



Guidelines, Standard Operating Procedures and Clinical Practice – Preventing and Managing COVID-19 infections in Long-Term Care Facilities

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Given both the risks to older persons and the high risk of COVID-19 spread in long-term care facilities, providing practical information to care facility managers and staff on preventing the spread of the virus is essential. Many guidance documents have been produced by institutions globally, but this document aims to aggregate useful information, offering detailed step-by-step procedures, examples and scenarios and taking into account variations in resource availability and government support. It also draws on the experience of managing an outbreak at Highlands House care, a nursing home in Cape Town, South Africa.

This document was developed in South Africa and makes some reference to South Africa in terms of testing procedures but operating procedures should have general applicability in other Low and Middle Income Countries.

Care facilities may need to adapt these procedures to their individual circumstances, budgets and operating models.

This document has four sections: 1) infection prevention, 2) testing and screening, 3) managing infection/outbreak, and 4) broader policies and planning.

We hope that this can be a “living” document and invite additions and edits based on best practice and real cases. This document will also be updated as new evidence or guidance related to COVID-19 becomes available.

Please email gkelly@sifar.org.za with any suggestions or additions.

All resources used in this document, plus additional documents will be made available here: <http://sifar.org.za/covid-19-resources-0>

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Abbreviations

Covid-19: SARS-CoV2 is the virus causing COVID-19

HCP: Health Care Professional

PPE: personal protective equipment

PUI: person under investigation

GP: General Practitioner

DoH: Department of Health

NHLS: National Health Laboratory Services

SECTION 1 – Infection Prevention

1. Cleaning and Disinfecting

A. Environmental Cleaning

SARS-CoV2 (the virus causing COVID-19) is spread via respiratory droplets and can live on surfaces for many hours. To prevent virus spread, frequent and thorough environmental cleaning, followed by disinfection of communal areas, residents' rooms and share bathrooms or kitchens and office areas is essential. Expensive cleaning and disinfection agents are not required, but protocol should be carefully followed.

- All “touch-points” in the facility should be mapped out and these high touch areas included in a cleaning/de-sanitising checklist so that none are overlooked by cleaning staff
- Treat every person as potentially infected with COVID-19 – this means that each resident’s room and laundry is assumed to be contaminated and treated with care



Source: <https://www.businessinsider.com/coronavirus-lifespan-on-surfaces-graphic-2020-3?r=US&IR=T>

Types of cleaning:

- **Routine cleaning** – ongoing preventative cleaning
- **Terminal cleaning** - if there has been known contamination of the environment and the room of an infected patient

Routine cleaning and disinfection protocol

- Clean all frequently touched surfaces: door handles, bedrails, tabletops, light switches. First carry out mechanical cleaning and then wipe with disinfectant.
- Clean general surfaces – floors, ceilings, walls, blinds and fittings when visibly dusty or soiled and immediately after any spillage.
- Curtains should be regularly changed in addition to being cleaned
- Damp mopping is better than dry mopping
- Sinks, basins and toilets to be cleaned on a regular basis and wiped down with disinfectant
- Communal/public areas should be cleaned and disinfected AT LEAST every 4-6 hours, with a special focus on high-touch areas:
 - Door handles
 - Handrails
 - Elevator buttons
 - Clocks
 - Phones
 - Keyboards/mouse
 - Non-automatic water faucets / soap dispensers / paper towel dispensers
 - Toilet Handles
 - Radios
 - TV remote
 - Walkers/wheelchairs
 - Copy Machines
 - Coffee maker / water cooler
 - Light Switches
 - Appliances in a shared kitchen
- *Wipe* (spraying is not sufficient) all regularly touched surfaces with disinfectant wipes/bleach or hydrogen peroxide solution – wait 1 minute before wiping away.
- Use PPE (mask, gloves, apron) while cleaning and dispose afterwards in a plastic bag.

Terminal cleaning/infectious clean

- Terminal cleaning involves deep cleaning, combined with a disinfecting process. This can either be done as a two-step process, first using detergent and then disinfectant or a combined detergent/disinfectant product.

Steps for terminal cleaning of residents' rooms:

- Wash hands
- Wear PPE for cleaning (mask plus face shield, gloves and apron)
- Move clockwise from the door, skipping the bathroom
- Empty trash containers
- Throw away open tissue boxes or toilet paper rolls
- Change bed screens and curtains that are soiled or contaminated
- Dust all surfaces, furniture and fittings, starting with areas above shoulder height (TV, clock, lights etc.)
- Clean windows, sills and frames
- Clean all surfaces of bed and mattress

- Mop floor and vacuum all carpets
- Follow with disinfection of all hard surfaces with chlorine-based product such as bleach, including ledges, door handles, light switches, cabinets and drawers, sinks and faucet, refrigerator, window sills and ledges, walls, thermostat
- Discard cleaning rags and clean and disinfect bathroom with new rags
- In the bathroom, clean switches, door handles, sink and counter, wipe out all cabinets and shelves, wipe towel rack, wipe shower or tub, walls, toilet including seat/rim, and any assistive rails.
- Remove PPE and perform hand hygiene
- Clean all cleaning equipment and return to storage area
- Perform hand hygiene

If there has been a COVID-related death in a room or apartment carry out the following procedures in addition to terminal clean:

1. Do NOT enter room/apartment for four days
2. After four days, allow family to enter room/ apartment and remove belongings.
3. Discard anything left in the room/apartment after the family is finished with the personal belongings.

Frequency of cleaning

Patient area	Frequency ^a	Additional guidance
Screening/triage area	At least twice daily	<ul style="list-style-type: none"> • Focus on high-touch surfaces, then floors (last)
Inpatient rooms / cohort – occupied	At least twice daily, preferably three times daily, in particular for high-touch surfaces	<ul style="list-style-type: none"> • Focus on high-touch surfaces, starting with shared/common surfaces, then move to each patient bed; use new cloth for each bed if possible; then floors (last)
Inpatient rooms – unoccupied (terminal cleaning)	Upon discharge/transfer	<ul style="list-style-type: none"> • Low-touch surfaces, high-touch surfaces, floors (in that order); waste and linens removed, bed thoroughly cleaned and disinfected
Outpatient / ambulatory care rooms	After each patient visit (in particular for high-touch surfaces) and at least once daily terminal clean	<ul style="list-style-type: none"> • High-touch surfaces to be disinfected after each patient visit • Once daily low-touch surfaces, high-touch surfaces, floors (in that order); waste and linens removed, examination bed thoroughly cleaned and disinfected
Hallways / corridors	At least twice daily ^b	<ul style="list-style-type: none"> • High-touch surfaces including railings and equipment in hallways, then floors (last)
Patient bathrooms/ toilets	Private patient room toilet: at least twice daily Shared toilets: at least three times daily	<ul style="list-style-type: none"> • High-touch surfaces, including door handles, light switches, counters, faucets, then sink bowls, then toilets and finally floor (in that order) • Avoid sharing toilets between staff and patients

Recommended frequency of cleaning of environmental surfaces, according to the patient areas with suspected or confirmed COVID-19 patients (Source: WHO, 2020¹)

a. Environmental surfaces should also be cleaned and disinfected whenever visibly soiled or if contaminated by a body fluid (e.g., blood); b. Frequency can be once a day if hallways are not frequently used.

Use of disinfecting solutions

- **Hard surfaces** can be disinfected using hypochlorite solution (bleach e.g. JIK brand), alcohol (at least 60% concentration), hydrogen peroxide (3% concentration) or a hospital-grade disinfectant with activity against viruses.
- **Soft surfaces** - should be laundered (see **laundry** section)

¹ World Health Organisation. Cleaning and disinfection of environmental surfaces in the context of COVID-19L: Interim Guidance, 15 May 2020. <https://www.who.int/publications/i/item/cleaning-and-disinfection-of-environmental-surfaces-in-the-context-of-covid-19>

- **Electronics** - such as keyboards, remote controls, touch screens, tablets and cell phones screens should be wiped down with alcohol-based wipes or sprays (70% alcohol concentration or more) and dried thoroughly.

Preparation of chlorine-based disinfectant solution

- Bleach is the cheapest option for disinfecting hard surfaces, but can be hazardous for humans, so special precautions must be taken, and it must be used exclusively on non-porous surfaces (it will damage metal and materials)
- Environmental spraying of walls, floors, ceilings and passages is NOT recommended and risk of transmission from these areas is low in any case.
- As bleach is toxic, it must always be wiped off afterwards – leave on for 1 minute to act against the virus
- Mix solution using protective gloves and eyewear
 - The WHO recommends using bleach with a 0.5% concentration when diluted with water
 - Not all bleach brands have the same concentration of sodium hypochlorite, so this can be confusing –the concentration of standard household bleach can range from 3-6%, so please check on the bottle before mixing with water. To achieve 0.5% concentration:
 - 3.5% concentration in bottle (e.g. JIK or Domestos) – use 1 part bleach to 6 parts water (e.g. 250ml of bleach to 1.5 litres of water)
 - 5% concentration in bottle - use 1 part bleach to 9 parts water (e.g. 1 litre of bleach and 9 litres of water in a 10L standard bucket)
 - Do not combine bleach with other products such as toilet bowl cleaners or anything containing ammonia as this could cause dangerous chemical reactions
- Solution must be mixed daily as prediluted solutions can lose potency over time and with exposure to sunlight
- Paper towels or disposable cloths should be used for wiping areas with bleach solution

Information to share with cleaners

- The risk when cleaning is not the same as the risk when face-to-face with a sick person who may be coughing or sneezing.
- Cleaning staff should be informed to avoid touching their face, especially their mouth, nose, and eyes when cleaning.
- Cleaning staff should wear impermeable disposable gloves and a surgical mask plus eye protection or a face shield while cleaning.
- The surgical mask and eye protection act as barriers to people inadvertently touching their face with contaminated hands and fingers, whether gloved or not.
- If there is visible contamination with respiratory secretions or other body fluid, the cleaners should wear a full-length disposable gown in addition to the surgical mask, eye protection and gloves.
- Cleaners should use alcohol-based hand rub before putting on and after removing gloves.
- Alcohol-based hand rub should also be used before putting on and after removing the surgical mask and eye protection.
- Avoid touching contaminated items from a patient's immediate environment without gloves – toothbrushes, cigarettes, eating utensils, dishes, drinks, towels, washcloths or linen.

B. Laundry

- Contaminated linen should be put into a laundry bag and should not be shaken or touched (use single use or washable utility gloves and protective clothing)

- Machine wash should be carried out at 60-90 degrees with regular detergent for the length of a regular cycle.
- Utility gloves should be cleaned with soap and water and then decontaminated with 0.5% bleach solution (see instructions for mixing solution above).
- If a laundry service is used, place any laundry from a COVID-19 positive resident or PUI in a separate sealed and marked bag.
- Staff working with COVID-19 positive residents or PUIs should ideally have their uniforms laundered at the facility or take them home in a plastic bag and wash them carefully on a hot wash without shaking them, being aware that their uniforms could potentially infect their home environment. The bag should be disposed directly afterwards.

