Living with COVID: management of COVID-19 for New Brunswick Long Term Care Homes

Department of Social Development

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Purpose
This document is a revised version of the Living with COVID: management of COVID-19 for New Brunswick Long Term Care homes, which was first published in July 2022 and replaced the following two documents:

- Living with COVID: General LTC Guidance (for homes NOT in outbreak)
- Living with COVID: Case & Outbreak Management in LTC Homes

In addition to the information that was contained in the documents listed above, this document includes additional resources such as key contact information and information on COVID-19 prevention measures. The document has also been re-organized in the following sections for ease of use:

1. **Prevention**
2. **Case Management**
3. **Outbreak Management**
4. **Appendices**

This is a *living document* (continually edited and updated) and will be revised as new information becomes available. **Unless otherwise indicated, information contained in this guide applies to both Adult Residential Facilities (ARFs) and Nursing Homes (NHs) which will further be referred to as long-term care (LTC) Homes. Any site-specific information will be identified as Nursing Home (NH) or Adult Residential Facility (ARF) in the heading.**

Adult Residential Facilities with a license for 10 or fewer beds: An ARF with 10 or fewer residents often is structured and functions similar to a household. Moving forward, they will self-manage individual positive COVID-19 cases within their facility, or situations involving 2 or more positive individuals. Outbreaks will no longer be declared within these facilities. Best practice recommendations for case and situation management in this setting still apply and are listed in Appendix 4.1.

Resources and Contact Information

Websites	
General GNB COVID-19 Testing	COVID-19 Testing (gnb.ca)
General GNB COVID-19 Resources	Guidance and Support (gnb.ca)

Emails and Phone Numbers	
SD PPE Team	PPETeam/EquipeEPI@GNB.CA
SD COVID Response Team (SD CRT)	SD_CRT@gnb.ca
COVID-19 Vaccine Orders (for NHs)	DHvacclog@gnb.ca
Extra Mural Program- EMP Care Coordination Centre	1-844-982-7367
Public Health Numbers	(see table below)

Public Health

Regions1-7_Public- Health_Notifiable_Disease_Reportable_Events_Posters.pdf (gnb.ca)

Region		During Business Hours (8:15[1]am-4:30pm Mon-Fri)	After Business Hours (EMERGENCY only)	Fax Numbers
Central	Zone 3 (Fredericton)	CDFredVal@gnb.ca (506) 444-5905	(506) 453-8128	(506) 444-4877
South	Zone 2 (Saint John)	ComDisjPH@gnb.ca (506) 658-5188	(506) 658-2764	(506) 643-7894
East	Zone 1 (Moncton)	(506) 856-3220	(506) 856-2004	(506) 856-3544
	Zone 7 (Miramichi)	(506) 778-6104 / 778-6102		(506)778-6756
North	Zone 4 (Edmundston)	(506) 735-2626	(506) 789-2428	(506) 735-2340
	Zone 5 (Campbellton)	(506) 790-4769		(506) 789-2349
	Zone 6 (Bathurst)	(506) 547-2062		(506) 547-2208

[1] Zone 2 business hours start at 08:30

COVID-19 MANAGEMENT FOR NB LTC HOMES DOCUMENT OVERVIEW		
SECTION	**KEY INFORMATION**	**SUPPORTING INFO**
1.PREVENTION Practices and measures to be in place to prevent introduction and transmission of COVID-19.	• Immunization 1.1 • PPE 1.2 • Screening 1.3 • Testing 1.5	• Hand Hygiene 4.3 • Cleaning & disinfecting 4.5 • Re-testing 4.6 • Visitation 4.7
2. CASE MANAGEMENT Measures for individual COVID-19 cases.	• Work Exclusion 2.1 / Isolation 2.2 • Enhanced Work Precautions 2.1.1 • Treatment 2.3	• COVID-19 positive household member 2.1.2 • Admission 4.9 •
3. OUTBREAK MANAGEMENT Measures to manage a declared COVID-19 outbreak.	• General Outbreak Principles 3.1 • Outbreaks that DO NOT include at least 1 resident 3.2 • Outbreaks that included at least 1 resident 3.3	• Visitation during an outbreak 4.8 • Admission 4.9
4. APPENDICES Additional resources that may be useful.	• Management of one or more cases of COVID-19 in ARFs with 10 or fewer residents 4.1 • Posters 4.2 • Hand Hygiene 4.3 • PPE Table 4.4 • Cleaning & disinfecting 4.5	• Re-testing 4.6 • Visitation 4.7 • Visitation during an outbreak 4.8 • Admission 4.9 • POCT throat - nares swabbing guidance 4.10 • Paxlovid Tool (for use in ARFs) 4.11

1. Prevention

1.1. COVID-19 Immunization

1.1.1. Staff Immunization

It is recommended that all staff receive and remain up to date with COVID-19 vaccinations as recommended by New Brunswick Public Health. For up-to-date information pertaining to COVID-19 vaccination, please visit COVID-19 vaccines (gnb.ca)

1.1.2. Resident Immunization

New-Brunswick Public Health continues to recommend that individuals remain up to date with their COVID-19 vaccination. This means completing your primary series and getting the most recent booster offered to you. Operators/staff of ARFs and NHs should coordinate immunization for residents when they become eligible per Covid-19 vaccines (gnb).

