# Long Term Care and Community Care Facilities Visitation and COVID- 19 Guidance

## April 24, 2023 Update

Since the COVID-19 global pandemic was declared on March 11th, 2020 restrictions have evolved in Long Term Care and Community Care Facilities across Prince Edward Island in order to protect residents and staff.

Please continue to review and reference the Prince Edward Island Guidelines for Infection Prevention and Control of COVID-19 in Long Term Care and Community Care Facilities available online.

https://www.princeedwardisland.ca/sites/default/files/publications/ltc_cc_covid_guideline_december_2022.pdf

**Masking Requirements**

- Universal masking is no longer required in LTC and CCFs; staff/residents/partners in care/visitors may continue to universally mask if they choose to.
- Masks should remain available at all entrances for those who choose to continue to mask.

**Visitors and PICs:**

- Visitors must be well and have no signs of illness. Symptomatic individuals will be excluded from visiting until they are well.
- Signage will be posted at points of entry reminding visitors to screen for illness or risk factors prior to entry.
- Access to hand hygiene product and medical grade masks will be made available to visitors at points of entry.
- Mask guidance for visitors and PICs will be provided if the facility is in an outbreak

**Staff (including Volunteers and Entertainment providers):**

- Staff will perform a point of care risk assessment (Appendix A) for encounters with residents to inform whether a mask and eye protection is required for care.

**Residents:**

- Residents should be provided with a mask if requested and as required for enhanced measures or source control.

## Visitation

- A resident may have **unlimited visitors**.

- Visits are permitted indoors and/or outdoors.
- Physical distancing **is not required** between the visitor and the resident. Physical distancing does not need to be maintained between the resident and visitor whether visitation occurs indoors or outdoors.
- Indoor visitation: Number of indoor visitors present at one time will be determined by the facility.
- Outdoor visitation: Number of outdoor visitors present at one time will be determined by the facility.
- Visitors **are not** required to maintain physical distancing of 2 metres (6 feet) from staff and other residents at the facility during the visit if well.
- Visitors must perform hand hygiene upon entry to the facility and after the visit at point of exit and when indicated. Must follow all infection control guidelines in place at the facility. New visitors must be provided infection prevention and control guidance by facility staff prior to beginning visitation at the facility.

**Outbreak Visitation**

- Each Resident may identify up to three (**3) PICs** who can have increased access and visitation when a facility is in an outbreak and routine visitation is on hold.
- During an outbreak a PIC may support mealtime, mobility, personal hygiene, cognitive stimulation, communication, meaningful connections, relational continuity and assist in supporting the resident.
- During an outbreak a PIC may visit the resident at any time, provided this visit does not have a negative impact on the care of any other resident in the facility.
- Partners in Care must follow all infection control protocols in place, including wearing appropriate PPE. Appropriate PPE for PICs not involved in direct care consists of 2 medical grade masks layered and eye protection.
- PICs shall maintain physical distancing from other residents and staff.

**Personal Drives/ Resident Passes**

- Drives can include disembarking from the vehicle to personal property.
- Drives can include disembarking from the vehicle to community settings. Residents can be supported in the use of a mask as appropriate for the situation (e.g. hair salon, shopping center, restaurants, church, bank).
- Hand hygiene should be completed by resident prior to and after drive.
- Residents who own/operate their own vehicle may go out on pass independently.
- Residents who own a property (e.g. cottage/personal dwelling) may go to these residences independently.

- Residents who are able to go for a walk or bike ride may do so independently.
- All residents will continue to be closely monitored for symptoms.

**Facility Church Service**

- Follow Entertainment Guidance for LTC and Community Care.
- Clergy and organist (if applicable) must maintain physical distancing from residents.