C. Waste Management

- All waste should be properly packaged in sealed, leak and puncture-proof bags
- All waste generated from residents in isolation or quarantine should be marked COVID-19, and placed in a box labelled with a bio-hazard sign, treated as health care risk waste and stored *separately* from other waste.
- All bags, bins and any boxes must be adequately sealed and wiped down with 0.05% chlorine solution before being stored or removed.
- The collection, transportation, treatment and disposal of COVID-19 waste should only be carried out by an appointed service provider and should be made aware it was generated by COVID-19 or suspected COVID-19 case.

2. Personal hygiene and respiratory etiquette

A. Respiratory etiquette

i. *Wearing of masks and face shields for source control*

- Cloth, surgical masks and face shields to help to prevent spread of respiratory secretions.
- A universal mask wearing policy should apply
- All staff to wear surgical masks at all times, regardless of whether there is COVID-19 in the facility.
- Essential visitors should wear surgical or cloth masks at all times
- Residents should be encouraged to wear masks, BUT masks should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- See detailed guidance on mask wearing below.

ii. *Residents with dementia and masks*

- Residents with dementia may struggle to remember to wear masks or may be confused or upset by mask wearing or other PPE and care givers should remind residents regularly why people are wearing masks and why it is important to wear one. Some tips for care givers or health workers for easing distress include:
 - Have your name and picture clearly visible on clothing.
 - Laminate or draw a smiley face and flowers on PPE.
 - Use tone of voice and open body language to demonstrate warmth.
 - Draw or use written words to communicate where appropriate.
 - Explain why you are taking a sample – these may need to be repeated.
 - Play some of the person's favourite music to aid relaxation.
 - Ensure hearing aids and glasses are worn and working.

iii. *Coughing and sneezing*

- All staff and residents must be regularly reminded to cover mouth and nose when coughing or sneezing – using a disposable tissue to cover if possible and then disposing immediately into a waste bin.
- Make tissues and waste bins available throughout the facility
- If this is not possible then individuals must sneeze into the crook of their elbow or sleeve.

iv. *Other protocol*

- **The use of nebulisers within the facility should be limited or ceased** as they generate aerosol particles that can carry bacteria and viruses deep into the lungs and may also cause coughing that increases risk of the disease. Meter-dosed inhalers with a spacer should be used instead.
- **Portable cooling fans should be removed to prevent spread.**

B. Hand hygiene

i. *Measures to put in place:*

- Liquid hand-soap and paper towels must be available at all hand basins
 - Hand soap should be provided in a closed container that is either manually or elbow-operated with a pump action or an automated dispenser
 - Ideally soap should be supplied in disposable containers, but if decanting is required then re-usable soap dispensers need to be thoroughly cleaned and heat disinfected in a bowl of water in a microwave or using a heat sprayer and carefully dried.
 - Containers should never be topped-up with additional product – they must be cleaned and disinfected as above.
 - The product used should be hypo-allergenic and be well tolerated.
 - Consider tippy-taps where insufficient wash basins are available in under-resourced facilities (see this video link for instructions on making a tippy tap https://www.youtube.com/watch?v=HNkl1Zqs_40)
- Alcohol-based rub stations must be available at the point of care, at the entrance to each resident's room, in high-touch areas, in communal areas (residential and staff areas), eating spaces, and in all office spaces.
 - Alcohol-based rub should be isopropyl alcohol or ethanol with a minimum 70% concentration
 - Pump bottles rather than sprays are preferred
 - Foot operated pumps for staff and pumps that can be operated with the elbow at wheelchair accessible height are best
 - Do not place large pump bottles in rooms of cognitively impaired patients – smaller 50-60ml bottles carried by care workers are preferred and residents should be encouraged to use alcohol wipes.

Procedure for decanting alcohol-based hand sanitiser from large containers:

- Decanting must not happen near any ignition sources or near any other chemicals
 - Decanting must happen in a well-ventilated area or outside
 - Immediately clean up any spills or leaks
 - A fire extinguisher should be available
- Paper towel dispensers should be wall mounted close to the hand wash basin where soap dispensers are available.
 - Warm air dryers are not recommended
 - Paper towel should be strong enough to withstand contact with wet hands
 - Single use pull-out paper towels or no-touch dispensers are best
- Training of all staff on hand washing and hand sanitising protocols

- A mapping exercise of all high touch areas in the facility should be undertaken and hand sanitiser should be available in the close vicinity of all of these areas.
- Signs should be placed throughout the facility in places where activities that necessitate hand washing or hand sanitising take place – e.g. dining areas, bathrooms, entrance/exit points to patient rooms, entrance to facility, care giver workspaces.

ii. *Hand hygiene education for staff, residents and education*

Signs demonstrating appropriate hand washing and hand sanitising techniques should be placed at all wash sinks and hand sanitising stations in the facility.

Online hand hygiene course available here: <https://www.bha.org.au/online-learning/learning-module-information>

- **Residents**
 - Residents should be reminded to wash their hands after toileting, after blowing their nose, before and after eating and when leaving their room.
 - If the resident's cognitive state is impaired, staff caring for them must be responsible for helping residents with this activity.
 - In the case of residents with dementia, encourage care givers to link washing hands with a song, music or story.
 - Hand washing rather than hand sanitising should be used after toileting
 - Residents should be informed that alcohol-based rub (i.e. hand sanitiser) should not be applied to wet hands as this can damage the skin.
- **Staff**
 - All staff must understand that hand washing takes priority over other activities, even when the facility is understaffed.
 - Hand hygiene must take place in the following circumstances:
 - BEFORE leaving home, preparing food, eating any food, donning PPE, touching a resident, taking a break and leaving work
 - AFTER arriving at work, touching surfaces in residents' rooms, touching a resident, removing PPE, decontaminating equipment, handling waste, using the toilet, taking a break, after smoking.
 - ADDITIONALLY, all staff or health care visitors with direct bodily contact with residents should adhere to the "5 moments for hand hygiene"
 1. Before touching a patient,
 2. Before clean/aseptic procedures,
 3. After body fluid exposure/risk,
 4. After touching a patient, and.
 5. After touching patient surroundings.

Read the full WHO Guidelines on Hand Hygiene in Health Care here: https://apps.who.int/iris/bitstream/handle/10665/44102/9789241597906_eng.pdf?sequence=1
 - Health and care workers should be taught how to sanitise hands with alcohol correctly, starting with the finger tips.
 - The use of gloves should never be considered an alternative to hand hygiene. Hand hygiene is required before putting on gloves and immediately after they have been removed.
 - Residents should be informed that alcohol-based rub (i.e. hand sanitiser) should not be applied to wet hands.

- Care workers and nursing staff should be advised to keep their nails short and nail polish should not be allowed.
 - Jewellery should not be worn by care workers
 - Care and nursing staff should not travel to and from work in their uniforms and should instead change into their uniforms at work if possible.
- **Visitors** should be reminded to perform hand hygiene on entering and leaving the facility, and before and after visiting any resident.

iii. Procedures for using alcohol-based rub and hand washing

Procedure for sanitising hands using alcohol-based rub:

Source: Infection Control Society of Southern Africa (ICSSA). <https://www.fidssa.co.za/ICSSA>



Procedure for hand-washing:



3. Personal protection equipment (PPE)

All personnel should wear PPE while caring for vulnerable people

- PPE will only prevent spread of infection if it is:
 - Used and changed at the right time
 - Accompanied by good hand hygiene
 - Cough etiquette is applied
 - Mobile phones should not be used whilst wearing PPE
 - All staff, including cleaners & housekeepers, must be trained in how to use PPE
- Facemasks, eye protection, gowns, gloves should be available outside of residents rooms
- A receptacle must be available near the exit of the room for single use equipment
- A sign outside of the room describing precautions required and PPE needed
- All staff with direct contact to older people should be wearing mouth-nose protection to protect patients, even when they are not engaging in direct care cases.

A. PPE requirements

Overcoat / lab coat

- Who wears it & when
 - i. Staff
 - 1. Whenever working with a resident who has COVID-19 or PUI
 - 2. Non COVID-19 or non PUI – optional
 - ii. Residents
 - 1. COVID-19 Positive or PUI
 - a. 2 outside each room, to be shared by staff entering rooms
 - 2. All other residents
 - a. Nil
- Quantity issued
 - i. Staff
 - ii. 1 overcoat to be stored at duty station
 - iii. All doctors & RN's, other health care professionals (HCP) – 1 each per 3 months
- Maintenance
 - i. Non washable
 - ii. Can be reused until soiled or damaged
- Storage
 - i. 1 overcoat for each individual HCP
 - ii. to be stored with doctors' or nurses' equipment, labelled and neatly stored

Plastic poncho

- Can be used in place of overcoat or disposable lab coat
- **Who wears it & when**
 - i. Staff
 - 1. Carers, cleaners, social workers, food handlers
 - a. Compulsory when working with COVID-19 residents
 - 2. Optional for use by all other staff
- Quantity issued
 - i. Staff : 1 per 3 days
- Maintenance
 - i. Sprayed with 70% alcohol after every use
 - ii. Hung up on daily basis

- iii. Labelled with staff member's name

Plastic Aprons

- **Who wears it & when**

Use to protect your uniform or clothes from contamination when providing care or handling food

- i. Staff:

- 1. Carers, cleaners, social workers, food handlers
 - a. Compulsory for any care with COVID-19 residents or PUI than involves touching a resident, worn over poncho
 - b. Wear when within 2 metres of a resident who is coughing

- **Quantity issued**

- i. As required

- **Maintenance**

- i. Single use, disposed of after each use

Masks:

- Masks protect:
 - your nose & mouth from respiratory droplets from residents
 - residents and other staff from respiratory droplets from your mouth and nose (as you might be carrying the infection)
- You can wear a mask for caring for different residents BUT do not touch the mask
 - you could transfer virus to your hands
- Wear the mask on your face – NOT round your neck
- Remove and discard the mask when:
 - you take a break or finish your shift
 - it is damp, soiled, uncomfortable, difficult to breathe

1) Cloth Masks:

These are material masks designed to be re-used.

- Who wears it & when
 - ii. All Staff when off site (especially on public transport)
 - iii. Admin, maintenance, laundry, drivers, kitchen staff when on site
 - iv. Residents who do not have COVID-19 whilst on or off site
- Quantity issued: 2 masks per resident and staff
- Maintenance: Washable, reusable, can be used until soiled and then washed in 60C water

2) Surgical masks, 3 ply:

These are blue masks or green masks, with elastic loops that go behind the ears or have ties for behind the head. 3ply surgical masks are preferable to cloth masks as they have a better fit and are more comfortable (and therefore more likely to be properly worn) and give better filtration protection against droplets and splashes for health care work.