Residents who are determined to be eligible for admission to an ARF or NH are to be admitted, regardless of their COVID-19 vaccination status.

1.2. Personal Protective Equipment (PPE)

It is recommended that LTC homes have a minimum amount of PPE on hand. Please refer to the table below for the recommended amount for a 72-hour period where outbreak measures would be in place.

Emergency PPE Recommended for 72 Hour Period

	Quantity Recommended for 72 Hours			
Number of Beds	**Face Masks**	**Isolation Gowns**	**Face Shields**	**Gloves**
10	300	300	300	1,050
30	900	900	900	3,150
60	1,800	1,800	1,800	6,300
100	3,000	3,000	3,000	10,500

1.2.1. Staff PPE

It is imperative that PPE be used correctly to protect staff and residents. Improper use of PPE can lead to rapid transmission throughout facilities. Refer to PPE Table for an overview of PPE used to prevent the spread of COVID-19.

Please note additional use of PPE may be directed by PH in certain situations or based on a point of care risk assessment.

a) **Masks:** optional for continuous use and based on PCRA. Masks are required if a staff member is on Enhanced Work Precautions, during an outbreak as per outbreak management guidelines, staff develop symptoms, or entering into an isolation room where masking is required.

b) **Eye protection:** based on PCRA, unless required during an outbreak as per outbreak management guidelines.

1.2.2. Resident Masking

Masks should be made available to residents if they wish to wear one. A resident may request to have staff wear a mask when receiving care.

1.3. Staff Screening

A facility specific policy for workplace health must include direction to not work while ill (form of passive screening). See Section 1.5. for testing. Using an established protocol when staff call in ill or become ill during their shift will ensure a healthy and productive workforce. Screening questions should include: is there anyone sick at home with COVID symptoms?" If yes, staff should follow the measures listed in section 2.1.2 Staff with Household Member who has tested positive for COVID-19 or has recent ILI symptoms). Household members of staff working in vulnerable settings should monitor for symptoms and test if symptomatic to provide additional protective measures to residents.

1.4. Resident Assessments

Residents should be assessed as clinically indicated and as per facility specific policy.

Guidance for ARF with 10 or fewer residents:

- Monitor resident's symptoms and ability to cope with illness daily. i.e., Fever, cough, or difficulty breathing, diarrhea, fatigue; and stability, alertness, intake.
- Refer to Caring for Someone with Covid-19.
- If there are concerns related to the health of the resident, contact their primary care provider. If resident does not have a primary care provider, or they are unavailable, contact EMP, ***EMP Care Coordination Center 1-844-982-7367.***
- Watch for signs that indicate immediate help is needed. Call 911* if you notice:
    - significant difficulty breathing.
    - chest pain or pressure.
    - new onset of confusion; or
    - difficulty waking up.

*Make sure you let 911 and the hospital know that you or the person you're caring for has symptoms or has tested positive for COVID-19.

1.5. Testing

COVID-19 Rapid Antigen POCT is recommended for use in symptomatic individuals only. POCT should not be used as a screening tool of asymptomatic individuals.

1.5.1 Staff Testing

Rapid antigen POCT testing should be the first choice for symptomatic staff members of NH/ARF facilities (refer to symptom checker criteria,) If clinically indicated, staff members in NH/ARFs can access PCR testing through consultation with their medical care provider. Those who do not have or are unable to contact their medical care provider may access testing through eVisitNB,

Telecare 811, or other outpatient services. PCR testing will be done at the location indicated by the Regional Health Authority (RHA). Individuals will continue to have access to PCR test results via their MyHealthNB account, as well as the ordering medical care provider. Please see Appendix: Retesting for staff who previously tested positive (PCR/POCT).

If **POCT result is positive,** follow guidance for work exclusion, found in Section 2.1. Employees/volunteers must immediately notify their employer if they receive a positive POCT or PCR test.

PH recommends the following best practices for work exclusion if **POCT is negative** for a symptomatic staff member:

- If initial POCT result is negative and symptoms persist or worsen, retest with POCT in 24 hours.
- If second test is still negative, and symptoms persist or worsen re-test in another 48 hours. If symptoms have resolved, further testing is not required, and staff member may return to work.
- If third test remains negative, staff may return to work when the individual is fever free (without fever reducing medications) for at least 24hrs, 48 hours free of vomiting or diarrhea and symptoms are improving. Follow Enhanced Precautions for 5 days after returning to work.

1.5.2 Resident Testing

Only symptomatic residents should be tested. A positive result from a PCR test or a rapid POCT test performed by trained staff or observed by a health care professional may be used to access Paxlovid. Given the changes to availability and access of PCR testing a Medical Officer of Health may manage cases and outbreaks in a vulnerable setting using POCT, Abbott ID Now, or PCR results; and/or may also determine that additional testing is required. Please see Appendix: Retesting for residents who previously tested positive (PCR/POCT).

