COVID-19 Specific Disease Protocol (Winnipeg) – Acute and Community Health-care Settings

This guidance is informed by currently available scientific evidence and expert opinion and is subject to change as new information on transmissibility and epidemiology becomes available.

Most recent updates are included in blue. Changes are also referenced on the final page of this document.

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Cause/Epidemiology
The causative organism is a coronavirus. Transmission is described as occurring from animal host to human and later from human to human host. The initial animal host is not yet confirmed.

Infection Prevention and Control Practices
Implement the Personal Protective Equipment Supply Management and Stewardship Planning and Guidance Framework.
Follow Routine Practices and Enhanced Droplet/Contact Precautions in addition to the following:

Entrance Screening Points

- Ensure appropriate signage available in all patient entry locations (e.g., triage, registration, clinics, out-patient labs, diagnostic imaging)
- Encourage patients to perform hand hygiene (provide alcohol-based hand rub), and provide a medical mask to the patient. If patient has signs or symptoms of a respiratory infection, encourage respiratory hygiene/cough etiquette (provide, tissues, alcohol-based hand rub and a waste receptacle
- All escorts, designated caregivers, and general visitors must pass screening. Encourage escort/designated caregiver/visitor to perform hand hygiene (provide alcohol-based hand rub); provide them a medical mask
- Assess patients presenting with exposure criteria in a timely manner and ensure staff asking the listed questions for active case finding (e.g., travel or exposure history) do the following
    - Have patient and escort perform hand hygiene
    - Mask all patients (medical) and escort (even if asymptomatic)
    - Segregate immediately into a single room; maintain 2 metre separation
    - If not possible to immediately isolate, direct symptomatic patient(s) and escort to a segregated waiting room/area that is physically separate from the main waiting room/area and supports a 2 metre separation between patients
        - Screen escort for signs and symptoms of acute respiratory illness, refer for medical assessment where appropriate, and manage in accordance with this document
- Factors that raise the index of suspicion should also be considered. Other exposure scenarios may arise and may be considered (e.g., history of being a patient in the same ward or facility during a healthcare-associated outbreak of COVID-19)
- Patients vaccinated for COVID-19 should be managed like all other COVID-19 suspects: screened for symptoms and potential exposure; and if present, appropriate placement on Enhanced Droplet/Contact precautions. Consult IP&C/designate to assist with determining if testing should be conducted
- If a patient develops symptoms of COVID-19 following vaccination, isolate immediately; test for COVID-19 after 24-hours if symptoms persist.
- Clinic teams should screen via telephone, whenever possible, before scheduling an appointment for a patient who screens positive for COVID-19 and consider rescheduling non-emergent appointments

- Remove any frequently handled unnecessary items from waiting rooms, i.e., magazines and toys.

Recovered Laboratory-Confirmed COVID-19 Cases

There is not enough evidence to ensure prolonged immunity from previous COVID-19 infection. For persons previously identified as COVID-19 positive (within 180 days of initial infection)

- Do not re-test unless there is a known exposure or outbreak. Before retesting, consult IP&C/designate
    - Asymptomatic person: Further testing is not recommended, including asymptomatic admission screening
        - Comprehensive clinical assessment
    - Symptomatic person: Investigation according to clinical presentation (example: testing for influenza or other respiratory viruses for acute respiratory syndrome)
        - Clinician must perform a diligent and in-depth clinical evaluation to verify whether the symptoms can be explained by an alternative diagnosis (e.g., bacterial pneumonia, pulmonary embolism, heart failure, etc.) and document the epidemiological context of the new episode
        - Isolate case during the investigation. In the absence of an alternative diagnosis, manage as COVID-19 suspect.
        - If it has been less than six months since they were determined to be a confirmed case and they require hospitalization for their new symptoms, testing for COVID-19 may be considered. COVID-19 testing should be done if they require admission to the intensive care unit for their symptoms. The laboratory requisition should say “possible reinfection” under testing indication
- Patients may have chronic respiratory symptoms and/or a post-viral cough, which do not require maintenance of enhanced precautions for COVID-19
- If re-testing, place on Enhanced Droplet/Contact precautions. Evaluate results in cooperation with IP&C/designate, for interpretation to determine if case is considered communicable and any contact tracing necessary
- There are no restrictions to admitting COVID-19 recovered patients to either green units or ones with orange/red patients. This decision can be based on bed availability; private room is not required. NOTE: At 180 days from date of positivity, persons deemed recovered from COVID-19 should not be on COVID-19 designated units, or cohorted with Orange or Red Zone patients. For persons previously identified as COVID-19 positive (within 180 days of initial infection) see: Infection Prevention and Control Guidance COVID-19 Recovered.

Contact Tracing/Management

Refer to Updated IP&C COVID-19 Contact Management in Acute and Long-Term Care Facilities algorithm.