- Who wears it & when
 - i. Staff:
 - a. medical, nursing, other healthcare personnel, cleaners, carers, catering, kitchen, laundry, maintenance, security, reception, admin - *at all times when on site*
 - b. If in a private office or during breaks staff may remove masks to eat or drink, but must remain 2m away from one another at all times. If more than one person in an office, then both to wear masks
 - ii. Residents

- a. Non-COVID
 - i. if preferred to cloth masks and budget is available, when out of room
 - b. COVID-Positive or PUI
 - i. At all times when in contact with staff or staff enter room
- **Quantity issued**
 - i. Staff: medical, nursing, other healthcare personnel, cleaners, carers – issued 1 mask every day. Policies should be in place to manage issuing of new masks in case of loss or damage during the day.
 - ii. Staff - catering, kitchen, laundry, maintenance, security, reception, admin - 1 mask every 3rd day. Policies should be in place to manage issuing of new masks in case of loss or damage during the day.
 - iii. Residents
 - a. Non-COVID
 - i. 2 per week (if no budget then cloth masks to be used instead)
 - b. COVID Positive or PUI
 - i. 1 daily
- **Maintenance of masks**
 - i. Non washable
 - ii. Can be reused until soiled or damaged
 - iii. Masks can last between 3-4 days if cared for properly

3) N95 / KN95 / FFP2 Masks

- **Who wears it & when**
 - i. Staff:
 - a. Medical, nursing staff & unit managers when seeing residents with suspected COVID-19, when doing NP swab
 - b. Under exceptional circumstances, if staff have major comorbidities which are confirmed by a doctor
 - ii. Residents
 - a. Not needed
- **Quantity issued**
 - i. Doctors doing COVID-19 care issued 5 masks per 3 month cycle
 - ii. Nurses & Night staff doing daily COVID-19 care issued 5 masks per month
 - iii. Nurses doing ad-hoc COVID care issued 5 masks per 3 months
 - iv. If masks are soiled, damaged or lost, then they must be returned and a new one is issued
- **Maintenance**
 - i. Non washable
 - ii. Can be reused until soiled or damaged
 - iii. Storage
 - a. 1 mask to be stored in 1 individual paper bag
 - b. Paper bag to be labelled with person's name and mask number (1-5)
 - iv. Mask are to be used on a rotational basis as follows
 - a. day 1 - mask 1
 - b. day 2 – mask 2
 - c. day 3 – mask 3
 - d. day 4 – mask 4
 - e. day 5 – mask 5
 - f. day 6 – mask 1

- g. day 7 – mask 2
- v. Minimum time between mask reuse is 5 days
- vi. Masks to be replaced every 3 months

Face shields

- **Who wears it & when**
 - i. All Staff
 - a. Working with suspected or proven case of COVID-19 or PUI
 - b. who have screened positive for one symptom on symptom screener, but are not at that time deemed to be COVID-19 positive or under investigation e.g.
 - c. staff member has any one of the following symptoms
 - 1. sore throat or
 - 2. a runny nose or
 - 3. a cough or
 - 4. diarrhoea or
 - 5. headache or
 - 6. conjunctivitis
 - ii. Carers, cleaners, drivers, kitchen & catering staff whenever in contact with all residents
 - iii. Doctors, nurses, social workers, admin staff working with non-COVID-19 residents optional for use
 - iv. Residents who wish to have their own face shields
- **Quantity issued:** 1 face shield per resident and staff per 3 months. Policy to replace lost or broken shields to be put in place.
- **Maintenance:**
 - i. Sprayed with Quatricide or other disinfectant after each contact with COVID-19 positive resident
 - ii. Kept at duty station
 - iii. Washable, reusable, can be used until broken

Eye protection

- Wear for direct contact with residents if there is a risk of respiratory droplets getting into eyes
 - e.g. resident who is coughing or vomiting
- Clean after each use using either:
 - disinfectant wipe
 - detergent and water
 - followed by bleach disinfectant (see guidelines for mixing bleach solution)
 - check manufacturer's guidelines

Gloves

- There is little evidence for benefit for wearing gloves in caring for COVID-19 positive residents and may present an unnecessary expense.
- Rather, appropriate hand hygiene protocol should be observed
- Gloves should only be used when handling body fluids, soiled linen, faeces, urine, blood.
- Always remove gloves and wash hands after handling body fluids

COVID-19 PUI or Positive	Cloth Facemask	Surgical Mask	N95 / KN95 / FFP2	Face Shield	Gloves	Overcoat / Lab coat / Poncho	Plastic apron
Doctor			x	x		x	x
RN / ENA			x	x		x	x
Carer		x		x		x	x
Cleaner		x		x		x	x
Social Worker		x		x		x	x
Admin Staff		x		x		x	x
Driver		x		x		x	x
Kitchen / Food		x		x		x	x
Maintenance		x		x		x	x
Resident		x		x			
Soiled Material					x		

Usual Care of Resident	Cloth Facemask	Surgical Mask	N95 / KN95 / FFP2	Face Shield	Gloves	Overcoat / Lab coat / Poncho	Plastic apron
Doctor		x		x		x	x
RN / ENA		x		x		x	x
Carer		x		x		x	x
Cleaner		x		x		x	x
Social Worker		x		x		x	x
Admin Staff		x		x		x	x
Driver		x		x		x	x
Kitchen / Food		x		x		x	x
Maintenance		x					x
Resident	x	x		x			
Soiled Material					x		

x	Personal preference
x	Obligatory at all times

B. Putting on (donning) and removing (doffing) PPE correctly

It is important that PPE be put on and removed properly and that hand hygiene be performed before and after using PPE.

See diagrams on donning and doffing PPE in the [Appendices](#)

Video resources:

- Putting on Full Personal Protective Equipment video:
<https://www.publichealthontario.ca/en/videos/ipac-fullppe-on>
- Taking off Full Personal Protective Equipment video:
<https://www.publichealthontario.ca/en/videos/ipac-fullppe-off>

- Donning <https://youtu.be/ozY50PPmsvE>
- Doffing: <https://youtu.be/ozY50PPmsvE>
- Guidance for mask use in long-term care homes and retirement homes: <https://oltca.informz.ca/OLTCA/data/images/Guidance%20for%20Mask%20use%20in%20LTC%20and%20RH%202020-04-15.pdf>

C. Strategic use of PPE in resource-constrained settings to avoid shortages

- Extended use of some PPE (respirators, facemasks, face shields, eye protection) for an entire shift is possible but care must be taken to avoid touching the PPE. If this happens hand hygiene must be performed immediately.
- Face shields and goggles can be carefully decontaminated and re-used on another shift
- Gowns/aprons should be prioritised for high-contact care or where splashes and sprays are anticipated.
- Gowns/aprons should not be used for caring for different residents unless caring for a cohort of residents with COVID-19 infection and they do not have other known infections.

4. Managing consumables

- In addition to the consumable products required for ongoing prevention, there should be adequate stocks of consumables needed for an outbreak and regular stock takes should be carried out for:
 - Cleaning materials and disinfectant products
 - Hand hygiene products (liquid soap, alcohol-based hand sanitiser, paper hand towels)
 - PPE for cleaning, care and health care staff

5. Physical distancing

A. Residents

- Residents should be encouraged to stay in their rooms or apartments as much as possible
- Signs reminding residents to stay at least 2m from other residents in communal areas should be placed throughout the facility.
- It may be difficult to expect residents living with dementia to maintain physical distancing behaviour. It may also be difficult to restrict the movement of residents living with dementia who “walk with intent” or wander. Wandering behaviour may also increase as their routines are disrupted by COVID-19 restrictions. Some important considerations²:
 - Check in on residents with dementia frequently
 - Try and develop a new routine
 - Keep calm when trying to get them back to their room as residents are sensitive to tone of voice, behaviour and body language as displays of stress and anxiety will negatively influence their behaviour.
 - Do not use physical or chemical restraint
 - Try to guide a resident who is wandering back to their room
 - Try and find activities for residents to do in their room
 - Take residents for walks at low traffic times
 - Rather than saying “no” or “re-directing” requests, try and say “yes” to some part of the request if possible to avoid aggression, motor restlessness and low mood – e.g. “Yes, it is frustrating that you can’t do what you want. Why don’t we...” or “Yes, things

² The Society for Post-Acute and Long-term Care Medicine. Caring for PALTC residents with dementia during the COVID-19 outbreak. May 17, 2020. <https://rosewoodvillage.com/wp-content/uploads/2020/05/Caring-for-Residents-With-Dementia-1.pdf>

are very different now.” Or “Yes, let’s wash your hands and then go back to your room”.

- Delirium may contribute to walking behaviour and an increase in wandering behaviour should be noted and communicated to health care staff
- Try to promote cough etiquette
- Try to promote hand cleansing and offer them hand wipes regularly
- Clean high touch surfaces more frequently

Sharing rooms

- In facilities where it is not possible to place residents in separate rooms it is important that rooms be setup to facilitate social distancing (beds, furniture etc.) at least 2 meters apart.
- Rooms should be cleaned daily and high touch areas disinfected.
- Residents should be requested to wear cloth masks as much as possible and be extra cautious with hand hygiene and respiratory etiquette (sneezing/coughing etc.)
- Shared bathrooms should be cleaned and disinfected at least twice per day (e.g. morning and evening) and trash cans emptied regularly.
- Residents sharing bathrooms should be instructed not to put personal belongings such as toothbrushes directly onto counter surfaces.

Reducing occupancy

- Where possible, discharging residents to home care could help reduce the risk of contagion in high occupancy facilities.
- Where possible, residents should be placed in single rooms – particularly those with cognitive impairment that might make adhering to hand hygiene, physical distancing or mask wearing protocol challenging. However, no one suspected to have COVID-19 should be moved unless strictly necessary.

Communal areas and public spaces – lounges, dining areas, communal kitchens

- It is advisable to suspend all group activities to reduce potential spread of the virus
- Furniture in communal lounge areas and other public spaces should be reduced or removed
- Communal dining should be suspended and meals served in residents’ rooms where possible or stagger dining times (see [Catering](#))
- Physical distancing should be encouraged by spacing any remaining seating 2m apart and placing markers in appropriate areas
- If there is a case of COVID-19 in the facility, all communal spaces should be closed
- Communal areas should be well-ventilated and cleaned and disinfected regularly (every 4-6 hours)
- Limits should be placed on the number of people who can use communal areas (based on size of communal space)
- Elevators: Tissues should be made available on a table/stand outside all elevators to enable people to use the tissue to press the button as shown in the picture below. A trash can should be placed inside the elevator for tissue disposal. These tissues should be re-stocked throughout the day.
 - A sign should be placed outside the elevator to explain the purpose of the tissues.
 - Alternatively hand-sanitiser should be made available outside of the elevator for use at entry and exit.
 - A sign should be displayed advising that no more than two persons should travel in the elevator at a time.
- Visitors should not be allowed into communal areas that may be open for use

B. Employees

Employee areas

- Includes offices and work stations, service areas, employee areas (entrances, tea room, toilets)
- Carry out assessment of these areas and points of contact between people
- Develop disinfection plan based on high-touch areas, especially computer equipment
- Space desks and other work stations to facilitate physical distancing (2m apart)
- Place hand sanitiser at all work stations and desks
- Provide alcohol wipes or spray to staff members to wipe down personal and communal computer equipment and devices.
- Place floor markings to encourage physical distancing
- Require mask wearing
- Keep areas well ventilated
- Discourage the sharing of stationery

Staff shifts

- Place employees in teams/shifts to minimise contact with other teams or shifts
- Don't move employees between teams or shifts
- Stagger lunch and tea breaks to enable social distancing
- If there is space, appropriate facilities and agreement from care workers, having care workers stay in the facility for their shifts to minimise their community exposure and need to travel on public transport should be considered.
- Staff should not be allowed to work in multiple facilities and should rather be brought into one facility full-time.