ARFs:

Rapid antigen (POCT) testing should be the first choice when testing symptomatic residents of an ARF. An ARF operator who has concerns related to the health of a symptomatic resident should contact their medical care provider, and a PCR test may be ordered for the purposes of treatment or care. If the resident does not have a medical care provider, or they are unavailable, the operator may contact EMP Care Coordination Center to receive an onsite assessment and possible PCR testing.

PCR Testing for mobile ARF residents will be done at the location indicated by the Regional Health Authority (RHA). ARF residents who are homebound, may request the assistance of EMP if PCR testing has been ordered by a medical care provider.

NHs: Residents of NH facilities may be tested using POCT, Abbott ID Now, or PCR, at the NH's discretion, by following their usual processes; complete the combined referral and requisition form, collect sample for PCR testing and send to laboratory for processing.

ARFs and NH Testing Results

If test is positive: Positive POCT results are interpreted as being COVID positive and managed as per Section 2.2 of this document. A positive POCT result may be used to access Paxlovid treatment; PCR confirmation is not required. **If resident tests positive and an outbreak is declared, follow guidance in section 3.3.2: Resident Testing during an outbreak that includes at least one resident**

If test is negative:

- If initial POCT result is negative and symptoms persist or worsen, retest with POCT in 24 hours.
- If second test is still negative, re-test in another 48 hours. If symptoms have resolved, further testing is not required.
- If third test remains negative and symptoms continue, where possible, continue enhanced precautions until feeling better (i.e., until 24-hours fever free without fever reducing medications, 48 hours free of vomiting or diarrhea, and all symptoms improving).

1.6. Public Health Reporting

1.6.1. ARFs and NHs with greater than 10 residents: the first employee/staff person or resident testing positive with POCT/PCR shall be reported to Public Health within 24 hours. All deaths of COVID positive residents or staff who work or live in an LTC facility are required to be reported to Public Health. The LTC home must inform Public Health whether COVID was a primary or contributing factor to cause of death as per the attending physician. If in a declared outbreak, report subsequent cases once daily[2] by line list via email or fax to PH CD Team to fulfill reporting requirements, as per the Public Health Act.

1.6.2. ARFs with 10 or fewer residents: LTC home must report COVID hospitalizations and deaths to PH. Reporting should be done during PH regular business hours.

1.7. Reporting to Social Development

1.7.1. SD COVID Response Team: if Public Health declares an outbreak, please send an email to the centralized team at SD_CRT@gnb.ca as soon as possible with the following details: Name of home, date your outbreak was declared, and any questions you may have.

1.7.2. Reporting incidents as per ARF and NH standards. In addition to reporting to PH and to the SD COVID Response Team, ARFs and NHs are to continue reporting incidents as per the process and requirements from their respective standards.

[2] RMOH will specify time of day that line lists are to be received.

2. Case Management

2.1. Staff Work Exclusion

If tested & positive (POCT / PCR)	• Exclude from work for 5 days (test date is day 0) and until symptoms are improving, the individual is fever free x 24hrs (without fever reducing medications) and 48 hours free of vomiting or diarrhea. Required to use Enhanced Work Precautions for an additional 5 days after returning to work.
If Critical Staffing Shortage	• Exclude from work if symptomatic and until symptoms are improving, the individual is fever free x 24hrs (without fever reducing medications), and 48 hours free of vomiting or diarrhea. • Can return to work using Enhanced Work Precautions for the balance of 10 days from the positive test result.
If staff refuses to get tested & symptoms meet symptom checker criteria	• Exclude for 5 days and until symptoms are improving, the individual is fever free x 24hrs (without fever reducing medications) and 48 hours free of vomiting or diarrhea. • Can return to work with Enhanced Work Precautions for an additional 5 days after returning to work.

2.1.1. Enhanced Work Precautions

- Wear a well fitted medical grade mask.
- Perform hand hygiene frequently.
- Maintain physical distancing and limit non-essential contact with other staff, and residents (as able).
- Avoid meeting spaces and lunchrooms.
- Eating/drinking must be performed in a private area. If you cannot find a place to eat or drink alone, ensure there is two metre distancing from others while your mask is off or consider staggering lunch hour for staff who are positive and negative etc.
- Use washrooms within the organization which are the most frequently cleaned if a designated washroom is not possible.
- Employees should also clean high touch areas after use.

2.1.2. Asymptomatic Staff with Household Member who has tested positive for COVID-19 or has recent ILI symptoms

- No work exclusion is required
- Enhanced Work Precautions for staff member X 10 days (see note below)

NOTE: enhanced work precautions are in place for staff who have household contacts as well as staff returning to the workplace while positive for COVID-19. It is important that breaks be staggered for staff on enhanced work precautions and all enhanced work precautions followed to minimize the risk of transmission.

2.2. Resident Isolation

Residents with any COVID-19 symptoms should be placed on **contact droplet precautions**.

2.2.1. COVID-19 test result - NEGATIVE:

- If initial POCT result is negative and symptoms persist or worsen, retest with POCT in 24 hours.