Orange and Red Zone:

Accommodation & Monitoring
Implement Enhanced Droplet/Contact Precautions

- Place appropriate signage at the entrance to the room to indicate necessary precautions required for staff and visitors
- Do not cohort COVID-19 suspects. Cohorting is only possible for patients with confirmed COVID-19 infection (red zone), including variants of concern (VOC). If cohorting is necessary, consult Infection Prevention and Control
    - Where patients with confirmed COVID-19 infection (red zone) have been cohorted and one has recovered, this patient may be moved into the Green Zone as required
- Maintain a 2 metre separation between patients with signs/symptoms and exposure criteria consistent with COVID-19 infection and all other patients and/or visitors
- Dedicated red units: can only admit red patients, with the following exception:
    - Recovered COVID-19 patients within 180 days of their positive COVID-19 test can be admitted to all units, including designated COVID-19 units
- When green, orange and red zone patients all on the same unit
    - Cohorting red patients in one end of the unit is preferred; should have a buffer between this area and orange and green patients. The buffer could be empty room if possible; room with recovered (within 180 days of their positive COVID-19 test) patient; if available, a non-patient room. There should be a visible barrier to separate cohorted red patients from the rest of the unit (e.g., screen, “stop sign”). Note: Cohorting red zone patients does not indicate it is a COVID-19 designated unit that supports extended gown use outside of the patient room; staff must follow the precaution signage/instructions for entering the area/rooms
        - May have shared rooms for red patients
        - Transferring/decanting patients to another unit is not recommended unless there is a vacant space available to decant patients
        - Staff should be dedicated to caring for red patients if possible; should not also be caring for orange and green patients
- Provide clear signage that outlines the zone and the PPE requirements
- Establish twice daily symptom and temperature checks for Exposed COVID-19 contacts for 14 days after last contact (see Covid-19 Daily Patient/Resident/Client Screening Tool)
- For aerosol-generating medical procedures (AGMPs), follow the COVID-19 Provincial Guidance for Aerosol Generating Medical Procedures (AGMPs).
  Note: Upon arrival to a healthcare facility: all patients/residents transferred *from a healthcare unit/facility experiencing an outbreak (unit or facility, if unit not identified) should be treated as Orange zone, regardless of symptoms. Consult IP&C to determine if a change in zones is appropriate (i.e., orange zone to green zone where appropriate). Current outbreak information is posted on the Shared Health Website –*

COVID-19 OUTBREAKS.
Strict implementation of cohorting is not feasible in some settings. For example, if a significant proportion of the patients/clients have dementia, they may not remember the location of their new room and redirecting them would be resource intensive. Nevertheless, it may be possible to implement some elements of cohorting. For instance, after delineating non-infected, infected, and resolved infection cohorts (and revisiting this as often as recommended), consider setting up appealing recreational activities during the day to help these cohorts remain together. Even modified cohorting may be a significant challenge when several patients/clients have dementia. If you are considering a strong implementation of cohorting where many patient/clients have dementia, request a consult with Infection Prevention and Control to help you evaluate the risks. See Promoting Physical Distancing During Outbreaks – Behavioral Support for additional resources.
In outbreak situations, it may be challenging to meet these recommendations. Prioritize keeping curtains closed between bed spaces, dedicating a bathroom/commode to each individual and enhancing the cleaning/disinfection of the space. Physical distancing of 6 feet is encouraged. Also reinforce hand hygiene, appropriate PPE use, and safe donning & doffing procedures with staff. Where resources allow, increase support to help redirect patients.

Community

- Instruct clients or patients who are symptomatic with COVID-like symptoms or test positive for COVID-19 to notify any service providers that come into the home.

New COVID-19 Positive Case

- Confirm the COVID-19 status of all new COVID-19 positive cases
    - IP&C/designate reviews previous COVID-19 test results (including verbal notification of community rapid tests), symptoms, and history of prior illness compatible with COVID-19 and not tested
    - Based on this review, if the case may be consistent with a residual positive test from known or untested prior infection, the IP&C physician/designate must review the Ct value with a Medical Microbiologist
        - Repeat testing maybe required to determine status in these situations
- Determine if IP&C/designate deems patient COVID-19 recovered

Laboratory Specimens/Tests

- In addition to routine investigations relevant to the patient's symptoms and care, testing for COVID-19 requires a nasopharyngeal (NP) swab placed in viral transport medium (VTM) or NP aspirate. If such a specimen is being collected for ILI or presumed viral RTI, then a second swab is not required.
- More severely ill patients may require deep lung specimens be submitted, such as ETT secretions or broncho-alvelolar lavage specimens. Tracheal aspirates can be sent in VTM.
- There are very few clinical indications for COVID serology, thus all requests for COVID serology require prior CPL physician on-call approval. The current clinical indications only include investigation of MIS-C (Multisystem Inflammatory Syndrome in Children)

or related investigations. Requests to see if a patient had prior SARS-CoV-2 exposure and where the result will not change clinical management will be not be approved. The CPL on-call physician can be reached through paging at 204-787-2071.