6. Catering

- Stagger dining times to limit the number of people in the dining room at once
- Create at least a 2m space between tables and chairs
- Make handwashing/sanitising possible before and after eating
- During an outbreak, serve meals in residents' rooms if possible
 - Meals should be wrapped before delivery
 - Catering staff delivering food must drop-off food on a tray outside of the residents' door where possible.
 - Where entry to the resident's room is necessary, catering staff are to sign the room register and to sanitise their hands before and after entry.
 - Residents should be advised to wipe the tray, crockery and cutlery with a disinfecting wipe before.
- Cutlery and crockery should be placed in a dishwasher and washed at the highest temperature.

7. Managing entry to the facility and residents' rooms

A. Employee protocol:

- Care workers should sign in at the door to the facility and perform hand hygiene immediately
- Daily COVID-19 screening and temperature checks to be performed at the door to the facility (see [Screening Stations in Section 2](#)).
- All employees should be made aware of COVID-19 symptoms and should be instructed to phone the facility for screening if they are showing any symptoms or feeling unwell in any way.

- Employees should take special care while using public transport
- Care workers should not travel to work in their work uniforms and should change immediately after arriving.
- All care workers should only work at one care facility
- Non-punitive pay policies should be developed for quarantine/isolation or COVID-related sick-leave to discourage employees from concealing sickness.

B. Health visitors

- Where possible, all health consults should be performed using telehealth services
- Where this is not possible the following measures must be in place:
 - Temperature checks and COVID-19 screening of all health visitors (see [Screening Stations in Section 2](#))
 - Registration of all health visitors to facilitate contact tracing
 - The wearing of masks and following facility hand hygiene protocol is required

C. Friends and family

Lockdowns for residents can have unintended consequences which include: increase in staff workload, loneliness, boredom, loss of physical and cognitive function, increase in behaviours suggesting unmet needs and an increase in chemical and physical restraint.

However, the possibility of allowing essential visitors needs to be weighed up against the virus reproduction rate and community prevalence.

In the case of **HIGH RISK OF COMMUNITY TRANSMISSION**, a no visitor policy should be strictly enforced, except in circumstances where a resident is gravely ill. In these cases, family or persons providing emotional care should be allowed on compassionate grounds. Examples of compassionate grounds include:

- Resident is nearing end of life
- To support residents with dementia or other mental illness who are distressed

In these cases, careful procedures must to be in place:

- No children under the age of 16
- Temperature checking and COVID-19 screening of all visitors see ([Screening Stations in Section 2](#))
- Registration of all visitors to facilitate contact tracing
- Limit visitors to one at a time
- All visitors should be required to wear masks. Residents may not be able to based on their physical or mental state.
- All visitors should be required to sanitise hands before entering the facility and again before entering a residents' room.
- Physical distancing needs to be strictly adhered to between residents and visitors
- If the resident is COVID-positive or suspected of having COVID-19, visitors should wear appropriate PPE (mask, gloves and apron).

In the case of **LOW COMMUNITY TRANSMISSION**, if essential visitors *are* allowed, careful procedures need to be in place:

- No children under the age of 16
- No visitors from "hotspot areas"
- Temperature checking and COVID-19 screening of all visitors
- Registration of all visitors to facilitate contact tracing
- Implement booking system to manage visitor numbers

- Limit visitors to one at a time and consider restrictions on the number of visitors per week and the length of time.
- All visitors and residents receiving visitors should be required to wear masks
- All visitors should be required to sanitise hands before entering the facility and again before entering a residents' room.
- Non-essential services or volunteers should not be allowed
- Physical distancing needs to be strictly adhered to between residents and visitor
- If the resident is COVID-positive or suspected of having COVID-19, visitors should wear appropriate PPE (mask, gloves and apron).

D. Managing access to resident rooms

- Sign-in sheets should be placed outside each residents' room to track anyone who is NOT a care giver who is entering the room
- When a resident has high care needs and given the need for multiple care workers to handle a patient at a given time, it is unrealistic to expect care givers to repeatedly sign the room register throughout the day.
- Care givers should be allocated to work in a certain section each day and the assumption made that they are likely to have contact with all residents in that section.
 - For contact tracing purposes, a register should be kept of which section each care giver is allocated to on a daily basis.

E. Managing residents returning from hospital

- Due to the high likelihood of infection in healthcare settings, residents who are admitted to hospital, either for COVID-19 or non-COVID related reasons should be quarantined and carefully watched for symptoms.
- The table below can be used to track residents leaving for and returning from hospital.

FIRST NAME	LAST NAME	UNIT #	UNIT TYPE	SYMPTOMS	Diagnosis, if available	DATE OF ONSET OF SYMPTOMS	Date of Exposure, if known	SUSPECTED COVID RELATED?	TESTED FOR COVID-19	DATE RESULTS EXPECTED	COVID-19 TEST RESULTS	HOSPICE?	DATE TO HOSPITAL	DATE RETURNED	DATE OF QUARANTINE	EXPECTED DATE OF CLEARANCE	DISPOSITION	STATUS	REASON

- Further information on quarantine procedures and COVID-19 is available in [Section 2](#).

8. Deliveries

Deliveries to facility

- All deliveries and packages for residents should be collected outside the hotel and no delivery personnel should be allowed into the building.
- Wash or disinfect hands before and after touching any delivered item.
- Obtain the name of the person making the delivery
- Screen the person dropping off the delivery
- Complete package log and obtain the name of the resident or staff member who is receiving the supplies and/or package.
- Disinfect item either directly with spray bottle on a paper towel or with a disinfectant wipe. This should be done even if delivery is in a paper bag. Let the package stand until dry, approximately three minutes.
- Disinfect the surface the package was placed on

Deliveries to residents' rooms:

- Whenever possible, leave deliveries received outside resident's door.
- Inform the resident when you are coming, knock on the door and inform resident of the following:
 - You are leaving food or delivery outside their door.
 - Resident can bring the food or package inside, keeping a safe distance of six feet.
 - Resident can discard the plastic bag/cardboard boxes in their trash.
 - Resident to wash their hands with soap and water after opening package.

- If it is not possible to leave delivery outside a resident's door, sign room register and follow typical room entry procedures, sanitising hands before and after entry and exit.

9. Transporting residents

- Avoid any unnecessary transport of resident outside of room
- Resident to wear a mask during transport
- Transport staff also to wear a mask during transportation
- Clean and disinfect equipment used for transportation after use

SECTION 2 – Screening and testing

1. Definitions

Close contact:

- Being within 1 metre of COVID-19 case (or PUI) for 15 minutes or more
- when a person has had face-to-face contact (within 1 metre) of a COVID-19 person, or has been in a closed environment (like room or vehicle) with a COVID-19 person for at least 15 minutes
- Having unprotected direct contact with infectious secretions or excretions of a COVID-19 case (or PUI)
- Direct physical contact with COVID-19 case (or PUI).
- Being present in the room where an aerosol generating procedure was performed on an COVID-19 resident (or PUI).
- Performing an aerosol-generating procedure on a COVID-19 resident (or PUI).
- All persons living in the same household as a COVID-19 case, and people working closely in the same environment as a case.

Brief contact:

- Being in a room or ward with a COVID-19 case (or PUI) without having direct contact with their secretions/excretions
- Conversing with a COVID-19 case (or PUI) at a distance of >1 metre

2. Screening and risk assessment at building entrance for staff and visitors

A. Setup of screening area

- All staff and any essential visitors should be screened daily for COVID-19 symptoms.
- A screening station should be established at the facility entrance and staff entrance (if separate).
- A non-contact infrared thermometer should be available for temperature checks.
 - This should be held 15cm from the entrant's forehead, temple or neck
 - Any temperature over 38 degrees Celsius is considered a fever
- Each entrant who passes the temperature check should fill in their details and should be asked to note if they are experiencing any of the listed symptom. See example of spreadsheet below:

Date:

Name	Reason for visit	Person visiting	Contact number	New, continuing cough or worsened cough	Sore throat	Fever	Chills	Persistent pressure or pain in chest	Diarrhoea, vomiting, abdominal pain	Headache	Loss of taste/smell	Shortness of breath at rest	Fatigue	Muscle pain	Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19?

- The register of those entering each day should be filed at the end of each day and a new sheet used for the following day. This will allow for easier contact tracing should there be an outbreak in the facility.
- The screening station should have pens available in two containers marked “New” and “Used”. Pens should be taken from the new cup and used pens should be sanitised using an alcohol wipe.

B. Screening process

- Any entrant should first be temperature checked at the door.
 - If the temperature is below 38 degrees Celsius, the entrant should proceed to fill out the sign in sheet
 - If the temperature is above 38 degrees Celsius, the entrant should be denied entry and housekeeping called to sanitise the area
 - If the thermometer requires contact it should be wiped with an alcohol pad between uses
- Those entering the building should sanitise hands before approaching the screening station
- Each person should complete the spreadsheet
- The individual managing the screening station should check their questions
 - If all is in order, entrants should be provided with a pre-cut sticker that they can place on themselves
 - If an entrant indicates that they have **any** of the symptoms listed on the spreadsheet, they should be denied entrance.
 - They should go home to self-isolate immediately.
 - Staff should contact their manager/immediate supervisor so that appropriate testing protocol can be applied.
 - Essential visitors should be told to contact the NICD helpline to discuss their symptoms and/or exposure and seek advice on testing.

3. Staff co-morbidity screening/risk assessment and testing procedures

A. Risk Assessment

- It is important to understand whether any staff are at significant risk due to co-morbidities or age
- Provisions should be made for admin staff with underlying chronic conditions or who are over the age of 60 to work from home if possible.
- All staff should complete a confidential health screener which determines the presence of significant underlying conditions, including:
 - Cardiovascular disease
 - Diabetes mellitus
 - Hypertension
 - Chronic respiratory disease, including asthma
 - Immunosuppression due to:
 - Cancer treatment
 - Bone marrow or organ transplantation
 - Immune deficiencies
 - Poorly controlled HIV or AIDS
 - Prolonged use of corticosteroids and other immune weakening medications
 - People with chronic kidney disease undergoing dialysis
 - People with liver disease
- Care workers or health staff with the above underlying conditions who are likely to have close contact with residents, should not be expected to work with confirmed COVID-positive residents.

B. Testing procedures for staff

- Testing procedure followed will vary in accordance with government testing policy at the time.
- If there are large backlogs in public testing, symptom monitoring should be employed and testing only conducted if an individual is likely to have had significant close contact with vulnerable individuals without PPE.
- See table below, which outlines levels of risk and actions required for staff based on type of exposure.