- If second test is still negative, re-test in another 48 hours. If symptoms have resolved, further testing is not required.
- If third test remains negative and symptoms continue, where possible, continue enhanced precautions until feeling better (i.e., until 24-hours fever free without fever reducing medications, 48 hours free of vomiting or diarrhea, and all symptoms improving).

At any point if symptoms are worsening, regardless of the number of POCT performed, it is important to ensure appropriate clinical assessment to determine if the resident may have an alternate condition or infection other than COVID-19 which needs further medical intervention or assessment.

2.2.2. COVID-19 test result - POSITIVE:

- Isolate for 5 days after testing.
- Remove from isolation after day 5 with improving symptoms and minimum 24 hrs. without fever (without fever reducing medications) and 48 hours without vomiting &/or diarrhea
- For an additional 5 days, extra measures are in place for resident.

Extra Measures:

- resident to wear a mask (as able)
- physically distance
- eat meals distanced from other residents.

2.3. Treatment - PaxlovidTM

Primary care providers can prescribe nirmatrelvir/ritonavir (PAXLOVID™) for COVID-19 positive residents who are eligible. Eligibility form can be found here: https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/NBDrugPlan/PaxlovidEligibilityForm.pdf
Please refer to Section 2.14 of this document for further detail on Paxlovid.

3. Outbreak Management

This section of the document is intended for use by operators and managers of LTC homes to guide their decision-making related to outbreak response.

Public Health remains committed to supporting LTC homes in managing COVID-19.

- Public Health will lead and manage outbreaks[3] within LTC homes if the outbreak includes at least 1 resident.
- For LTC homes who have outbreaks that do not include any residents, the home will self-manage using general outbreak management principles unless directed by Public Health.

3.1. General Outbreak Management Principles[4]

a) Public Health will declare the start and end to outbreaks.
b) Resident assessment: daily active monitoring of residents.
c) Staff screening: passively screen before every shift and self monitor throughout shift.
d) Work exclusion for staff who meet symptom checker criteria.
e) Enhance cleaning and disinfection of staff areas (break/lunchrooms, workstations etc.)
f) Stringent adherence to masking and eye protection for staff working on affected unit/area.
g) Ensure staff break/lunch areas do not promote transmission – limit capacity, ensure adequate distancing and barriers, if possible, between staff, wipes for disinfection etc.
h) **Reporting Guidance**: if an outbreak is confirmed, Public Health will communicate this to the home. Subsequent cases should be reported in a daily line list that will be sent to Regional Public Health at an agreed upon time in the day.

It is important for homes to note that not all outbreaks are the same. Therefore, guidance will vary depending on each situation and circumstance. Direction may be adjusted by Public Health / the MOH as needed based on the result of their risk assessment and applicable factors. If homes are unsure why certain directives might be given to them, they should seek to have their questions clarified.

3.2. Outbreak that does NOT include a resident

3.2.1. Role of PH

Supportive (including declaration of beginning and end of outbreak); facility self manages using general outbreak management principles.

3.2.2. End of Outbreak

Typically, an outbreak is declared over by MOH 10 days from last exposure and absence of symptomatic or positive individuals.

3.3. Outbreak that includes at least one resident

3.3.1. Role of PH (outbreak that includes at least one resident)

Active including:

- Initial touchpoint with facility to review the situation, declare the outbreak and adjust/clarify the above guidance as well as any additional guidance required.
- Receive daily line lists to maintain situational awareness.

[3] COVID-19 outbreaks are defined as 2 laboratory confirmed cases in either staff or resident where transmission on site has not been ruled out. Outbreaks are declared by MOH.
[4] Outbreak management principles apply to residents and staff of affected unit, unless otherwise directed by MOH.

- Answer questions from facility.
- Involved in determining risk level of exposures.
- Declare outbreak over.

3.3.2. Resident Testing during an outbreak that includes at least one resident

- Once an outbreak has been declared, testing of all symptomatic residents may not be required.
- Cases (probable) may be identified and managed based on presence (one or more) of new or worsening symptoms.
- One round of mass testing may be prescribed by the MOH. The MOH will determine the timing of such testing if required.
- Testing may be prescribed for the purpose of determining eligibility to treatment (i.e.: Paxlovid)
- Refer to Appendix: Re-testing for residents who have recently tested positive for COVID-19.
- Additional testing may be required to rule out co-infections with other respiratory illnesses.

3.3.3. Control measures to be implemented during an outbreak that includes at least one resident:

- Restrict residents to affected wings/units
- Group activities can continue provided small, consistent groups are maintained. Masking and physical distancing for residents as able.
- General visitation restricted except for designated support persons or when residents are palliative, see Appendix: Visitation during an outbreak for details on visitation during an outbreak. General visitation may occur *during an outbreak* if facility has implemented control measures and is able to adequately function in outbreak management as determined by PH.

3.3.4. End of Outbreak

10 days after last high-risk exposure (as determined by PH).

