents
- Before and after visiting with people who are sick
- After using the toilet
- After blowing your nose, coughing or sneezing

Appendix H: Eye Protection, Surgical/Procedural Masks & Gloves

Eye Protection

Eye protection is recommended to protect the mucous membranes of the eyes during case/probable case/suspect case care or activities likely to generate splashes or sprays of body fluids including respiratory secretions.

- Eye protection should be worn over prescription eye glasses. Prescription eye glasses alone are not adequate protection against respiratory droplets.
- Protective eye wear should be put on after putting on a mask.
- After applying eye protection, gloves should be donned (see below).
- To remove eye protection, first remove gloves and perform hand hygiene. Then remove the eye protection by handling the arms of goggles or sides or back of face shield. The front of the goggles or face shield is considered contaminated.
- Discard the eye protection into a plastic lined waste container. If the eye protection is not intended for single use, clean it with soap and water and then disinfect it with a bleach solution. Refer to Appendix K.
- Perform hand hygiene.

Surgical / Procedure Masks

Face masks (surgical / procedure masks) provide a physical barrier that may help prevent the transmission of the virus from an ill person to a well person by blocking large particle respiratory droplets propelled by coughing or sneezing. However, using a mask alone is not guaranteed to stop infections and should be combined with other prevention measures including respiratory etiquette and hand hygiene.

Applying a consistent approach to putting on and taking off a mask are key in providing overall protective benefits. The following steps will help to ensure masks are used effectively:

- Before putting on a mask, wash hands with soap and water or ABHS. The mask should be worn with the coloured side facing out.
- Cover mouth and nose with mask and make sure there are no gaps between your face and the mask, press the mask tight to your face using your fingers to secure along the perimeter of the mask, pressing firmly over the bridge of your nose. Wash hands again with soap and water or ABHS.
- Avoid touching the mask while using it; if you do, clean your hands with soap and water or alcohol-based hand sanitizer.
- If re-wearing of masks is recommended, staff must remove their mask by the ties or elastics taking care not to touch front of mask, and carefully store the mask in a clean dry area, taking care to avoid contamination of the inner surface of the mask, and perform hand hygiene before and after mask removal and before putting it on again
- Masks should be disposed of and replaced when they become wet, damp, or soiled or when they come in direct contact with a resident.
- To remove the mask, remove both straps from behind the ears. Do not touch the front of mask and ensure that the front of the mask does not touch your skin or any surfaces before you discard it immediately in a closed waste container. Wash hands with alcohol-based hand rub or soap and water.

Gloves

Disposable single use gloves should be worn when in direct contact with the ill person, cleaning contaminated surfaces, and handling items soiled with body fluids, including dishes, cutlery, clothing, laundry, and waste for disposal. Gloves are not a substitute for hand hygiene; caregivers must perform hand hygiene before and after putting on and taking off gloves.

- Gloves should be removed, hand hygiene performed, and new gloves applied when they become soiled during care.
- To remove gloves safely, with one of your gloved hands pull off your glove for the opposite hand from the fingertips, as you are pulling, from your glove into a ball within the palm of your gloved hand. To remove your other glove, slide your ungloved hand in under the glove at the wrist and gently roll inside out, and away from your body. Avoid touching the outside of the gloves with your bare hands.
- Gloves must be changed, and hand hygiene performed when they are torn.
- Discard the gloves in a plastic-lined waste container.
- Perform hand hygiene.
- Double-gloving is not necessary.

Reusable utility gloves may be used; however, they must be cleaned with soap and water and decontaminated after each use. Refer to Appendix K.

Appendix I: Routine Practices and Point of Care Risk Assessment

Routine Practices include:

1. A point of care risk assessment (see below) of the resident and the planned interaction is completed prior to each interaction.
2. Hand hygiene before and after physical contact with the resident and / or with the resident's environment
3. Hand hygiene by residents and visitors. Residents may require assistance from health care providers
4. Use of barriers to prevent HCW contact with blood, body fluids, secretions, excretions, non-intact skin or mucous membranes (e.g. gloves, gown, mask, eye protection).
5. Single room and private toileting facilities for residents who soil the environment with blood, body fluids, excretions or secretions.
6. Safe handling of sharps to prevent injury including the use of safety-engineered devices and the provision of sharps containers at point-of-care where required.
7. Safe handling of soiled linen and waste to prevent exposure and transmission to others
8. Cleaning and disinfection of equipment that is being used by more than one resident between residents.
9. Respiratory Hygiene
    - Post signage at facility entrances re performing hand hygiene and donning a surgical/procedure mask if sneezing or coughing
    - Use disposable tissues for wiping nose
    - Cover both mouth and nose with disposable tissues when coughing or sneezing
    - Discard tissues after one use into a hands-free receptacle
    - Sneeze and cough into sleeve or shoulder when tissues are not available rather than the bare hand
    - Perform hand hygiene immediately after coughing, sneezing or using tissues
    - Turn head away from others when coughing or sneezing
    - Keep hands away from the mucous membranes of the eyes and nose
    - Maintain a spatial separation of 2 meters between residents symptomatic with an acute respiratory infection (new cough/shortness of breath and fever) and those who do not have symptoms of a respiratory infection.

Point of Care Risk Assessment (PCRA):

Prior to any patient interaction, all HCWs have a responsibility to assess the infectious risks posed to themselves, other HCWs, other patients and visitors from a patient, situation or procedure.

- The PCRA is based on the HCWs professional judgment (i.e. knowledge, skills, reasoning and education) about the clinical situation as well as up-to-date information on how the specific acute healthcare facility has designed and implemented engineering and administrative controls and the use and availability of PPE.
- PCRA is an activity implemented by the HCW in any acute healthcare facility to:
    - Evaluate the likelihood of exposure to them and others to infectious agents (e.g., COVID-19)

        - for a specific interaction,
        - for a specific task,
        - with a specific patient,
        - in a specific environment, and
        - under available conditions.
    - Select the appropriate actions and/or PPE to minimize the risk of exposure for the specific patient, other patients in the environment, the HCWs, visitors and others.

A PCRA includes determining if there may be:

- Contamination of skin or clothing by microorganisms in the patient environment
- Exposure to blood, body fluids, respiratory secretions or excretions
- Exposure to contaminated equipment or surfaces

Patient factors include:

- Patient's volume of respiratory secretions, and ability to control secretions and cough.
- Patient's ability to comply with IPC practices (e.g., hand hygiene, wearing a mask, respiratory hygiene or other IPC precautions).
- Patient in an intensive care unit or other designated area for COVID-19 patients or requiring extensive hands-on care.

PPE should always be used as determined by PCRA for routine practices, as outlined in droplet and contact precautions and for airborne precautions when AGMPs are anticipated or are being performed.

Appendix J: Droplet Contact Precautions for Nursing Homes

- Perform a point of care risk assessment to determine appropriate accommodation.
- Prioritize residents who cannot be confined to their bed/bed space maintaining spatial separation of ≥ 2 meters from others for a private room / private Bathroom
- In shared accommodations the privacy curtains must remain pulled
- The resident's door may remain open if the distance from the resident to the door is ≥ 2 meters
- Cohorting of residents may be required.

Personal Protective Equipment

- Gloves for entry into the room, cubicle or bed space if a shared room
- Surgical/procedure mask for activity within 2 meters
- Eye Protection for activity within 2 meters. Prescription eye glasses do not provide protection
- Long sleeved gowns if it is anticipated that clothing or forearms will be in direct contact with the resident, environmental surfaces, or objects within the resident, environmental
- Instruct visitors on necessary infection control measures including:
  - How to put on and remove isolation attire
  - Hand Hygiene (alcohol-based hand rub and/or soap and water)

Hand Hygiene

- Most important measure to prevent spread of infection,
- Clean hands before and after contact with the resident and/or resident's environment with alcohol-based hand rub or with soap and water
- Do not use the resident's bathroom sink for hand hygiene.

Isolation Supplies

- Alcohol based hand rub 60 – 90% (minimum of 70% alcohol is method of choice for hand hygiene in all healthcare facilities)
- Long sleeved isolation gowns
- Gloves
- Eye protection
- Surgical / procedure mask
- Dedicated thermometer
- Stethoscope
- Laundry hamper
- Waste containers
- Specimen bags
- Pen
- Post-it notes
- Isolation Signage (Droplet Contact Precautions)
- Approved disinfectant for equipment cleaning (e.g. accelerated hydrogen peroxide)

Resident Care Supplies

- Limit the disposable supplies taken into the room to the amount anticipated for use
- Disposables not used cannot be returned to stock. If not used by this resident, they must be discarded
- Provide the resident with tissues, a waste container for used tissues and a mechanism to perform hand hygiene following coughing/sneezing.