**Cohorts**

- Resident cohorts allow for resident engagement and social interaction while ensuring quick recognition of close contacts among residents in the event of a positive case of COVID-19 or other communicable disease within the home.
- Cohorts or Neighborhoods are IPAC best practice following the small home model (CSAZ8004:22), whereas the communal activities of day to day living involves a limited number of residents.
- Resident cohorts are recommended where operationally feasible, with 10-12 residents per cohort.
- Cohorts should be consistent, and changes documented for contact tracing purposes.
- Co-horts should be in place for all facility activities, examples include dining, entertainment and recreational drives.
- Residents who reside in the same hallway, unit or household may be part of a cohort. As much as possible, members of cohorts should not be from different sections of the facility.
- Resident cohorts should be physically distanced from one another, as much as possible when attending facility-based events.

**Other Considerations**

- Service providers (footcare, hairdressing) may provide care and services within LTC and CC following all facility IPAC measures.

**Protecting All Residents**

- Residents who go out on pass should be monitored for symptoms and if symptoms develop be placed on appropriate additional precautions and tested.
- Facilities must monitor rates of COVID-19 vaccination among residents and should ensure ongoing access and timely administration of COVID-19 vaccine including boosters, for residents and staff.
- Continued self-screening for illness and risk factors of all visitors and staff that enter facility.
- Continued adherence to infection prevention and control protocols and public health measures.
- Monitoring of local epidemiology and COVID-19 variants of concern by CPHO.

## Admission Guidance and Management of Close Contacts and Cases

**Reminder:**

1. There is no differentiation based on vaccination status of the resident.

2. There is no differentiation based on where the resident is being admitted from (i.e. community vs. acute care or other facility).
3. Contact and droplet precautions are to be initiated for new admissions **only if symptoms are present or develop.**

**Admissions**

- Test resident admissions at time of admission to the facility using rapid point-of-care LUCIRA Molecular test kit **if** symptoms are present.
- New admissions will be placed on contact and droplet precautions **only** if symptoms are present or develop.
- If symptoms develop, test resident with rapid point-of-care LUCIRA molecular test kit, if negative continue precautions and send a specimen for FLUVID/RSV PCR .
- Symptomatic and positive COVID-19 residents tested with rapid point-of-care Lucira molecular test kits can initiate access to Paxlovid treatment.
- Confirmation PCR testing does not need to occur to access Paxlovid treatment.

**Previous Positive Admission**

People who have previously had COVID may now be at risk of getting infected again with the current Omicron strains in circulation (BA.5, XBB.1.5). People who previously tested positive can be tested again **as early as 60 days after their previous positive test** (this has been reduced from 90 days).

- If a new resident has never had COVID, or it has been more than 60 days since their COVID infection, **admission testing is required only if symptoms present**.
- If a new resident has had COVID in the last 60 days, there is no need to test *unless the resident has symptoms of COVID*.
- There is no requirement for isolation or contact and droplet precautions if the new resident is asymptomatic.
- Monitor all new residents for symptoms. Initiate contact and droplet precautions if respiratory symptoms develop, and alert house physician or health care provider for additional testing orders (e.g. FLUVID/RSV PCR).

## Management of Resident Cases and Close Contacts

**Cases**

- Residents with suspected or confirmed COVID-19 will be placed on contact and droplet precautions.
- Residents diagnosed with COVID-19 should be placed on contact and droplet precautions for 5 days following the symptom onset date or the positive test date (whether vaccinated or

unvaccinated).

- Precautions should remain in place for 5 days **and** until resolution of fever for 24 hours without fever reducing medication and symptoms have improved.
- Enhanced measures after precautions have been discontinued include continued masking when outside of room space and/or avoidance of group activities until 10 days following symptom onset date.
- No group dining for 10 days following symptom onset or positive test date.
- Residents who are immunocompromised require 14 days of contact and droplet precautions.