4. Appendices

4.1. Management of one or more cases of COVID-19 in ARFs with 10 or fewer residents

Best practice recommendations for case and situation management in this setting still apply and are listed below. However, it is recognized that ability to implement may be limited by staffing levels, facility size, or capacity of residents:

Testing	• Test only symptomatic residents and staff. Refer to Section 1.5 • Once one case of COVID-19 is identified, others who become symptomatic will be considered to have COVID-19 and there will be no need to test them unless eligible for Paxlovid treatment
Case and Symptomatic Resident Isolation	• Cases and symptomatic residents isolate separately, and apart from other residents, as best as possible. • A symptomatic person or positive case can eat in their room; or consider having different dining shifts to increase separation between residents at table. Isolation: • Isolate for 5 days after testing. • Remove from isolation after day 5 with improving symptoms and minimum 24 hrs. without fever (without fever reducing medications) and 48 hours without vomiting &/or diarrhea • For an additional 5 days, extra measures are in place for resident where possible. **Extra Measures:** • resident to wear a mask (as able) • physically distance • eat meals distanced from other residents.
Daily Care	• Monitor resident's symptoms and ability to cope with illness daily. i.e., Fever, cough, or difficulty breathing, diarrhea, fatigue; and stability, alertness, intake. ○ Refer to Caring for Someone with Covid-19. • If there are concerns related to the health of the resident, contact their primary care provider. If resident does not have a primary care provider, or they are unavailable, contact EMP, ***EMP Care Coordination Center 1-844-982-7367.*** • Watch for signs that indicate immediate help is needed. Call 911* if you notice: ○ significant difficulty breathing. ○ chest pain or pressure. ○ new onset of confusion; or ○ difficulty waking up. • *Make sure you let 911 and the hospital know that the resident has symptoms or has tested positive for COVID-19.
Washroom	• Designate separate washroom for case if possible. • If shared with others, try to clean between users or as often as possible each day.
Cleaning	• Per section 4.5, as able.

Staff PPE	• Resources permitting, and where possible, contact/droplet precautions are recommended with cases for their 5 days of isolation as well as with any other symptomatic residents.
Group activities	• Active daily monitoring. Only asymptomatic participate. • On site, with masking and distancing in place as much as possible. Provide hand sanitizer and encourage cough/sneeze etiquette.
Visitors	• DSP only, or palliative visitation permitted.
End of additional precautions	• 5 days after last case identified

4.2. Posters/Printable resources

If you require posters for donning and doffing PPE or PCRA (point of care risk assessment), please email SD_CRT@gnb.ca.

For NHs - these resources are available on iTacit.

4.3. Hand Hygiene

Hand hygiene 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 contaminated hands. Use of an alcohol-based hand rub (ABHR) with between 70-90% ethyl alcohol is best practice for ARFs and NHs. Facilities should continue with a comprehensive hand hygiene program that includes all departments with involvement from staff, residents, and families.

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

1. Before initial resident/resident environment contact.
2. Before aseptic procedure.
3. After body fluid exposure risk.
4. After resident/resident environment contact.

Personal hand hygiene should also be performed:

- Upon entering facility
- Before assisting residents with meals
- Before and after preparing food
- Before and after eating meals
- Before and after smoking/vaping
- After using the rest room
- After blowing your nose, coughing, or sneezing

Please note: if there is visible soiling or exposure to bodily fluids, hands should be washed with soap and water. Soap and water should also be used after using the toilet.

4.4. PPE Table

ALL PPE MUST BE CHANGED IF IT BECOMES SOILED, WET OR DAMAGED		
Type	**Description**	**Tips**
Masks	Face masks (ASTM level 1) provide a physical barrier that help prevent the transmission of the virus from person to person by blocking large particle respiratory droplets propelled by coughing or sneezing	**Must be changed upon exit of an isolation room, UNLESS providing sequential care between COVID POSITIVE residents OR providing sequential care between NON COVID residents.**
N95 respirators	Respiratory protective device designed to have a very close facial fit and efficient filtration of airborne particles.	Edges of the respirator are designed to form a seal around the nose and mouth.
Eye Protection	Eye protection (e.g., goggles, face shields etc.) 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. **Prescription eyeglasses alone are not adequate protection against respiratory droplets.**	**Must be changed (or cleaned if using non-disposable eye protection) upon exit of an isolation room, UNLESS providing sequential care between COVID POSITIVE residents OR providing sequential care between NON COVID residents.**
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.	• **Must be changed between each resident.** • **Not a substitute for hand hygiene**; staff must perform hand hygiene before putting on and taking off gloves. • Not for continuous use outside of an isolation room. • Gloves should be removed, hand hygiene performed, and new gloves applied when they become soiled or torn during care. • Double gloving is not necessary.
Gown	AAMI Level 2 gowns are used to protect your clothing and skin from becoming contaminated/soiled from: splashes/sprays of blood, body fluids, secretions, or excretions, contact with soiled/contaminated items/surfaces.	• **Must be changed between each resident.** • Not for continuous use outside of an isolation room. • Must be tied at the neck and the back. If clothing exposed underneath, two gowns should be worn, first covering the back (tied in front), second covering front (tied in back).
Donning & Doffing	Proper donning and doffing (putting on and taking off) of PPE is key in preventing the spread of COVID-19 from one individual to another. **When removing PPE (doffing):** • **PPE below the neck**: gown and gloves, are removed *in the room (close to the door)*. • **PPE above the neck**: eye protection and masks, are changed *outside of the room*.	