- Inability to collect NP swab: In situations where a patient cannot undergo a NP specimen, a throat swab can be collected
- Additional laboratory testing for surveillance purposes only: COVID-19 virus testing has been added to all respiratory virus testing. Positive results will be reported to Public Health and Infection Prevention and Control.

Note: Patients can be infected with more than one virus at the same time. Coinfections with other respiratory viruses in people with COVID-19 have been reported. Therefore, identifying infection with one respiratory virus does not exclude COVID-19 infection, and vice-versa.

Specimen Collection

Follow Routine Practices as well as Enhanced Droplet/Contact Precautions at all times when handling specimens. Process:

- Assemble all supplies outside isolation space.
  - Dedicate specimen collection equipment to the specific patient
  - Do not take phlebotomy trays/carts into the room/space
  - Plan and take all required equipment into the room at the start of the procedure after donning PPE
- Perform hand hygiene
- Put on personal protective equipment
- Collect specimen per laboratory sample collection manuals. See Tips to Reduce Leaking of COVID-19 Specimens
- Remove gloves and gown
- Exit room/space
- Deposit specimen(s) into an impervious, sealable bag immediately following removal from the patient room. Each site might vary in the process of how to achieve this step, with the goal to ensure the outside of the bag does not become contaminated
- Perform hand hygiene

Health Record/Health Record Documents, Other Papers (e.g., vital sign sheets, election ballot)

- Do not take the health record, medication administration record (MAR), or mobile computer into the isolation room.
  - If the MAR has been in the isolation room: wipe the pen and external surface of the MAR with facility-approved disinfectant upon leaving. Allow to air dry completely.
  - Consider using PYXIS slips, where available, to perform bedside checks.
- In situations where paper must be handled by patient and a staff member hand hygiene should be performed before handling and after handling, by all parties involved

Other papers that must be brought into the patient room for the patient to touch (e.g.,

legal):

- Assist patient to perform hand hygiene.
- Wipe the surface/table the document will be placed on with facility approved disinfectant. Allow to air dry completely before placing items on the surface/table.
- Prior to removing papers and pen from the room, wipe the pen with facility-approved disinfectant.
- Use disposable folders or wipeable clipboards for holding paper documents. Wipe with disinfectant and allow to air dry completely before placing on clean surface outside the doorway or discard prior to leaving the room.

Duration of Enhanced Droplet/Contact Precautions

Refer to Testing and Clearance document for details on removing precautions. Consultation with IPC/designate* is required to remove a COVID positive/suspect from Additional Precautions.

To discontinue precautions for a patient who is COVID-19 positive consult IP&C/designate. 10 days from symptom onset and 72 hours while asymptomatic must have passed, whichever is longer.

To discontinue precautions for

- Patients in ICUs
- Patients transferred out of ICU to a unit, and
- Patients requiring Optiflow (in and out of ICU):

In consultation with the IP&C physician/designate, discontinuation of Droplet/Contact plus Airborne Precautions for AGMPs can occur when the following criteria are met:

1) ≥ 14 days since POSITIVE test AND
2) Afebrile for last 72 hours AND
3) Clinical improvement:
    a. If patient is ventilated, signs of clinical improvement could include:
        i. Mechanical ventilation (i.e., ventilator) support decreased
        ii. Decreased respiratory secretions
        iii. Improved oxygenation

NOTE: At the discretion of the IP&C physician/designate, a repeat nasopharyngeal swab may be performed and if positive, a cycle threshold (Ct) value above or below 25 will guide decision making. In addition, special consideration is required for immunocompromised patients who may have prolonged shedding of viable virus, as well as ongoing and/or intermittent AGMPs.

To discontinue precautions for an asymptomatic COVID-19 suspect patient with known exposure history, refer to Updated IP&C COVID-19 Contact Management in Acute and Long-Term Care Facilities.

To discontinue precautions for a high-risk contact, also refer to Updated IP&C COVID-19 Contact Management in Acute and Long-Term Care Facilities.

Where patients with confirmed COVID-19 infection have been cohorted and one has

recovered, this patient may be moved into the Green Zone as required.

COVID19 positive patients may be discharged home positive; they do not have to stay in a facility.

Where there are negative COVID-19 test results in a patient that does not meet the 'exposure' criteria OR exposure to a confirmed case of COVID-19 in patients with respiratory symptoms:

- Consult IP&C/designate. Patient management maybe adjusted to follow seasonal viral respiratory management protocols (i.e., droplet/contact precautions and discontinuation of precautions when symptom resolve)
- Decisions are based on relevant epidemiological data (i.e., known COVID-19 case(s) in a facility, community or congregated/work setting, or outbreaks).

Those with known exposure history (contact, travel, or lab exposure) would not change additional precautions, regardless of swab results.