Isolation Room Set up

- Post signs with the required precautions (both official languages) outside the resident room— must be clearly visible
- Waste can and laundry hamper in resident room
- Ensure that the resident can dispose of used tissues
- Set up the personal protective supplies outside the resident room (anteroom or corridor).

Enter/Exit Room Procedure

Before entering room, cubicle, or bed space in a shared room:

- Perform hand hygiene
- Put on gown— if required
- Put on surgical/procedure mask
- Put on eye protection ▪ Put on gloves.

To exit room:

- PPE is removed prior to exiting the room
- Remove gloves and dispose
- Remove gown (if worn), touching only the inside of gown and place in hamper
- Perform hand hygiene
- Remove eye protection (front of eye protection is contaminated)
- Remove mask-remove by ties (front of the mask is contaminated)
- Perform hand hygiene.

Note: Re-usable eye protection must be cleaned and disinfected after each use

Charting

Do not take any part of the resident chart into the room to transfer information from the resident room:

- Keep dedicated pen and post-it notes inside resident room
- Write information on post-it and stick on window/door of resident room
- Exit the resident room following the Enter/Exit Room Procedure
- Use another pen outside the room to record information on chart/paper.

Equipment

- Use disposable equipment, when possible.
- Dedicate reusable equipment to this resident and leave in room.
- Clean and disinfect reusable equipment before removing from the room.

Laundry and Waste

- Tie off the laundry and waste bags before leaving the room
- Place outside the room for pick-up
- No further special handling is required for laundry and waste.

Food Trays

- Regular dishes and cutlery
- Regular dishwashing procedures.

Room Cleaning

- Twice daily cleaning and disinfection of all high touch surfaces, bed rails, light switches, bathrooms, bedside tables, walker, wheelchair, cane, and drawer handles remotes, phone, etc.
- If resident is discharged or transferred out of room, carry out discharge (terminal) cleaning (per facility policy) and discard all magazines, personal care supplies, disposable supplies, etc.

Resident Transport

Resident remains confined to room except for medically required activities.
Re-schedule all non-urgent medical appointments. If it is necessary to leave the room for tests/facility transfer/therapy:

- Sending facility must notify receiving facility of required precautions
- Transport Personnel to don Personal Protective Equipment (PPE) to enter resident room
- Resident to don a surgical/procedure mask and clean clothing
- Utilize clean linens on the clean transport-wheelchair/stretcher (the resident's linen should not be used for transport
- Assist resident with hand hygiene
- When leaving the room with the resident, transport personnel should remove PPE (gowns and gloves) and perform hand hygiene and don clean PPE. The surgical mask and eye protection do not need to be changed
- Use facility supplied disinfectant (i.e. accelerated hydrogen peroxide) to provide a clean area for hands on the transport equipment
- If equipment from the resident's room must also be transported, it must be disinfected and allowed to air dry prior to use
- Use a transport route that avoids populated areas
- Maintain ≥ 2 meters from others
- Use a dedicated elevator, with no other persons in it
- Disinfect equipment after transfer

Appendix K: Cleaning and Disinfection for COVID-19

Increasing the frequency of cleaning and disinfecting high-touch surfaces is significant in controlling the spread of viruses, and other microorganisms. All surfaces, especially those general surfaces that are frequently touched, such as door knobs, handrails, etc., should be cleaned and disinfected at least twice daily and when soiled.

When choosing an environmental cleaning product, it is important to follow product instructions for dilution, contact time and safe use, and to ensure that the product is:

- Registered in Canada with a Drug Identification Number (DIN)
- Labelled as a broad-spectrum virucide.

All soiled surfaces should be cleaned before disinfecting, unless otherwise stated on the product.