4.5. Cleaning and Disinfection

Continue regular cleaning and disinfecting of all general surfaces. 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 doorknobs, handrails, etc., should be cleaned and disinfected at least twice daily and when soiled.Use an environmentally acceptable cleaning and disinfecting product for COVID-19 .

Cleaning & Disinfection	
Area and Description	**Frequency (min)**
Surfaces: in resident rooms and central areas	
Horizontal (e.g., tables)	Twice Daily (and when soiled)
High touch (e.g., telephone, bedside table, overbed table, chair arms, call bell cords or buttor door handles, light switches, bedrails, handwashing sink, bathroom sink, toilet and toilet hanc and shower handles, faucets, or shower chairs, grab bars, outside of paper towel dispenser.)	
Low touch (e.g., shelves, bedside chairs or benches, windowsills, headwall units, overbed light fixtures, message, or white boards, outside of sharps containers).	Once Daily (and when soiled)
Resident Care Equipment	
E.g., BP cuffs, electronic thermometers, oximeters, stethoscope etc. Hospital grade disinfectant (e.g., cleaner, and disinfectant wipes) using the recommended contact time should be used to clean and disinfect smaller resident care equipment. Important Note: Ensure all staff responsible for utilizing resident care equipment is adhering to required cleaning and disinfection practices.	After Each Use
Single Use Devices: discard in a waste receptacle after a single use on one resident. Single person/resident devices: discard after use with one resident (may be more than one use).	
Outside Resident Room (e.g., surfaces that are touched by or in contact with staff)	
Computer carts and/or screens, medication carts, charting desks or tables, computer screens, telephones, touch screens, chair arms. Staff should ensure that hands are cleaned before touching the above-mentioned equipment.	Once Daily (minimum) and when soiled.
Floors and Walls: Kept visibly clean and free of spills and debris.	
Terminal Cleaning and Disinfecting	
Items that cannot be appropriately cleaned and disinfected should be discarded upon resident transfer or discharge. 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.	After discharge, transfer, or discontinuation of contact droplet precautions.
Ensure all staff responsible for environmental cleaning adhere to required cleaning and disinfection practices.	

4.6. Retesting - recommendations for individuals who have previously tested positive for COVID-19 (PCR/POCT) in LTC

When clinically indicated, POCT testing is recommended for individuals previously infected with COVID-19 presenting with new or worsening respiratory symptoms. If POCT test is negative, further testing may be indicated (at the discretion of the primary care provider or the MOH) based on symptoms and presence/ circulation of other viruses in the community.

4.7 General Visitation

Each facility must have a visitation policy which includes:

- No visiting when ill, signage at door stating not to enter if unwell
- Visitors should be provided information outlining safe visiting practices, including frequent hand hygiene and respiratory etiquette with each visit, and postponing a visit when ill.
- Mask use is optional for a visitor; however, a resident may request a visitor to wear a mask.
- There is no age restriction related to visitation within an LTC facility.
- There is no limit on visitation capacity at one time.
- There is no requirement for visitors to provide proof of vaccination or medical exemption.

During an outbreak, certain visitation continues to be permitted, please see Visitation During an Outbreak.

4.8 Visitation During an Outbreak

VISITATION GUIDANCE DURING OUTBREAK	
For units/facilities which are in outbreak certain types of visitation are permitted as outlined below.	
Designated Support Persons (DSPs)	Permitted into **affected units/facilities**. These individuals are to be informed that an outbreak is occurring and to visit one resident within the facility only and not go from room to room. DSPs must follow the same infection control measures as staff, including the appropriate use of PPE during visits as indicated. If resident is not on isolation precautions DSP must wear medical grade mask and eye protection continuously as required as part of outbreak management.
Palliative[5] Visitation	• In collaboration with the home, a physician or nurse practitioner determines if the resident's condition is considered end-of-life based on current clinical assessment findings.

[5] For the purposes of this document, palliative residents, are defined as individuals whose condition is considered end-of-life and death is anticipated as imminent.

	• When death is anticipated as imminent, palliative visitation may occur, with a visitation plan developed in consultation with the care team of the home. • Resident/POA/substitute decision maker may have a list of 10 visitors • Homes should develop a safe visitation plan for any palliative visitation which will occur. Safe visiting interventions may include: ○ Visitors understand the risk of exposure to COVID-19 (for self and others); ○ Visitors follow all related home policies and public health measures in place within the home; and ○ Visitors remain vigilant in protecting themselves and others while on site, including use of continuous medical grade mask and eye protection, appropriate hand hygiene, following isolation precautions as required.