**IP&C/designate: Person(s) with responsibility for providing IP&C guidance at the site. This may include, but not limited to, ICP, unit manager, educator, director of care, IP&C physicians, or medical officer or health.*

Discharging COVID Positive Patients
Refer to:
COVID-19 Staff Discharge Planning Self-Isolation Assessment
Government of Manitoba Factsheet and Website
Follow Discharge Transport - COVID-19 Positive or Suspect (Acute Care) processes for patients who are COVID positive or suspect.

Discharging COVID Suspects
Government of Manitoba Factsheet and Website
Follow Discharge Transport - COVID-19 Positive or Suspect (Acute Care) processes for patients who are COVID positive or suspect.

Deaths
COVID-19 Associated Fatality: COVID-19 associated deaths are defined as all laboratory-confirmed COVID-19 cases who have died within 10 days before or 30 days after the earliest specimen collection date in the most recent investigation. **Note the reason for death does not have to be attributable to COVID-19**. Notify IP&C for completion of a Clinical Notification of Reportable Diseases and Conditions form.

Consult IP&C/designate for consideration to test for COVID-19 after a patient death in a healthcare facility if the following are true:

- Prior testing
  - The deceased did not have a NP swab positive for COVID-19 prior to death OR
  - The deceased did not have two or more NP swabs negative for COVID-19 in the past week AND
- Symptoms or cause of death

- Death was preceded by influenza-like illness (ILI), upper or lower respiratory tract infection, or any symptoms compatible with COVID-19, even if very mild OR
- Cause of death is unclear If a previous swab was positive, no further testing is required.

Where COVID-19 is suspected in a recently deceased individual who is no longer in the facility, consult IP&C/designate for consideration to test (e.g., leaked specimen or missed opportunity) and contact:

- Office of the Chief Medical Examiner
- General Office (204) 945-2088 (Office hours are from 8:00 a.m. - 4:30 p.m. Monday to Friday)
- Afterhours: listen to message to obtain on call OCME number to call directly.

Notification

Site IP&C/designate must be notified of ALL ADMITTED suspected or confirmed cases, and COVID-19 related deaths. After hours leave a voice message for follow up. If urgent, contact IP&C designate:

- Children's Hospital - Pediatric ID: 204-787-2071
- St. Boniface Hospital – Dr. Evelyn Lo: 204-237-2053
- HSC and all other sites - Dr. John Embil: 204-787-2071

Mother/Child

- Follow Enhanced Droplet/Contact precautions
  - The infant can remain with the mother
  - Breast-feeding: mother can breast feed while wearing a procedure or surgical mask. Prior to breast-feeding she must:
    - Perform hand hygiene AND
    - Clean/wash her skin (chest/breast area) with soap & water

Note: See Provincial Obstetric Anesthesia Guidelines for COVID-19
Winnipeg Regional Health Authority and Shared Health for PPE for Obstetric Patients During COVID-19 Pandemic

Patient Movement and Activities

Restrict patients while on Enhanced Droplet/Contact Precautions to their room. Defer participation in group activities for this entire time. Restrict patient movement and/or transport to essential diagnostic tests and therapeutic treatments. **Transfer within and between facilities should be avoided unless medically indicated.**

Patient Transport of Orange and Red Zone Persons

Transport patient out of the isolation room for medically essential purposes only.
Notify **Patient Transport Services** and the receiving department regarding the need for precautions *in advance* of the transport.

- Two individuals should be available to transport the patient if necessary
- Determine how traffic pathways will be controlled and secured prior to transport (e.g., dedicate corridors and elevators). Hallways may require clearing in advance
- During transport, the 'clean' person (no patient contact) shall open doors and push

elevator buttons

- The chart shall be carried by the 'clean' person or placed in a protective cover (e.g., plastic bag) and transported on the bed. *NOTE – the outside of the protective cover is contaminated*
- If the patient is being transported in his/her own bed, clean and disinfect siderails, footboard, and headboard prior to transport
- Cover transport chair or stretcher with a sheet prior to transport
- Clean and disinfect transport chair or stretcher after use
- Healthcare workers involved in transport shall perform hand hygiene and wear a clean gown and gloves while still wearing same mask and eye/face protection (i.e., the PPE worn inside the patient space, excluding mask and eye protection [i.e., extended use PPE] cannot be worn to transport patient)
- Patient
    - Cover open patient wounds
    - Perform hand hygiene when leaving the room and wear clean clothes, housecoat, or cover gown. Do not place the patient in isolation gown
- Transporting the patient (No artificial airway):
    - Put a procedure or surgical mask on the patient if tolerated, including over nasal cannula if patient wearing
- Where possible, intubate patient prior to transport, rather than transporting on high-flow oxygen
- Transporting the patient (with an artificial airway):
    - Ideally, transport infants in an incubator
    - Resolve any air leaks prior to transport
    - Inflate/maintain inflation of endotracheal tube (ETT) cuff, (if present) for the duration of the transport; to minimize contamination
    - If an air leak occurs during transport and is not readily resolved, consider extubation and a tube exchange
    - Exhaled gases must be N100 filtered
    - For special circumstances consult Respiratory Therapy for guidance regarding airway management during the transport, as well as the site Infection Control Professional
- Transporting the patient with Tracheostomy or Laryngectomy:
    - Apply trach mask
    - Add Oxygen (O2) via trach adapter (if O2 needed to keep SpO2 more than 90%)
    - Apply a procedure/surgical mask (with ear loops) over the client's mouth and nose
    - Cover trach mask with non-occlusive barrier (i.e., face cloth) to prevent droplet expulsion