Type and degree of exposure	Level of risk	Initial action	Follow-up actions	Final actions
Brief contact with PUI with appropriate PPE	Minimal risk	None	None	None
Close contact with PUI with appropriate PPE	Minimal risk	None	None	None
Brief contact with PUI without appropriate PPE or PPE not used correctly	Low risk	<ol style="list-style-type: none"> Continue working, ideally performing low transmission activities Wear mask Strict hand hygiene Monitor for symptoms Await test results of PUI 	1. If PUI test result negative then resume normal activities, but maintain strict mask use and hand hygiene for 14 days	None
			2. If PUI test result positive then continue to monitor for symptoms	<ol style="list-style-type: none"> If symptoms develop then test for COVID-19 <ol style="list-style-type: none"> If test negative, then resume normal activities but maintain strict mask use and hand hygiene for 14 days If test positive then isolate and initiate follow-up of contacts If no symptoms after 14 days then continue as normal
Close contact with PUI without appropriate PPE or PPE not used correctly	Moderate risk	<ol style="list-style-type: none"> Continue working, ideally performing low transmission activities Wear mask Strict hand hygiene Monitor for symptoms Await test results of PUI 	1. If PUI test result negative then resume normal activities, but maintain strict mask use and hand hygiene for 14 days	None
			<ol style="list-style-type: none"> If PUI test result positive then quarantine as status changes to high risk. Continue to monitor for symptoms 	<ol style="list-style-type: none"> If symptoms develop then test for COVID-19 If test negative, then resume normal activities but maintain strict mask use and hand hygiene for 14 days If test positive then isolate and initiate follow-up of contacts If no symptoms after 14 days then end quarantine and continue as normal. (If staff member is in a scarce skills category then consider return to work, while taking strict mask/hygiene precautions, if there are no symptoms after 8 days)

Brief contact with COVID-19 person with appropriate PPE	Minimal risk	None	None	None
Close contact with COVID-19 person with appropriate PPE	Minimal risk	None	None	None
Brief contact with COVID-19 person without appropriate PPE or PPE not used correctly	Low risk	<ol style="list-style-type: none"> 1. Continue working, ideally performing low transmission activities 2. Wear mask 3. Strict hand hygiene 4. Monitor for symptoms 	1. If symptoms develop then test for COVID-19	<ol style="list-style-type: none"> 1. If test negative then resume normal activities, but maintain strict mask use and hand hygiene for 14 days 2. If test positive then isolate and initiate follow-up of contacts
			2. If no symptoms develop after 14 days continue as normal	None
Close contact with COVID-19 person without appropriate PPE or PPE not used correctly	High risk	<ol style="list-style-type: none"> 1. Quarantine (home or group facility) 2. Monitor for symptoms 3. Wear masks 4. Strict hand hygiene 	1. If symptoms develop then test for COVID-19	<ol style="list-style-type: none"> 1. If test negative then resume normal activities, but maintain strict mask use and hand hygiene for 14 days 2. If test positive then isolate and initiate follow-up of contacts
			2. If no symptoms after 14 days, then end quarantine and return to work (if staff member is in a scarce skills category then consider return to work, while taking strict mask/hygiene precautions, if there are no symptoms after 8 days).	None
Staff member has respiratory symptoms suggestive of COVID-19 infection, but not unprotected contact with COVID-19 patient or PUI	Moderate risk	<ol style="list-style-type: none"> 1. Test for COVID-19 2. Quarantine at home until test result available 3. Wear mask 4. Strict hand hygiene 	1. If test negative, then return to work after symptom resolution but maintain strict mask use and hand hygiene for 14 days.	None
			2. If test positive, then isolate and initiate follow-up of contacts.	

Source: Department of Health & Department of Social Development, 2020³.

³ Department of Health & Department of Social Development. *Practical Guidelines for the Prevention and Management of Coronavirus Infection in Long Term Care Facilities (LTCF)*. https://www.westerncape.gov.za/assets/departments/social-development/guideline_for_the_prevention_and_management_of_coronavirus_infection_in_long_term_care_facilities_ltcf.pdf

C. Symptom tracking for staff

- Persons who have had contact with persons under investigation or COVID-positive individuals should track their symptoms daily
 - Those in quarantine should be called daily and their symptoms recorded in a spreadsheet
 - Staff being actively monitored can be tracked via regular staff entry protocol but should be aware of both common and more atypical symptoms and should be instructed to call in to report any emerging symptoms rather than arriving to work.
- Symptom tracking can also be carried out using a publicly available app which will also provide staff with further advice and instructions, but this data is stored in a central repository and may not be available to the facility.

<https://app.testforcovid.co.za/>

4. Screening and testing of residents

All residents should be screened daily for COVID-19 symptoms and have their temperature checked.

- Screening and temperature checks should be conducted by nursing staff on duty
- Thermometer must be sterilised between uses on residents

A. Screening criteria

Date:

Name:

Room number/unit number:

Temperature:

Does the person have any of the following symptoms?

- ☐ Fever
- ☐ Chills
- ☐ New onset of cough or worsening chronic cough
- ☐ Shortness of breath at rest
- ☐ Difficulty breathing
- ☐ Persistent pressure or pain in chest
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Decrease or loss of sense of taste or smell
- ☐ Headaches
- ☐ Unexplained fatigue/malaise
- ☐ Difficulty waking up
- ☐ Muscle aches (myalgias)
- ☐ Nausea/vomiting, diarrhoea, abdominal pain
- ☐ Feeling confused (new or more than usual)
- ☐ Pink eye (conjunctivitis)
- ☐ Runny nose/nasal congestion without other known cause

- If the resident is experiencing any of these symptoms (i.e. screener is positive) they should be isolated according to protocol and tested.
- If the resident is experiencing the following four symptoms, they may need emergency care for COVID-19
 - Persistent pressure or pain in chest
 - Feeling confused (new or more than usual)

- Difficulty waking up
- Shortness of breath at rest

Atypical symptoms:

Not all older persons will not present with typical COVID symptoms and nursing staff should be briefed to make note of the following symptoms and alert the resident's doctor:

- *Unexplained tachycardia*
- *Decrease in blood pressure*
- *Unexplained hypoxia (even if mild – i.e. O2 saturation <90%)*
- *Delirium (hypo and hyperactive)*
- *Unexplained or increased number of falls*
- *Reduced appetite*
- *Acute functional decline*
- *Worsening of chronic conditions*

Screening of persons with dementia

- Communication with persons with dementia may be challenging and may make screening for COVID-19 more difficult among residents with dementia
- It is important that carers LOOK for signs of COVID-19 rather than rely on reported symptoms
- People with dementia may have swallowing difficulties which could put them at increased risk of developing chest infections and dehydration – a swallowing assessment may be helpful.

B. Testing of suspected cases or exposed persons

- All residents who are symptomatic should be isolated and tested
 - If a resident displays any of the symptoms during screening or at any other time, the clinician on duty in the facility or the clinician's GP should be alerted and testing carried out if appropriate.
 - PUIs should be tested using a nasopharyngeal sample and should be carried out by the health professional handling the case
 - The PUI should immediately be placed in isolation and their symptoms closely monitored until their test results have been returned.
 - If the PUI tests positive, continue quarantine and patient management procedures and carry out contact tracing and staff management procedures as per Section 3 on Managing Infections
- If a resident is exposed to a staff member or other resident who has developed symptoms or tested positive, the resident should be quarantined and monitored closely for the emergence of symptoms.

C. Screening for general vulnerability

Physical distancing and reduced access to health services because of COVID-19 may result in general and ongoing health and psychosocial needs being overlooked. In addition to collecting daily information on COVID-19 symptoms, it may be useful to use a broader screener such as the interRAI COVID-19 Vulnerability Screener (CVS) ⁴ or another geriatric assessment instrument to understand residents' individual COVID-19 mortality risk and individual needs based on their comorbidities, frailty and cognitive state.

⁴ Follow this link to learn more about the CVS screener and associated software which is free to users: <https://www.esn-eu.org/sites/default/files/interRAI%20COVID-19%20Overview.pdf>

Residents identified as extremely clinically vulnerable must be “shielded” as per Section 1.

- Solid organ donor recipients
- People with cancer who are undergoing treatment (chemotherapy, radiotherapy, immunotherapy, targeted cancer treatments that can affect the immune system, bone marrow or stem cell transplants) and people with cancers of the blood or bone marrow in any stage of treatment.
- People with severe respiratory conditions – cystic fibrosis, severe asthma, severe chronic obstructive pulmonary disease (COPD)
- People on immunosuppression therapies
- People with immune suppressing diseases
- Other people considered extremely vulnerable based on clinical judgement and needs assessment

SECTION 3 - Controlling and managing infection

1. General terminology and procedures

Outbreak:

- Two or more confirmed or suspected cases of COVID within the same facility over 14 days.
- If an outbreak occurs, immediately contact the National Institute for Communicable Diseases (NICD) Outbreak Response Unit

Quarantine:

- Quarantine is required for people who awaiting test results or are asymptomatic, but may be infected because they have had close contact with an infected person.
- Those who develop symptoms becomes a Person Under Investigation (PUI) and should be tested and remain in quarantine until they receive test results.

Person Under Investigation:

- Person who has COVID-19 symptoms or has come into close contact with an infected person without appropriate PPE.

Isolation:

- Isolation is required for people who are who have become symptomatic or have tested positive, but don't require hospitalisation.
- Residents in isolation can share rooms with other persons who are *confirmed* COVID-19 positive via testing.

2. Management of staff showing symptoms or testing positive for COVID-19

A. Tracing contacts

- If a staff member or residents becomes ill, it is essential to trace all close contact within the facility (both staff and residents) so that quarantine and isolation processes can be put in place as quickly as possible.
- Those who have had close contact with a COVID-19 case or PUI *without appropriate PPE* should be entered onto a contact tracing sheet and treated in accordance with the table in Section 3.
- In the case of staff members who test positive, contact tracing must also be carried out in relation to their families and other persons they may have come into close contact with, but this will be carried out by the DoH rather than the facility. As soon a PUI gets tested, either privately (through facilities such as Pathcare, Lancet or Ampath), or publicly through the National Health Laboratory Service (NHLS), any positive COVID lab result and case details goes through the DoH provincial data centre where it is captured. The various districts or substructure leaders are able to access and retrieve this and then this is distributed to pods on the ground who then conduct the contact tracing process of the identified positive COVID case. This involves the case being called and educated about their positive test and what it will entail. The case is further managed for symptom severity, comorbidities, the need for contacts being quarantined and the provision of health resources, medication and food parcels and educational COVID guidance is also provided. All contacts are then documented and called upon if they are not living in the same residence as well as work contact-related contacts and clusters also being contacted with testing protocols set out to be followed. High risk cases and contacts are further managed with frequent check-up calls during the 14- day isolation period.