The following hard-surface disinfectant products meet Health Canada's requirements for emerging viral pathogens. These authorized disinfectants may be used against SARS-CoV-2, the coronavirus that causes COVID-19. https://www.canada.ca/en/health-canada/services/drugs-health-products/disinfectants/covid-19/list.html

If using household bleach, the following is recommended:

Disinfectant	Concentration and Instructions
Chlorine: household bleach – sodium hypochlorite (5.25%)	1000 ppm • 1 teaspoon (5 ml) bleach to 1 cup (250 ml) water or • 4 teaspoons (20 ml) bleach to 1 litre (1000 ml) water • Allow surface to air dry naturally

Precautions when using bleach

- Always follow safety precautions and the manufacturer's directions when working with concentrated solutions of bleach. To avoid injury, use appropriate personal protective equipment during handling (read the label and refer to the material safety data sheet).
- Chlorine bleach solution might damage some surfaces (e.g., metals, some plastics).
- Never mix ammonia products with bleach or bleach-containing products. This practice produces chlorine gas - a very toxic gas that can cause severe breathing problems, choking and potentially death.
- Clean the surface before using the chlorine bleach solution.
- A bottle of bleach has a shelf life, so check the bottle for an expiry date.
- Do not premix the water and bleach solution, as it loses potency over time. Make a fresh solution every day.

Appendix L: COVID 19 Combined Referral and Lab Requisition Form

COVID-19 Combined Referral and Lab Requisition Form

Patient Information

Caller Name:	Relationship with Patient:	
Patient Last Name:	Patient First Name(s):	
Cell Phone or Phone:	**Health Card Number (Medicare):**	
Email:	Include province if not NB, VAC, DND #	
Patient Address:	City:	Postal Code:
Primary Care Provider:	PCP Phone:	PCP Location:

Preferred Language ☐ English ☐ French Other:

Sex ☐ Male ☐ Female

Pregnant? ☐ Yes ☐ No

Date of Birth:_____ **Age:** _____

Guardian Name if < 16 _____

Work Location of Healthcare Professional or Staff with symptoms:

☐ EM/ANB ☐ First Responder ☐ NH/LTC/ARF ☐ Childcare centre ☐ Physician Office ☐ Other

☐ Horizon ☐ Vitalité ☐ Hospital ☐ Lab ☐ Clinic ☐ Community Health Centre ☐ Community Pharmacy

Assessment Details

➢ **Test those meeting any two of the following symptoms:**

☐ New onset fatigue ☐ Fever/chills ☐ Coryza

☐ Loss of taste or smell ☐ Headache ☐ New onset myalgia (muscle pain)

☐ Sore throat ☐ Diarrhea ☐ New onset/exacerbation of chronic cough

Date symptoms started: _____

Additional Information:

➢ **Test for those that are:**

☐ Asymptomatic (non-sentinel)

Notes:

➢ **Test Under 19 meeting a symptom:**

☐ Finger or toe vasculitis or ischemia

☐ IWK service/admission

Identify Risk Factors:

☐ Age 60+ ☐ Hypertension ☐ Chronic respiratory disease ☐ Diabetes ☐ Cancer ☐ Cardio-vascular disease ☐ Other:

Collect the following information, if applicable:

☐ Travelled outside of New Brunswick within past 14 days Location: ___Return Date: _____

☐ Contact with confirmed case within past 14 days

☐ Close contact with a person with acute respiratory illness/group exposure in last 14 days

☐ Lab exposure to biological material (e.g. primary clinical

	specimens, virus culture isolates) known to contain COVID

Referral Request Details

Name of individual completing form	**Phone number**	**Referral Date**
☐ 811 ☐ Vitalité Zone (1, 4, 5, 6) :___ ☐ Horizon Zone (1, 2, 3, 7) :__ ☐ Public Health	☐ EMP ☐ Ambulance NB ☐ DH-Call Centre ☐ Clinic/CHC	☐ Hospital/ED ☐ Provider Office ☐ Pre-Op - **Surgery Date**: ☐ Long Haul Truck Driver - **Test Location**: ☐ Correctional facility/Shelter/LTC - **Name**:

Laboratory Requisition Additional Details

Sample source: ☐ Throat ☐ Nasopharyngeal ☐ Other	**[Place copy of specimen label here]**
Collection Date (yyyy/mo/dd): Time:	Label specimen as follows: ☐ **PHPR** - PH Priority Referral ☐ **HCP** - Direct Care Healthcare Professional ☐ **HCW** - Healthcare Worker/Staff ☐ **LTC/CORR/SHELTER/DAYCARE** ☐ **HOSP** - Hospitalized patient ☐ **INDIGENOUS** – Member from Indigenous community ☐ **Long Haul Truck Drive** ☐ **Pre-Op** - Prior to Surgery
Collected by:	
Sentinel site: ☐ No ☐ Yes, SPECIFY: _____ ☐ Admission ☐ Compassionate Travel ☐ TFW ☐ Military ☐ LH Truck Driver ☐ Locum/Medical Res. / Medical Student ☐ ED ☐ Correctional Facility	
Contact Case: ☐ Yes ☐ No Test of Cure: ☐ Yes ☐ N	
Ordering Provider:	

*****Check Priority Group if Applicable *****

☐ 1. Person under investigation by Public Health	☐ 4. Patients/residents in institutional living settings
☐ 2. Healthcare professional with direct patient care/contact	☐ 5. Hospitalized patients with respiratory symptoms (new or exacerbated) and no alternative laboratory-based diagnosis
☐ 3. Staff in hospitals, nursing homes, childcare centres and institutional living settings with direct patient care/contact	☐ 6. Member of Indigenous Community

Please submit community referrals for testing to the following fax number: 1-506-462-2040 Missing information should be added at specimen collection prior to submitting the requisition to the Lab

Appendix M: COVID 19 Specimen Collection and Transportation

1. **Specimen collection kit**
   a. Level 3 NH can contact the nearest regional lab to arrange pick up of a collection kit (swab, viral transport media and requisition)

2. **Specimen collection information**
   a. Follow nasopharyngeal collection procedure
   b. After collection, send specimens to lab as quickly as possible; keep refrigerated
      i. Specimen is viable for 72hrs at 4°C; if > 72hrs, store at -70°C
      ii. Use a cooler and ice pack to maintain 4°C during transportation
      iii. Specimen frozen at -70°C should be transported on dry ice.

3. **Requisition requirements**
   The following information **must** be on the requisition for a specimen to be accepted for testing (including information required on second page of requisition form):
   a. Full Name
   b. DOB
   c. Medicare number
   d. Full address including postal code
   e. Ordering provider
   f. Date and time of collection
   g. Initials of person collecting the specimen
   h. Name of LTCF

4. **Specimen transportation needs**
   a. Include completed requisition form.
   b. Specimens must be packaged according to TDG training
   c. Anyone transporting specimens must be TDG certified
   d. Specimens must be placed in a cooler with ice pack to maintain 4°C temperature during transport.

Appendix N: List of staff, visitors and others entering facility during an outbreak.
Name of Nursing Home:

Date	Name	DOB	Tel Number	Job description	Temperature 2X/shift		Other symptoms If yes 1-833-475-0724
					Hr. Tº.	Hr. Tº.	
					Hr. Tº.	Hr. Tº.	
					Hr. Tº.	Hr. Tº.	
					Hr. Tº.	Hr. Tº.	
					Hr. Tº.	Hr Tº.	
					Hr Tº.	Hr. Tº.	
					Hr. Tº.	Hr. Tº.	
					Hr. Tº.	Hr. T.	
					Hr. Tº.	Hr. Tº.	
					Hr Tº.	Hr. Tº.	
					Hr. Tº.	Hr Tº.	
					Hr. Tº.	Hr. Tº.	

Has to be sent every morning to public health for the last 24h shift

- **To : - Fax: E-mail :**

Signature : Date :

References:

MMWR Report Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility — King County, Washington, March 2020

Public Health Agency of Canada Infection Prevention and Control for COVID-19. Interim Guidance for Long Term Care Homes

https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

https://www2.gnb.ca/content/dam/gnb/Departments/sd-ds/pdf/NursingHomes/SeasonalInfluenza.pdf

https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected

BCCDC: **http://www.bccdc.ca/Health-Professionals-Site/Documents/IPC_Guidance_Surgeries_Non-Hospital_Sites.pdf**

Vancouver Coastal Health:
http://ipac.vch.ca/Documents/Acute%20Resource%20manual/Portable%20Fans%20in%20Acute%20Care.pdf

De-escalation of COVID-19 Outbreak Control measures in Long-Term Care and retirement Homes:

https://www.publichealthontario.ca/-/media/documents/ncov/ltcrh/2020/06/covid-19-outbreak-de-escalation-ltch.pdf?la=en