  Note: Client may be able to tolerate a heat moisture exchanger (HME) for transport (HME to prevent droplet expulsion). Consult RT for evaluation and follow site specific protocol.

Outbreaks

- Declare an outbreak when two or more patients, who are not roommates or do not share a bathroom between two patient rooms, acquire healthcare-associated infections (HAI) attributed to a unit, within 10 days of each other. A HAI COVID-19 case is defined as a person with laboratory-confirmed COVID-19, provided that, with the best clinical judgement
    - the person developed COVID-19 associated symptoms > 10 days after admission to an acute care facility AND the person had no known exposure to COVID-19 outside the acute care facility within 10 days prior to symptom onset OR
    - the person developed COVID-19 associated symptom ≤ 10 days after admission to an acute care facility AND there is an established epidemiological link between the person and a probable or confirmed non-roommate COVID-19 case(s) or environmental source in the facility that the person was admitted to OR
    - the person was identified as a probable or confirmed COVID-19 case with symptom onset ≤ 10 days after discharge from an acute care facility AND there is an established epidemiological link between the person and the acute care facility that the person was previously admitted to

  Note: The application of this case definition should be conducted on a case-by-case basis following a case investigation
- Declare an outbreak over after 10 days with no new COVID-19 HAI cases starting after the last case was appropriately isolated and/or left the facility

For additional information refer to Appendix B.

Prevention Measures Across All Zones

Personal Protective Equipment

- Medical masks shall be worn at all times by HCWs, non-clinical staff, and visitors to acute care facilities
    - Medical masks can be removed for breaks or meals, provided:
        - Maximum space occupancy is determined, with designated seating to maintain Physical distancing of 2 metres (minimum) from others
            - 50% maximum occupancy for spaces dedicated to mask removal
            - Designated seating; person must remain seated with mask removal
    - Note: Arrangements for breaks or meals to occur in larger spaces and at staggered times should be strongly considered
- Wear PPE according to the Zone: Green Zone; Orange Zone; Red Zone
- Identify and implement use of Trained PPE Observers (dedicated individuals with the sole responsibilities of ensuring adherence to PPE recommendations during the care of COVID-19 cases and suspects)
    - PPE Observers are recommended in all healthcare settings.
    - PPE Observers will:
    - Complete PPE observer training

  - Donning & doffing PPE checklist
  - Incident log
  - PPE observer training
  - Trained PPE observer reference
- Act as a trained observer, and provide leadership on the front line HCWs regarding PPE use, including, but not limited to, identifying PPE breaches
- Complete the COVID19 Donning and Doffing PPE Checklist and incident log; ensuring zone-specific posters are posted outside the patient's room and/ or at PPE Donning and Doffing Stations (in a dedicated COVID19/red zone unit)

Environmental Cleaning

Only use a facility-approved disinfectant.
Ensure manufacturer's wet contact time is maintained on surfaces.
Increase frequency of cleaning and disinfection of high-touch surfaces. This includes all waiting rooms/areas and public washrooms.
Clean and disinfect all surfaces, especially those that are horizontal and frequently touched, at least twice daily and when soiled.
Common staff areas should be targeted for enhanced daily cleaning and disinfection (breakrooms, unit desks).
Follow isolation room discharge cleaning protocols after discharge, transfer, or discontinuation of precautions.
Clinic rooms should have all high-touch surfaces as well as any additional surfaces the patient or health care worker has come in contact with disinfected after each patient has left (e.g., patient chairs, exam tables, doorknobs, counter tops, desktops).

Patient Care Equipment

Minimize equipment and supplies in the room as much as possible.
Dedicate all reusable equipment and supplies to the use of the patient.
If use with other patients is necessary, clean and disinfect equipment and supplies (that can tolerate disinfection) before use with another patient with a facility-approved disinfectant or send to laundry if cannot be adequately disinfected or grossly soiled.
Consider all equipment (e.g., lifts, slings, sliders).
Discard items that cannot be appropriately cleaned and disinfected.
Discard single-use disposable equipment into a no-touch waste receptacle after use.