B. Identifying source of infection

- It is important to establish whether the exposure occurred at work or in a community setting
- All exposed staff members should be interviewed to determine how the exposure occurred. It should be made clear that the interview is not meant for disciplinary purposes, but in order to prevent future exposures.
- In cases where staff appear to have been infected at work, interview all exposed staff to improve systems / training on use of PPE and other protocols to prevent future cases within the facility and identify any other staff and residents that may not have been considered during contact tracing.
- Ask the following questions of staff depending on whether the exposure was to a resident or staff member⁵:

If exposure was to a COVID-19 or PUI staff member, then ask:

- Did they follow strict hand and surface hygiene measures when interacting?
- Did they congregate together in the staff room?
- Did they use the same kitchen equipment?
- Did they have physical greeting contact?
- Did they share a work surface or desk?
- Did they share a desktop computer, laptop, or tablet?
- Did they share any equipment?
- Did they share any stationery?
- Did they travel together?
- Did they attend to a patient together?
- Did they wear a mask?
- Did their colleague wear a mask?
- Was there any shortage of water, soap or alcohol-based sanitiser?
- Was hand and surface hygiene strictly followed during the shift?
- Was PPE used appropriately according to guidelines?
- Was any PPE reused? If yes, what were the circumstances of reuse? (e.g. how many times reused, how stored between uses)
- Was any PPE unavailable?
- How did the staff member don and doff PPE?
- Was hand hygiene performed before and after direct patient contact or contact with the patient environment?
- Was there any shortage of water, soap or alcohol-based sanitiser?

If exposure was to a COVID-19 or PUI resident, then ask:

- Was hand and surface hygiene strictly followed during the shift?
- Was PPE used appropriately according to provincial guidelines?
- Was any PPE reused? If yes, what were the circumstances of reuse? (e.g. how many times reused, how stored between uses)
- Was any PPE unavailable?
- How did the staff member don and doff PPE?

⁵ Department of Health & Department of Social Development. *Practical Guidelines for the Prevention and Management of Coronavirus Infection in Long Term Care Facilities (LTCF)*.
https://www.westerncape.gov.za/assets/departments/social-development/guideline_for_the_prevention_and_management_of_coronavirus_infection_in_long_term_care_facilities_ltcf.pdf

- Was hand hygiene performed before and after direct patient contact or contact with the patient environment?
- Was there any shortage of water, soap or alcohol-based sanitiser?

C. Testing procedures

- If staff or residents become infected or are placed under investigation, those with close contact with the infected persons should be traced using staffing logs to determine which other staff or residents the PUI or infected person has had close contact with.
- See testing procedures for staff under [Screening and Testing](#)

D. Quarantine and isolation procedures

i. Quarantine of staff

- Asymptomatic or pre-symptomatic people with close contact with a COVID-positive individual or PUI that have developed symptoms and are awaiting test results should quarantine for 14 days.
- Ideally, staff should isolate at home, but if this is not possible, they must go to a quarantine facility.
- Ideally, even people with negative test results, but who show COVID-19 symptoms should still go into quarantine for 14 days.
- In the case of essential health care workers, testing can be conducted after 8 days and if negative the health care worker can resume work sooner.
- Staff quarantining at home must be instructed to follow the following protocol:
 - Those in quarantine at home should avoid leaving the house and stay in a separate room to others in the house if possible.
 - Quarantined persons should not share dishes, drinking glasses, cups, eating utensils, towels or bedding with other people or pets in home settings.
 - Masks should be worn by both the person in quarantine and others providing care for or in contact with the quarantined person.

ii. Isolation of staff

- COVID-positive individuals must isolate for 14 days from exposure and can either self-isolate at home or be admitted to a dedicated isolation facility.
- Ideally individuals who do not require hospitalisation should isolate at home, but if this is not possible, they must go to a facility.
- Staff isolating at home must be instructed to follow the following protocol:
 - Those self-isolating at home should avoid leaving the house and stay in a separate room to others in the house.
 - Persons in isolation should not share dishes, drinking glasses, cups, eating utensils, towels or bedding with other people or pets in home settings.
- Isolation timeframes:
 - Asymptomatic: 14 days from positive test
 - Mild disease: 14 days from onset of symptoms
 - Moderate/severe disease: 14 days following stabilisation or 14 days after onset of symptoms if did not require oxygen.
 - Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post infection

iii. Returning to work after quarantine or isolation

Symptoms	Initial Test Result	Instructions
Yes	Positive	<p>Work could start after a minimum of 72 hours after illness resolving, defined as resolution of fever and improvement in respiratory and other symptoms</p> <p>While at work, the HCW should adhere to universal masking recommendations, maintain physical distancing (remaining greater than 2m/6 ft from others) except when providing direct care, and performing meticulous hand hygiene.</p> <p>The care worker should continue self-isolation practices at home for 14 days from symptom onset</p> <p>The care worker or health staff should ideally be cohorted to provide care for COVID-19 positive patients/residents if possible.</p>
Yes	Negative	<p>May return to work 24 hours after symptom resolution</p> <p>If the HCW was self-isolating due to an exposure at the time of testing, return to work should still be under strict measures 14 days from last exposure.</p> <p>While at work, the HCW should adhere to universal masking recommendations, maintain physical distancing (remaining greater than 2m/6 ft from others) except when providing direct care, and performing meticulous hand hygiene.</p> <p>The care worker should continue self-isolation practices at home for 14 days from symptom onset</p>
Never symptomatic but tested	Positive	<p>If there has been a recent potential exposure (e.g. tested as part of an outbreak investigation or other close contact to a case), return to work under strict conditions could start after a minimum of 72 hours from the positive specimen collection date to ensure symptoms have not developed in that time, as the positive result may represent early identification of virus in the pre-symptomatic period</p> <p>If there has been no known recent potential exposures (e.g., tested as part of surveillance and no other cases detected in the facility or on the unit/floor, depending on the facility size), there is no minimum time off from the positive specimen collection date as it is unclear when in the course of illness the positive result represents (i.e., consistently asymptomatic care workers should continue working with special precautions and self-isolating outside of work until 14 days from specimen collection date).</p>
Asymptomatic and not tested	N/A	<p>If there has been a recent potential exposure, care worker should continue to work and ideally performing low transmission activities, wear a mask, maintain strict hand hygiene and monitor for symptoms as per table in Section 2</p>

Source: Ontario Ministry of Health, 2020. COVID-19 Quick Reference Public Health Guidance on Testing and Clearance, May 28 2020
http://health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_testing_clearing_cases_guidance.pdf

3. Management of residents under investigation and confirmed cases

PUIs and resident testing positive for COVID-19 should be isolated from other residents. These residents should be in their rooms and should be allocated their own bathroom or have all their ablutions carried out in their rooms.

Cohorting (grouping) of positive residents and PUIs is not suggested if it requires moving the resident and potentially spreading the virus around the facility in the process.

A. Tracing contacts

- If a resident becomes ill, it is essential to trace all close contacts (both staff and residents) within the facility so that quarantine and isolation processes can be put in place as quickly as possible.
- Those who have had close contact with a COVID-19 case or PUI *without appropriate PPE* should be entered onto a contact tracing sheet and treated in accordance with the table in Section 3.
- If a resident has had contact with visitors, contact tracing must also be carried out in relation to their families and other persons they may have come into close contact with, but this will be carried out by the DoH rather than the facility.

B. Quarantine and isolation of residents

i. Quarantine of residents (PUIs)

- Quarantine timeframes
 - Ideally, even people with negative test results but who show COVID-19 symptoms should still remain in quarantine for 14 days.
 - Individuals must quarantine for 14 days from exposure
- Residents in quarantine should be housed in individual rooms to avoid infecting others or being infected by COVID-positive individuals (some PUIs will be positive while others may not be)
- Ideally residents in isolation should have their own bathroom
 - If this is not available, ablutions should be carried out in their individual rooms.
 - Alternatively, demarcate specific toilets, basins and showers for the exclusive use of quarantined residents.
 - All ablution facilities dedicated to quarantined residents should be cleaned 4-6 times per day.
- Rooms should be marked to alert staff to their status and residents should receive no visitors, wear a mask when interacting with care workers or health staff and appropriate PPE needs to be worn by any entering the room.
- In cases where residents were sharing rooms prior to COVID-19, the following protocol should be followed:
 - If the PUI or COVID-19 positive resident was already sharing a room and their roommate is asymptomatic or tests negative, the asymptomatic person should be quarantined in another single room, tested and watched closely for symptoms
 - In cases where a resident is moved, precautions need to be taken moving the asymptomatic person to another room so ensure that the virus is not spread in the move (e.g. minimise distance travelled where possible, sanitise all belongings before moving, resident must wear a mask and the areas they travel through should be disinfected).
 - If the PUI or COVID-19 positive resident is sharing a room and their roommate tests positive, both residents can remain in the shared room in isolation.

- Masks should be worn by both the person in quarantine and others providing care for or in contact with the quarantined person.
- In the case of an outbreak, it is not necessary to set up a quarantine section of the facility as re-locating residents is likely to spread the virus through the facility.
 - If, however, it is necessary to re-locate an individual to a single room or cohort residents in a quarantine section for the purpose of providing care, careful measures need to be in place before moving residents:
 - Plan to minimise the number of residents moved and distance they move
 - All personal items must be disinfected prior to travelling
 - Resident must wear a mask while travelling
 - Area travelled through must be thoroughly disinfected
- Limit the number of staff members entering the room to essential staff and ideally allocate one care worker to the individual per shift and one additional care worker who may be called upon for activities that require two persons (e.g. lifting).
- Care workers in close contact with isolated residents should not work with residents in the general population.
- Follow all infection and prevention control precautions outlined in Section 1, including use of PPE, enforcement of strict protocol in relation cleaning, disinfection and disposal of medical and other waste.

ii. Isolation of residents

- Residents quarantined in LTCFs should be in individual rooms, rooms should be marked to alert staff, residents should receive no visitors, wear a mask when interacting with care givers.
- Residents should not leave their rooms at any time and if they do not have their own bathroom adjoined to their room all ablutions should be carried out in their rooms.
- Isolation timeframes:
 - Asymptomatic: 14 days from positive test
 - Mild disease: 14 days from onset of symptoms
 - Moderate/severe disease: 14 days following stabilisation
 - Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post infection
- Limit the number of staff members entering the room and ideally allocate one care worker to the individual per shift and one additional care worker who may be called upon for activities that require two persons (e.g. lifting).
- Care workers in close contact with isolated residents should not work with residents in the general population.
- There is no need to re-test before isolation ends
- Follow all infection and prevention control precautions outlined in Section 1, including use of PPE, enforcement of strict protocol in relation to cleaning, disinfection and disposal of medical and other waste.

iii. De-isolation procedures for residents

- Asymptomatic cases that were tested: 14 days from positive test
- Mild disease: 14 days from onset of symptoms
- Moderate/severe disease: 14 days following stabilisation
- Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post infection
- After de-isolation, residents should continue to take all preventative measures taken by general residents

iv. *Managing isolation and quarantine of persons with dementia or cognitive impairment*

- Persons with dementia are likely to present challenges in terms of isolation or quarantine as they may resist protocol by wanting to leave their room or refusing to wear a mask or struggle with increased anxiety.
- Family and carers should help to plan activities to assist in alleviating boredom that can be undertaken without close contact with others.
- Keep in mind a list of activities, songs, conversations and interests that can be used quickly, particularly if they grow restless and suspicious about isolation.
- Provide support in contacting family and friends remotely (telephone, Whatsapp, Facetime, Skype and Zoom)
- Consider dedicating a staff member to quarantine in the room with people with dementia or cognitive impairments.