4.9 Admissions & Readmissions (return from hospital)

Individuals should not be unreasonably denied admission or readmission. When a risk of COVID has been identified, no admissions, readmission or transfer will be considered if either of the following criteria are met:

- Inability to isolate the resident (either availability of private room and bathroom, cognitive impairments that would impede isolation or other operational considerations), applicable to situations where a resident requires isolation upon admission
- Critical Staffing at the receiving NH/ARF facility.

It is recognized some hospitalized patients, determined as medically stable / ready for discharge, have been unable to be newly admitted or returned to their Nursing Home / Adult Residential Facility (NH/ARF) due to COVID. The situations where this may occur include:

- The NH/ARF has a current COVID outbreak
- The patient has had a possible COVID exposure during their hospitalization (in a room, on a unit with a COVID outbreak), OR,
- Is COVID positive and medically stable/discharged; and must continue isolation period post-discharge.

Admissions and readmissions to an affected unit/wing during an outbreak in the ARF/NH are not recommended unless the person was determined to be COVID positive within the last 90 days. Should it be necessary to admit residents during the outbreak the following factors apply:

- The outbreak is under control, as determined by PH.
- The resident's attending physician is in agreement based on the current health status of the resident.

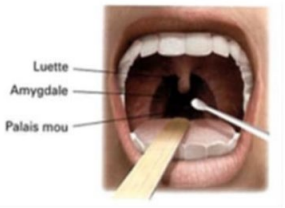
- Appropriate accommodation is available.
- Staffing is appropriate to meet the needs of the resident.
- The resident or substitute decision-maker has given an informed consent.

4.10 Throat – Nasal POCT Specimen Collection for COVID-19

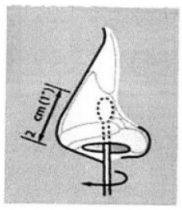
The use of throat and nasal swabs has been recognized as effective for rapid antigen point of care testing (POCT) in long term care (LTC) homes where staff have been trained in this process. Evidence shows that although both nasal and throat/nasal methods are acceptable, combined throat/nasal samples provide better results for detection of COVID-19 and the Omicron variant.

How to do a throat/nasal swab for COVID-19:

1. **Advise resident not to eat, drink, vape, smoke, brush teeth or chew gum 30 minutes prior to testing.**
2. **Prepare testing supplies:** Wash hands before starting. Prepare the testing area and lay out the supplies you will need on a clean surface. POCT supplies needed are:
   - Tube rack
   - Testing device
   - Tube and cap
   - Buffer fluid
   - Swab (keep in wrapper until ready to test)
   - Personal Protective Equipment for the staff member
3. **Prepare the test according to package instructions:** Tests vary by brand. Note that some swabs are scored to break easily. Hold the swab with the thumb and index finger on the score line to prevent breakage when swabbing.
4. **Obtain Throat Swab:** Swab the tonsil area in the back of the throat for five seconds on each side (avoiding the tongue, teeth and lips).
5. **Obtain Nasal Swab**: Swab the nostrils using the same swab. Gently insert the swab about 1-2 cm into the first nostril, or until resistance is felt. Rotate five times, remove and repeat on the other side.
6. **Process the sample:** Place the swab in the tube. Follow the test kit instructions.
7. **Positive results do not require a confirmatory PCR test**.



(a) Throat technique



(b) Nose technique

References:

- EM/ANB Throat/Nose Specimen Collection.pdf
- Provincial Public Health Laboratory Nova Scotia instructions-alternate-collection-throat-and-nares-covid.pdf
- Throat and Nares (Nasal) swabbing for Rapid Antigen Tests | SaskHealthAuthority
- Virus Respiratory (Combined Throat and Both Nostrils) Specimen Collection Instructions | Public Health Ontario

4.11 Paxlovid Tool (for use in ARFs)

Pre-outbreak considerations: Is My Resident Eligible for Paxlovid (antiviral used to treat Covid 19)?

Paxlovid™ is an anti-viral medication intended for those who are at risk to experience more severe illness from COVID-19. There are many criteria that must be met before it can be prescribed. This is not an official eligibility assessment for Paxlovid, but merely a tool to help your facility to be ready for the process.

Complete the following pre-outbreak considerations for each resident in your facility. A resident who has all "Yes" responses is better prepared for a PAXLOVID assessment, should they test positive for COVID-19.

Pre-outbreak considerations:	Yes	No
1)Can the resident swallow full size pills without crushing? A resident must be able to swallow pills whole to qualify for PAXLOVID.		
2)Does the family/resident consent to resident receiving PAXLOVID, if they qualify? Informed consent of family/resident is required. For more information, review Paxlovid™ Patient Information		
3) Is the resident at risk to experience more severe illness from COVID-19? People at risk to develop more serious forms of Covid 19 include: • ≥ 18 and at higher risk for severe outcomes **(see list)**		
4) Is the resident's medication list up to date? Some medications cannot be used in combination with PAXLOVID. Contact your attending pharmacist to get a complete list of medications ready for each resident.		
5) Does the resident have a personal account for eVisitNB and MyHealthNB? • PCR test results can be obtained faster using MyHealthNB. • If unable to contact a resident's health care provider, a prescription for Paxlovid may be obtained by contacting participating pharmacy, 811 or eVisitNB. ***eVisit is Free until March 2024 with valid New Brunswick Medicare card. For access to this FREE service, please ensure you are assessed by eVisit and not another online service company (EX. Maple)**		

If your resident has obtained YES responses for questions 1-4, they may be eligible for Paxlovid. Facility operators can further their readiness by taking the steps outlined in questions 5.