Personal/Other Items

Appropriately clean and disinfect essential personal use items (e.g., dentures, hearing aids), with care, upon arrival.
Newspapers and books are allowed

- Orange and Red Zones: single use
- Green Zones: where single use newspapers and books cannot be achieved, reuse no sooner than the following day could be considered if not visibly soiled, and if stored at least overnight in a clean, dry, and secure space (without being handled during that time). All hands must be clean prior to handling each time.

Dedicate all toys, electronic games, personal belongings, and so on to use of the patient.

Food and Beverages

- Unit kitchenettes
  - Close all unit kitchenettes to direct patient access
    - Staff will need to get patient's snacks, drinks and are to come up with a unit process to meet this requirement
- Ice Machines
  - Accessed by unit staff only
    - Hand Hygiene prior to use
    - Frequently clean/disinfect high touch areas/surfaces throughout the day
- Staff Break Rooms
  - Regular (daily) scans of breakroom areas using the COVID-19 PPE and Physical Distancing Compliance Scan for Healthcare Leaders and Teams
  - Physical distancing is strongly encouraged in all meeting rooms, staff lounges and lunchroom areas:
    - Place signs with maximum persons per room
    - Wherever possible, decrease seating in these areas to adhere to appropriate distancing
    - Follow proper hand hygiene protocols and disinfect any surface you touch in common areas.
  - Perform hand hygiene if touching any shared condiments prior to eating
  - High touch areas must be frequently cleaned/disinfected throughout the day
  - For healthcare workers who have been diagnosed with COVID-19 (tested positive), follow direction as outlined in the Health-Care Workers – Screening, Testing & Return To Work FAQ
  - Refer to COVID-19 Physical Distancing in Staff and Common Areas
- Designated caregivers and general visitors should be restricted from accessing common service areas within sites (e.g., cafeterias, etc.)
- Refer to the Physical Distancing and Restoring Services at Health Facilities document for further information and direction

Handling Linen, Cutlery and Dishes

No special care is required for handling linen, cutlery or dishes. Routine Practices are sufficient.

Waste

No special care is required for handling patient waste. Routine Practices are sufficient

Handling Deceased Bodies

Routine Practices, along with additional precautions appropriate for the patient and/or the zone should be used for handling deceased bodies, preparing bodies for autopsy, and transferring bodies to mortuary services.

Designated Caregivers* and Visitors

- Access is limited. Explore alternate mechanisms for interactions between patients and other individuals (e.g., video call on cell phones or tablets).
- Follow Shared Health inpatient visitation principles

- Designated caregivers and visitors must follow hand hygiene, physical distancing, respiratory hygiene, and PPE recommendations as outlined
- Instruct designated caregivers and visitors to speak with a nurse or physician before entering the room to assess risk to their health and ability to adhere to Routine Practices and Additional Precautions.
- Provide designated caregivers and visitors with instructions on and supervision with appropriate use of PPE for Droplet/Contact precautions.
    - Designated caregivers and visitors should not be present during AGMPs

*Previously called Essential Care Partner

Leaves/Passes

Passes from acute care facilities are not routinely permitted. Passes related to trial for discharge must follow the usual facility pass guidelines, including assessment to determine if the patient is medically stable to leave the facility PLUS the following COVID-19 specific actions:

- Pass will need to be coordinated and planned. Last minute requests will not be permitted.
- Traveling in a vehicle is a high-risk situation for both the driver and the passenger, due to the close proximity of the individuals, the air flow in the vehicle and the time spent in close contact. When leaving the facility in a vehicle, the following is recommended:
    - All drivers/escorts that will be in the vehicle must be screened before entry to facility.
    - Drivers/escort(s)should be informed on how to put on and remove a mask, and the importance of maintaining physical distancing from others.
    - The number of people in the vehicle should be minimized to those considered necessary.
    - All patients and all drivers/escorts wear a medical mask. Patients are provided a medical mask for the out-going and return rides
    - During transport, if possible, travel with vehicle windows open. Hand hygiene should be practiced often
- Use of masks and physical distancing are recommended at all times other than for the purposes of eating/drinking. Hand hygiene should be practiced often. Driver(s)/escort(s) shall be designated, up to a maximum of two (2). The number of people in the vehicle should be limited. Passes shall follow the Expanded Visitor Access Acute and Long Term Care. Driver screening will be dependent on the circumstances
    - If entering the facility, screening at entry is sufficient
    - If not entering the facility, screening can be performed by unit staff over the phone
- On return to the unit staff to discuss any potential exposure(s) that may have occurred during pass. This includes screening of the driver(s)/escort(s) for return trip to facility if driver(s)/escort(s) not entering the facility/unit
- Travel should be direct from the facility to the destination and back, with no stops in between. During transport, if possible, travel with car windows open. Hand hygiene should be practiced often. If the destination is a private home, the

attending physician/designate must confirm with the driver(s)/escort(s) that no one in the home meets the symptoms or exposure criteria for COVID-19 or any other communicable disease.
- Unit to document in the health record the direction provided (and to whom) and confirmation of safe home to have pass to

If all elements outlined are not adhered to, place patient on Enhanced Droplet/Contact Precautions for 10 days, and monitor for COVID-19 signs/symptoms for an additional 4 days. Consult IP&C for assistance.
Indigenous patients requiring escorts and temporary accommodations may benefit from a referral to Indigenous Health, if there is any need for interpretation or coordination support.