4. Caring for PUIs or COVID-19 positive residents

A. Medical management

- All PUIs and positive residents should be monitored carefully for symptoms and the appropriate clinical management protocol put in place for symptomatic patients
- See [Appendices](#) for COVID-19 clinical management protocol. *Note: These are based on existing guidelines and clinical experience of the authors working in a nursing home and are not evidence-based.*

C. Medical equipment

- Care homes who do not yet have the capability to measure heart rate, blood pressure, respiratory rate and pulse oximetry should be provided with, or consider buying this equipment for residents that will be managed within the facility rather than transferred to a hospital.
- Any medical equipment used on COVID-19 residents should be dedicated to the use of infected residents only.
- Any medical equipment used on PUIs should be dedicated to the use of PUIs only (not shared with COVID-19 positive residents).
- No PPE should be stored in the room of any PUI or COVID-19 positive resident.

D. Escalation

- Any escalation should be done in accordance with the resident's advance care plans.
- All resident's advance care plans should be updated as a matter of urgency – see Section 4 on [Advance Care Plans](#)
- Care homes should be aware that escalation decisions to hospital will be taken in discussion with paramedics, general practitioners and other health care support staff.
 - Transfer to hospital may not be offered if it is not likely to benefit the resident and if palliative or conservative care within the home is deemed more appropriate.
 - Care homes should work with health care providers to support families and residents through this.

E. Transfer to hospital

- The provincial Emergency Medical Services manager must be contacted when an ambulance is requested to transfer a suspected or confirmed COVID-19 patient to a designated /referral hospital.

- The Provincial Communicable Disease Control centre must be informed prior to EMS medical evacuation of any suspected/confirmed COVID-19 patient.

F. Returning from hospital

- Any resident returning from hospital after a COVID-19 diagnosis should be isolated for 14 days from the onset of symptoms ([See table for managing residents returning from hospital in Section 1](#))

G. End of life care within LTCFs

People in care homes and their families should be involved, as much as possible, in planning and decisions about their health and care, including end of life care, and should be supported in having honest, informed and timely conversations.

- Visits by family should be allowed at end of life. Guidance on safe distancing during these visits is available in [Section 1](#).
- Personal advanced care plans should be followed in terms of palliative care
- When making decisions during the pandemic about the care and treatment of people who lack the relevant mental capacity, staff should seek consent on all aspects of care and treatment to which the person can consent.

5. [Dealing with the death of COVID-19 positive residents](#)

Certifying death

- Any confirmed COVID-19 resident must have COVID-19 recorded on their death certificate.
- If COVID-19 was the suspected cause of death, confirmatory testing should be undertaken as soon as possible via a nasopharyngeal test.

Managing human remains⁶⁷

- To date there is no evidence of persons having become infected from exposure to the bodies of persons who died from COVID-19
- Keep both the movement and handling of the body to a minimum
- The body should be cleaned and wrapped by care workers in full PPE, including mask, apron, gloves and eye protection.
- Prepare the body for transfer including removal of all lines, catheters and other tubes.
- Ensure that any body fluids leaking from orifices are contained
- Wrap body in cloth and arrange for transfer it as soon as possible to the holding area. No special transport equipment is required.
- There is no need to disinfect the body before transfer to the holding area.
- Body bags are not necessary, although they may be used for other reasons (e.g. excessive body fluid leakage).
- The undertaker should be contacted and informed that they will be collecting the remains of a COVID-19 positive or suspected COVID-19 case so that they can make adequate preparations to receive the body.
- If the family wishes to view the body, they may do so, using standard precautions. They are not allowed to touch or kiss the body. Embalming is not recommended to avoid excessive manipulation.

⁶ World Health Organization Infection Prevention and Control for the safe management of a dead body in the context of COVID-19. WHO interim guidance, March 24 2020. <https://apps.who.int/iris/handle/10665/331538>

⁷ Department of Health. COVID-19 Disease: Infection Prevention and Control Guidelines Version 2, 21 May 2020. <https://www.nicd.ac.za/wp-content/uploads/2020/05/IPC-guidelines-covid-19-version-2-21-may-2020.pdf>

- Adults >60 years and immunosuppressed persons should not directly interact with the body.

Cleaning

A terminal clean of the resident's room is required (see [Cleaning in Section 1](#))

SECTION 4 – Preparation and policies

1. Preparations by Management

- Designate one person as the Infection Prevention Control focal point person
 - This person should oversee:
- Outbreak committee
- Review clinical governance processes and apply to the current situation, which may change rapidly.
- Develop plans with local GPs and other primary care colleagues, to agree on escalation processes, and communication plans about residents' changing care needs.
- Consider how the service will respond if staff are unwell or unable to work, this may include deploying an alternative workforce.
- If parts of organisation have closed (e.g. day centres or day respite) consider how staff can be redeployed according to their skills and personal circumstances.
- Consider whether your organisation can implement flexible work hours in order to maintain services.

2. Preparing staff and maintaining staff availability and well-being⁸

- Review and update all staff contact details, and emergency contact details.
- Provide regular updates to staff as new information is released, and when there is any change to processes and priorities.
- Identify how you will communicate regularly with staff and who is responsible for contacting staff.
- Identify any staff members in at risk groups, staff who are unwilling to deliver face to face care, and in what circumstances.
- Identify whether these staff can be redeployed to alternative roles, such as making phone calls to residents who are unwell at home, monitoring daily staffing and updating supervisors, contacting families of any concerns or emergencies, completing paperwork etc.
- Identify who staff should contact if they are unwell or are unable to come to work, and provide that person's contact details to all staff.
- Staff training is important – all care givers and nursing, cleaning, kitchen and laundry staff need to be trained on:
 - Hygiene protocol relevant to their work function
 - Standard Operating Procedures relevant to their work function
 - PPE appropriate to their work function
 - How to support and communicate with residents (care and nursing staff)
 - How to protect themselves at home and while travelling to work
 - Keep records of training, particularly training relating to infection prevention and control.
- Confirm whether the organisation has developed procedures to address unforeseen circumstances, and who will be responsible for managing and coordinating the response to unforeseen circumstances.
- Identify who is responsible for providing information to residents and families as situations change.
- Keep a record of staff members who have recovered from COVID-19 and therefore may

⁸ Australian Government Department of Health. Guide for Home Care Providers. 21 May 2020.
<https://www.health.gov.au/resources/publications/coronavirus-covid-19-guide-for-home-care-providers>

be immune.

- Encourage and promote flu vaccination. Keep records of staff immunisation.
- Where possible apply for or raise additional funding to employ additional care staff or pay bonuses to staff who are likely working under significant pressure and experiencing anxieties about their own safety
- Care staff should have a platform for support and asking questions.
 - Care givers in South Africa are invited to join this Whatsapp group by following this link: <https://chat.whatsapp.com/E8QI5jNrMGZ28MQJQQIez5> or a facility-specific group can also be set up,

3. Preparing residents⁹

- Update residents' records, including their contact details, emergency contact details, and current GP.
- Identify any residents at risk of harm due to non-compliance with public health requirements e.g., hand hygiene, or self-isolation.
- Identify residents who have advance care plans and keep a copy if possible.
- Encourage advance care planning, and discussion between residents, their doctors and families to clarify wishes and intentions.
- Encourage and promote flu vaccination.
- Develop an emergency plan for use by residents and carers.

The emergency plan should contain:

- details of the name, address and other contact details of the resident
- emergency contacts, such as their friends, family, legal representative, or others;
- details of any medications they take, including dose and frequency;
- details of current GP and any other relevant professionals;
- details of any ongoing treatment; and
- details of the residents' advanced care plan/directive

4. Advance directives¹⁰

- Care homes should work with General Practitioners, community health care staff and community geriatricians to review advanced directives as a matter of urgency with care home residents as existing directives may not hold in the context of the pandemic (e.g. do not respiration).
- This should include discussions about how COVID-19 may cause residents to become critically unwell, and a clear decision about whether hospital admission would be considered in this circumstance. There are some situations in which supportive treatments such as care home-based oxygen therapy, antibiotics and subcutaneous fluids should be supported as part of the local responses to COVID-19.
- The harms and benefits of such treatments must be considered carefully, and they should not be used in place of good palliative care.
- Advanced directives must be easily understandable and useful for the health care professionals called in an emergency situation. A paper copy should be filed in the care home records and, where the facility already exists, an electronic version used which can be shared with relevant services

⁹ Australian Government Department of Health. Guide for Home Care Providers. 21 May 2020.

<https://www.health.gov.au/resources/publications/coronavirus-covid-19-guide-for-home-care-providers>

¹⁰ COVID-19: Managing the COVID-19 pandemic in care homes for older people. Good Practice Guide. British Geriatrics Society. 2 June 2020. <https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes>

5. Supporting residents and families

- COVID-19 presents particular challenges in supporting people to make their own decisions, and where necessary making decisions in their best interests, in the context of protecting the person's own health and reducing the risk of infection to others.
- Clear communication with families about new policies and procedures within the facility, any outbreaks and updates on residents' health are essential over this time.

A. Compensating for physical distancing

- Restricting visitation and reducing communal activities is likely to increase loneliness which can have significant negative effects on the well-being of residents.
- In collaboration with families, management must ensure that all residents have the ability to communicate with friends and family, either telephonically or through digital means and care workers or other staff should provide the necessary hands-on support to achieve this.
- Lower levels of physical activity due to facility lockdown, quarantine or isolation may cause de-conditioning and loss of fitness that has serious implications for the physical and mental health of older persons.
 - Provided there is no outbreak at the facility, residents should be allowed to do socially distanced walks around or outside of the facility, keeping their distance from other residents or encouraged by care workers to do exercises in their rooms.
 - Residents in quarantine should be allowed to do supervised walks in a limited area well away from other residents or encouraged by care givers to do exercise in their rooms.

B. Supporting people with dementia and cognitive impairment:

- People with dementia and cognitive impairment are likely to be most affected and confused by physical distancing and changes in routine.
- Care givers should be trained on how to support these residents over this time. Some measures to support them include:
 - Posters and reminders
 - Clear communication
 - Tell residents that the advice is from a trusted person – e.g. GP, children or government so they know it isn't the care giver's choice
 - Stay calm, matter of fact and upbeat as people with dementia will pick up on anxiety and panic
 - Limit access to COVID-19 news and conversations
 - Keep the mood light
 - Encourage regular phone and digital contact
 - Link washing hands with a song, music or story
 - Keep in mind a list of activities, songs, conversations and interests that can be used quickly, particularly if they grow restless and suspicious about isolation.

APPENDICES

Standard Operating Procedures for Doctors in LTC facilities for residents who have been diagnosed with COVID-19 or suspected COVID-19 positive.