**Close Contacts**

- Day 0 is the last day of exposure to the case.
- Close contacts will be tested at time of identification on days 0, 4, and 6. If symptoms develop test immediately and do not wait for next testing day.
- Close contacts with a positive rapid point-of-care Lucira do not require confirmatory testing using lab based NAAT or PCR testing.
- Close contacts will be placed on contact and droplet precautions for minimum 4 days.
- Contact and droplet precautions can be discontinued at day 4 if resident is asymptomatic and day 4 test is negative.
- Residents should receive meals in their room and avoid group activities until they have a negative test on day 6.
- All close contact restrictions are removed when the day 6 test is negative.
- Symptomatic residents with a positive Lucira molecular test are eligible to initiate access to Paxlovid treatment.

**Previous Positive Close Contact**

**If no symptoms:**

Residents identified as a close contact who have had COVID in the past 60 days **do not** require contact and droplet precautions if asymptomatic. Close contacts should still be monitored for symptoms.

**If symptomatic:**

**There are some individuals who are being re-infected with COVID-19 prior to 60 days, so if there are risk factors prior to 60 days, re-testing is appropriate if symptomatic.** Discuss with CPHO or physician if unsure to test resident.

- Consideration can be made to test the resident with a viral panel.
- Discontinue precautions if symptoms have resolved or improved, and if COVID test results are negative and no other infectious disease diagnosis made (e.g. Influenza).

## Entertainment Guidance

Based on our current knowledge and local epidemiology, entertainment may continue in Community Care and Long Term Care facilities with strict adherence to guidance and infection prevention and control.

**Guidance for Entertainment:**

- Entertainers must be well and have no signs of illness.
- Entertainment should be in a designated area which may be outdoors or indoors.
- Resident co-horts should be maintained for entertainment activities.
- Resident co-horts should be physically distanced from one another during entertainment activities.
- Physical distancing (6ft/2meters) must be maintained at all times between residents and entertainers.
- Entertainers should remain in their designated area for the duration of the provided entertainment.
- Symptomatic individuals will be excluded from providing services until they are well.
- Entertainers must perform hand hygiene upon entry to the home and after the visit at point of exit and when indicated.
- Clean designated area after entertainment completed.
- Entertainers can provide services to more than one facility, pending strict adherence to guidelines and infection control protocols.
- Singers in an outdoor setting must be minimum 6 feet from everyone else.

# *Apppendix A - Point of Care Risk Assessment Tool for COVID-19*

Prior to any patient interaction, all health care workers (HCWs) have a responsibility to always assess the infectious risk posed to themselves and to other patients, visitors, and HCWs. This risk assessment is based on professional judgement about the clinical situation and up-to-date information on how the specific healthcare organization has designed and implemented engineering and administrative controls, along with the availability and use of Personal Protective Equipment (PPE).

Point of Care Risk Assessment (PCRA) is an activity performed by the HCW before every patient interaction, to:

1. Evaluate the likelihood of exposure to COVID-19,
    a. from a **specific interaction** (e.g., performing/ assisting with clinical procedures/ interaction), non-clinical interaction (i.e., admitting, teaching patient/ family), transporting patients, direct face-to-face interaction with patients, etc.)
    b. with a **specific patient** (e.g., residents not capable of self-care/ hand hygiene, have poor- compliance with respiratory hygiene, copious respiratory secretions, frequent cough/ sneeze, early stage of illness, etc.)
    c. **specific environment** (e.g., single rooms, shared rooms/ washrooms, hallway, assessment areas, emergency departments, public areas, therapeutic departments, diagnostic imaging departments, housekeeping, etc.)

AND

2. Choose the appropriate actions/ PPE needed to minimize the risk of patient, HCW/other staff, visitor, contractor, etc. exposure to COVID-19

PCRA is not a new concept, but one that is already performed regularly by professional HCWs many times a day for their safety and the safety of patients and others in the healthcare environment. For example, when a HCW evaluates a patient and situation to determine the possibility of blood or body fluid exposure or chooses appropriate PPE to care for a patient with an infectious disease, these actions are both activities of a PCRA.