HOW TO OBTAIN A PAXLOVID ASSESSMENT FOR RESIDENTS

1. A resident in your facility has symptoms of COVID-19. Have the resident's symptoms started within the last 5 days?
Paxlovid must be started within 5 days of symptom onset. It is intended for people experiencing mild-moderate illness. If symptoms are severe, they DO NOT qualify for PAXLOVID. For a complete list of COVID symptoms go to: About COVID-19 (gnb.ca)

2. Test to confirm COVID-19:

- **To access Paxlovid, individuals must have a confirmed positive test, either PCR or Point of Care Test (POCT). If a POCT is used, it is recommended to be observed by a health care provider or done by staff trained in POCT. *Note: Contact EMP if concerned about health of resident.**

If test result is positive for COVID-19, resident may be eligible for Paxlovid.

<table>
<tr><th>If resident is followed by EMP:</th><th>If resident is not followed by EMP but has a primary care provider.</th><th>If resident is NOT followed by EMP AND does NOT have a primary care provider (or cannot reach their primary care provider).</th></tr>
<tr><td rowspan="2">Contact EMP.
EMP will follow-up with Primary Care Provider to determine if resident is eligible for PAXLOVID and will send completed eligibility form to your attending pharmacy.</td><td>Notify primary care provider
Primary care provider will determine if resident is eligible for PAXLOVID and will send completed eligibility form to your attending pharmacy. If unable to connect with their physician/nurse practitioner, contact a participating pharmacy to be assessed. List of participating pharmacies HERE</td><td>Contact a participating pharmacy to be assessed. (List of participating pharmacies HERE)
If unable to be assessed by participating pharmacy, contact 811 or visit www.eVisitnb.ca*. Get an online New Brunswick Physician/Nurse Practitioner to assess resident's eligibility for PAXLOVID. For access to this free service, please ensure you're assessed by eVisit and not another online service company (Ex. Maple)</td></tr>
<tr><td colspan="2">*Note: Contact EMP if concerned about health of resident or need support accessing Paxlovid.</td></tr>
</table>

ONCE A PRESCRIPTION IS OBTAINED:

3. Obtain PAXLOVID from your attending pharmacy for eligible residents. Carefully follow instructions provided with this medication. Additional resources: Refer to LIVING WITH COVID: management of COVID-19 for NB Long Term Care Homes **and** Caring for someone with COVID-19 (gnb.ca)

TIPs to be prepared:

- ✓ Make sure medication lists are up to date.
- ✓ Provide Paxlovid information to resident or next of kin
- ✓ Create a MyHealthNB account for each resident

Resident has symptoms of COVID-19

Refer to LIVING WITH COVID: management of COVID-19 for NB Long Term Care Home and Caring for someone with COVID-19 (gnb.ca)

To access Paxlovid, individuals must have a confirmed positive test, either Point of Care Test (POCT). Or PCR or If a POCT is used, it is recommended to be observed by a health care provider or done by staff trained in POCT. *Note: Contact the EMP Care Coordination Center at 1-844-982-7367 if concerned about health of resident.

COVID-19 Test results?

Negative:
Re-test if new or worsening symptoms appear and/or contact Primary Care Provider for further investigation.

Positive. Your resident may be eligible for Paxlovid.

If resident is yes to all the following, proceed for Paxlovid assessment by Physician/Nurse Practitioner

- ✓ Age:≥ 18 and at higher risk for severe outcomes (see list)
- ✓ resident's **symptoms started within the last 5 days**
- ✓ resident can swallow full size pills without crushing
- ✓ family/resident consent to resident receiving PAXLOVID if they qualify Paxlovid™ Patient Information

Is your resident followed by EMP?

YES

Contact local EMP Unit. They will contact Physician/Nurse Practitioner to assess resident for PAXLOVID eligibility.

NO

Does your resident have a Physician or Nurse Practitioner?

YES

Notify their physician/nurse practitioner to assess resident's eligibility for PAXLOVID. If unable to connect with their physician/nurse practitioner, contact a participating pharmacy to be assessed.

NO

Contact a participating pharmacy to be assessed. (List of participating pharmacies HERE)

If unable to be assessed by participating pharmacy, contact811 or visit www.evisitnb.ca*. Get an online New Brunswick Physician/Nurse Practitioner to assess resident's eligibility for PAXLOVID.

Contact EMP Care Coordination Center if there are concerns regarding health and/or need support accessing Paxlovid

*NOTE: Each resident will need an account to access eVisit. This service will be free until March 2024 with a valid New Brunswicker Medicare card. For access to this free service, please ensure you're assessed by eVisit and not another online service company (Ex. Maple).