Authors: Dr Leon Geffen and Dr Marcus Brauer, June 2020

These SOPs are based on clinical experience and current treatment guidelines and not evidence-based

PPE to be worn on round by Doctors & Registered Nurses

1. KN95, N95 or FFP2 mask
2. Visor
3. Outer gown

Items on Trolley

1. Pulse oximeter
2. Braun ear thermometer
3. Disposable ear covers for thermometer
4. BP Cuff
5. Stethoscope
6. Hand sanitiser (70% isopropyl alcohol) with plunger x 500ml
7. 70% isopropyl alcohol in spray bottle to clean instruments after each use X 500ml
8. Disposable gloves - Nitrile (for those doctors who want them),
 - a. Small - 1 box
 - b. Medium - 1 box
 - c. Large - 1 box
9. Patient folders for the round
10. Updated medication list for each patient to be seen, must be correlated with blister pack
11. A3 COVID Positive & PUI assessment & observation chart
12. Pen
13. Prescription pad
 1. Private
 2. Department of Health

Process for assessment

1) How to identify who is to be seen

- a) Any resident known to be COVID positive and defined as an active case
- b) Any resident with change from baseline who nursing staff identify as acute change from baseline
 - i) These patients need to be assessed carefully as older people may present with atypical symptoms e.g. delirium or neurological signs
- c) Any resident who has previously been seen by the COVID Dr and deemed to be in isolation or quarantine
- d) No person is de-isolated until confirmed by doctor

2) Medical Assessment & Treatment protocol

- a) Direct face to face contact to be kept as short as possible, ideally < 15 min
- b) Maintain 2 meter distance from patient or as much as is practically possible
- c) Patient's general wellbeing & know the patient's baseline symptomatology well so as to determine change over time
- d) Respiratory rate

- i) If > 28 bpm, then consider Nasal O2 irrespective of SpO2
 - ii) Requires regular review by nursing staff every 4 hours
- e) Temperature using ear thermometer
 - i) If > 38C add paracetamol for symptom control
- f) SpO2 using oximeter
 - i) Finger must be warm
 - ii) Ensure patient is well perfused
 - iii) Pulse oximetry pulse signal must match patient's pulse
 - iv) Try and determine pre COVID baseline SpO2 & Pulse on Room air
 - v) SpO2
 - (1) If < 94% on room air then prone patient if physically able, (this step is prior to application of O2 as there may not be an O2 concentrator readily & immediately available)
 - (a) Leave patient in prone position for 2-3 minutes and observe change in SpO2
 - (i) Prone patient with 2-3 pillows under chest & if necessary try add 2-3 pillows under pelvis as well to improve comfort - depending on size of tummy
 - (ii) Comfort may be improved if arms are placed in front of the head or folded under the forehead. Try different arm positions if the above is uncomfortable
 - (b) If SpO2 improves whilst prone to > 94% then
 - (i) Encourage to prone for 30-60 min as frequently as tolerated during day - at least 4 times per day
 - (ii) add nasal oxygen starting at 2l/min to keep SpO2 > 94%,
 - 1. increase O2 flow rate if required to keep sats > 94%
 - 2. Patients may have difficulty tolerating > 4-5 l/min for a prolonged time
 - (2) If SpO2 < 92%, then nasal O2 must be administered
 - (3) If SpO2 < 90% despite maximal nasal prong O2, then consider hospitalisation for HFNO
- g) Advise Clexane 40mg s/c daily for patients who are immobile and / or symptomatic, provided they are not on pre-existing anticoagulation and have no contraindications
 - i) Stop once asymptomatic and recovered (usually by Day 14)
- h) Prednisone 40mg daily (as alternative to dexamethasone 6mg daily) for 5 - 7 days as clinically indicated
 - i) Consider antibiotic cover if secondary bacterial infection is a possibility
- j) Weaning of nasal O2
 - i) Clinical improvement of symptoms AND
 - ii) Reduced respiratory rate AND
 - iii) Improvement of SpO2 > 94% (or back to pre COVID baseline) AND
 - iv) No reduction of SpO2 < 95% if nasal O2 flow rate is reduced
 - v) Process must be slow over days, not hours

3) How long to treat

- a) All positive residents and PUI to be in isolation for 14 days from date of test or onset of symptoms
 - i) All residents who meet above criteria to be seen daily by COVID doctor
 - ii) If someone has very mild symptoms or has, in the opinion of the doctor, not got COVID, then isolation can be reduced to 8 days

Infection and prevention control checklist

Source: Health Protection Scotland, 2020¹¹

¹¹ Health Protection Scotland. 17 COVID-19 Incident or outbreak control tool for social or community care or residential settings, Version 1.1. 17 April 2020. https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2980/documents/2_covid-19-tool-for-social-or-community-care-and-residential-settings.pdf

Immediate Infection Prevention and Control Checklist

Environment, Equipment and Practice

<input type="checkbox"/>	Are confirmed and possible cases isolated or cohorted; doors should be closed where possible; and appropriate signage in place (maintaining confidentiality as appropriate)?
<input type="checkbox"/>	Have confirmed and possible staff cases been sent home from work for a minimum of 7 days?
<input type="checkbox"/>	Are staff cohorted to care for either confirmed/symptomatic or non-symptomatic individuals?
<input type="checkbox"/>	Has the facility actively promoted and communicated to all individuals in the facility the importance of hand hygiene (HH) as per WHO 4 Moments?
<input type="checkbox"/>	Have staff who may be at increased risk due to underlying health conditions, immunosuppression or pregnancy been provided with appropriate advice from line management/occupational health?
<input type="checkbox"/>	Has the facility ensured that staff are aware of the correct personal protective equipment (PPE) to use; when it must be worn and removed; and that it must not be used inappropriately?
<input type="checkbox"/>	Has the facility ensured that staff always wear the correct PPE as per the COVID-19 guidance and that PPE is always removed on leaving the isolation/cohort area, and always perform hand hygiene after removing PPE?
<input type="checkbox"/>	Has a cleaning/disinfection regime been established for the cohort/isolation area and equipment in it? This must be undertaken with detergent then disinfectant (or combined detergent/disinfectant) at a dilution of 1000 parts per million available chlorine (or whatever product has been recommended for use by the facility).
<input type="checkbox"/>	Is twice daily cleaning and disinfection of all frequently touched surfaces in place?
<input type="checkbox"/>	Is there dedicated reusable care equipment available for use for individuals with confirmed COVID-19?
<input type="checkbox"/>	If it is not possible to have dedicated items of reusable equipment for isolation/cohort areas, is any equipment removed from isolation/cohort areas cleaned and disinfected before any use elsewhere?
<input type="checkbox"/>	Has the environment been de-cluttered and all non-essential items and equipment removed (or disposed of) from the room ensuring that when it is removed it is cleaned and disinfected before being placed in a storage area?
<input type="checkbox"/>	Have portable cooling fans been removed from areas (risk of airborne dissemination of virus)?
<input type="checkbox"/>	Are tissues and hand wipes available for symptomatic individuals; and foot-operated bins available for disposal of wipes and tissues?

Movement restrictions

<input type="checkbox"/>	Have all non-essential movements within the facility and to other facilities been cancelled or rescheduled?
<input type="checkbox"/>	Is the area closed to admissions, if considered beneficial to gaining control?
<input type="checkbox"/>	Has all non-essential visiting to the facility been restricted?
<input type="checkbox"/>	Have symptomatic staff or those who live in the same household as symptomatic cases been reminded to follow "stay at home" advice as described on NHS Inform?

Individual care assessment

<input type="checkbox"/>	Have unwell individuals had their condition reviewed as necessary by a clinician/GP?
<input type="checkbox"/>	Have samples (throat swabs) been collected from symptomatic individuals as advised by HPT?

Knowledge & Information

<input type="checkbox"/>	Have all staff in the facility been informed of the COVID-19 outbreak and IPC requirements?
<input type="checkbox"/>	Have all individuals (and relatives/carers as appropriate) been informed of the situation, precautions/restrictions and risks, and provided with information from NHS Inform?
<input type="checkbox"/>	If the facility is closed to admissions, is an approved notice in place on entry to the area?

<input type="checkbox"/>	Have all other relevant parties (e.g. care home parent organisation) been informed of the outbreak as per local policies and procedures?
<p>Criteria to discontinue isolation: Individuals should continue to be isolated for a minimum of 14 days from symptom onset (or first positive test if symptom onset undetermined) and resolution of fever for 48 hours without the use of antipyretics.</p>	
<div> Completed by (name/designation): Date: </div>	

Complete for contact of a confirmed Coronavirus disease 2019 (COVID-19)

Case

Details of health official completing form: Date: _____
Surname: _____ Name: _____
Role: _____ Facility name: _____
Email address: _____ Contact number: _____

Surname: _____ Name: _____

Date of birth: _____ Age(Y) _____ Sex ☐ M ☐ F

Healthcare worker ☐ Y ☐ If yes, facility name: _____

Contact number/s: _____ Email: _____ Next of kin: _____ Contact number: _____

Physical address:

House number _____ Street : _____ Suburb: _____ Town: _____

District: _____ Province: _____

Details of confirmed COVID-19 case:

Contact type: Close* ☐ Casual ☐ Relation to case: _____ NICD Identifier: _____ Surname: _____

DOB: _____

Instructions for completion: Mark “Y” if symptom present and “N” if not. If any symptoms present, contact 0828839920 and make arrangements for the collection of a combined nasopharyngeal and oropharyngeal swab. Days post-exposure to case.

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
Measured temp														
Chills	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Cough	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Sore Throat	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Myalgia/body pains	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Diarrhoea**	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/>
	N	N	N	N	N	N	N	N	N	N	N	N	N	N

**Close contact: A person having face-to-face contact(<2metres) or was in a closed environment with a COVID-19 case, this includes, amongst others, all persons living in the same household as the COVID-19 case and people working closely in the same environment as a case.*

***Diarrhoea defined as three or more loose stools in a 24 hour period.*

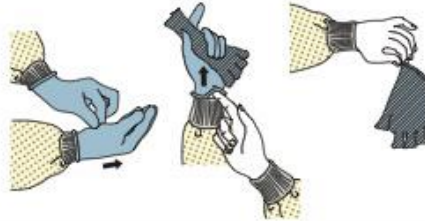
Donning and Doffing PPE

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container



2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container



3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

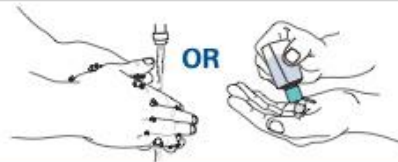


4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



**PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS
BECOME CONTAMINATED AND IMMEDIATELY AFTER
REMOVING ALL PPE**



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HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container



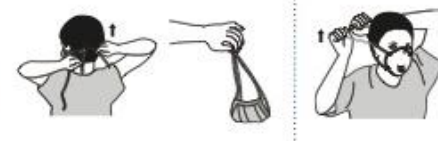
2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

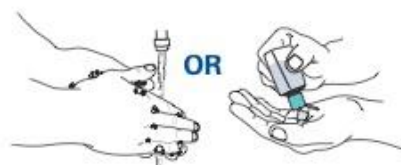


3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



**PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS
BECOME CONTAMINATED AND IMMEDIATELY AFTER
REMOVING ALL PPE**



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