Discharging COVID 'Green' Patients
- Collect a specimen to test for COVID-19 from symptomatic individuals prior to transfer back to First Nations/Indigenous and Northern Relations Communities. Information for Indigenous and Northern Relations Community profiles: https://www.gov.mb.ca/inr/publications/community_profiles.html.
  NOTE: Exclude persons previously identified as COVID-19 positive (within 180 days of date of initial positive test).

Pet Visitation
- Pet visitation not allowed for Orange or Red Zone patients
- Pet visitation for Green Zone patients:
  - Ensure no one in the household where the pet lives is isolating for COVID
  - Encourage a 2 metre/6 feet distance from anyone who is not the pet escort (including patients) at all times. Consult IP&C to consider compassionate/palliative based exceptions.
  - Regional IP&C guidance on Pet Visitation; Animals in Acute Care Facilities and Pets, Pet Therapy and Pet Visitation in Community Health Services Operational Directive

Physical Distancing
Use intentionally to reduce close contact between people to try to stop the progression of transmission of any virus. This means:
- minimize prolonged (more than 10 minutes direct or cumulative over 24 hours), close (less than 2 metres/6 feet) contact with other individuals
- avoid greetings that involve touching, including handshakes and hugs
- frequent disinfection of regularly used surfaces, electronics, and other personal belongings
- follow public health advice, including self-monitoring or self-isolation if have travelled or been exposed to someone who is ill with the virus, EVEN if not displaying any symptoms and regardless of vaccination status
- strongly considering avoiding travel, crowded places and large events, especially if at higher risk for influenza-like illnesses
- for appointments, consider alternate options such as telephone, video conferencing, or

other available options
- Refer to the Physical Distancing and Restoring Services at Health Facilities document for further information and direction

Group Activities (including therapeutic group activities)
- Maintain spatial separation between each person (2 metre/6 feet)
- Frequent hand hygiene, no handshaking
- Reduce size of the gathering
- Improving venue to allow for space
- Minimize contact and shared time together (10 minutes direct or cumulative over 24 hours)
- No sharing of items
- Consider the population attending and whether in-person groups or other means should be used
    - Do not include anyone unwell with an acute respiratory viral illness or suspected recent contact with someone with an acute respiratory viral illness

Celebrations, Gatherings and Services

It is important to note gatherings in places of worship have demonstrated to be a higher risk setting as shown by the number of outbreaks reported earlier in the pandemic from these types of gatherings. Congregants should focus on adhering to infection prevention and control guidance on physical distancing, medical mask use, hand hygiene and cough/sneeze etiquette to lower the risk of COVID-19.
- Frequent hand hygiene, no handshaking – ABHR available
- Consider pre-recording readings and single use paper bulletins or project materials to alleviate the need for people to share a microphone or hymnals
    - If shared books cannot be cleaned/disinfected between congregants, it must be removed and stored at least overnight in a clean, dry, and secure space (without being handled during that time). All hands must be clean prior to handling each time
    - Remove pens/pencils
    - If it is required for religious/spiritual reasons, touching of ceremonial objects (e.g., statues, religious symbols, rings) may occur if individuals perform hand hygiene before and after touching the object, and the objects are cleaned/disinfected before and after use
- Improving venue to allow for space − minimize the time that individuals are together. There is currently no evidence on a specific amount of time that is safe. If possible, increase ventilation by opening windows
- Keep doors locked when service is not occurring
- Consider alternative methods to the traditional passing of the peace with a handshake, such as a nod of the head, bow or other appropriate gesture that maintains a 2 metre/6 foot separation
- Do not pass objects between congregants (e.g., offering baskets/donation collection plates). Rather, consider providing online offering/giving options, placing a stationary basket at the front of the facility or offering other alternatives to offering

baskets/donation collection plates

For additional IP&C guidance on celebrations, gatherings and services refer to: Infection Prevention and Control (IP&C) Guidance for Celebrations, Gatherings and Services

Appendix A: Orange and Red Zone IP&C Practices in the Operating Room

1. Maintain Enhanced Droplet/Contact Precautions for AGMPs at all times within the OR environment (e.g. pre-op, OR theatre, post-op).
2. Notify Patient Transport Services, receiving area, and recovery area as appropriate, regarding the need for Enhanced Droplet/Contact Precautions for AGMPs, in advance.
3. Remove non-essential equipment from OR theatre whenever possible. Equipment that cannot be removed from the theatre shall be removed from the immediate area of the surgery and covered with a clean cover.
4. Transporting the patient to/from the OR
    a. Precautions relevant to the Patient for Transfer to/from the OR
        - Use a clean stretcher or wheelchair. If the patient's bed or personal wheelchair is used for transport, wipe the steering handles and side rails with facility approved disinfectant and allow required wet contact time prior to removing it from the room
        - Ensure all wounds are covered
        - Patient to perform hand hygiene on leaving room
        - Patient to wear clean clothes, housecoat or cover gown; no gloves required for the patient
        - Patient to wear a surgical/procedure mask upon transfer
    b. Precautions relevant to the Health Care Worker for Transfer to/from the OR
        - Perform hand hygiene and don gloves and gown, surgical/procedure mask and eye protection before entering patient room
        - Cover the clean facility transport chair/stretcher with a cover sheet, transfer patient and place a clean cover sheet over the patient
        - If the patient's bed or personal wheelchair is used for transport, wipe the steering handles and side rails with facility approved disinfectant and allow required wet contact time prior to leaving the room
        - After preparing the patient for transport, remove PPE before exiting the room and perform hand hygiene
        - Apply clean PPE once out of the room/cubicle/bed space, to transport patient
        - Place chart in a protective cover (e.g., plastic bag) to prevent contamination and clean and disinfect with facility-approved disinfectant if outside of the chart becomes contaminated
    c. Transport patient to the appropriate destination
        - Clean and disinfect the facility transport chair/stretcher when transport is complete
        - Remove PPE and perform hand hygiene
5. Intraoperative Care
    a. Post appropriate Precautions sign on the OR Theatre door.
    b. Apply appropriate PPE:
        - Any staff having contact with the patient or patient environment outside the sterile field shall wear gloves and gowns, procedure mask and eye protection

        *** Please note if an Aerosol Generating Medical Procedure is required

OR anticipated, staff must wear an N95 respirator in addition to gloves, gown and eye protection.

c. Patient chart: if the outside of the chart becomes contaminated, clean and disinfect with facility approved disinfectant.
d. Code Blue: All personnel entering the OR must wear appropriate personal protective equipment as outlined above.
   - Remove defibrillator from the Code Blue Cart and taken into the OR
   - Designate a staff member to hand any cart supplies requested by the Code Blue Team
   - If the Code Blue Cart or any of its equipment or supplies enters the OR, all items must be cleaned and disinfected, reprocessed or discarded according to manufacturer's recommendations

6. Postoperative Care
   a. Notify the receiving area the patient requires Enhance Droplet/Contact Precautions.
   b. Staff shall wear clean PPE for transport to the receiving area and follow the procedures in 4.
7. Environmental Cleaning
   a. Between Procedure:
      - Each OR theatre must be cleaned and disinfected immediately after each case.
      - Prior to cleaning, remove all trash, linen, and recycling from the room including soiled anesthesia equipment and supplies.
      - All surfaces that have been in direct or indirect contact with the patient or body fluids are considered to be contaminated and therefore are to be cleaned/disinfected with a hospital approved disinfectant.
      - It is the responsibility of the perioperative nurse to ensure OR Theatres are cleaned/disinfected as required after each patient.
      - Environmental cleaning of the OR Theatre will begin after the patient has left the area.
      - Wipe touched objects and areas as well as **all items within 2 metres/6 feet** of the patient/bed after each procedure (i.e., control panel, switches, knobs, work area, handles, computer keyboards and components) with a hospital approved disinfectant.
      - Cleaning and disinfectant should progress from least contaminated to most contaminated and top to bottom areas.
      - Clean floors within 1.5 meters of the operative area, extend area if visibly soiled, including floor area under the OR bed.
      - Clean and disinfect walls if soiled or potentially soiled.
      - Items used for patient care and during a surgical or invasive procedure should be cleaned and disinfected, including but not limited to
        - OR beds and reusable straps
        - OR bed attachments (i.e., arm boards, stirrups, head rests)
        - positioning devices (i.e., gel rolls, vacuum pack positioning devices)
        - patient transfer devices

- overhead procedure lights
- tables and Mayo stands
- mobile and fixed equipment (i.e., suction regulators, medical gas regulators, imaging viewers, viewing monitors, radiology equipment, electrosurgical units, microscopes, robots, lasers).

Note: Clean and disinfect items used for anesthesia after each patient use, including:

- Anesthesia carts
- Equipment (i.e., IV poles, IV pumps)
- Anesthesia machines
- Patient monitors
- Non-critical equipment such as blood pressure cuffs.

8. <u>When performing Aerosol Generating Medical Procedures (AGMP)'s in an Operating Room (OR)</u>
   In most instances, ORs are positive pressure to all adjacent spaces (sterile core and circulating corridor) in order to ensure no contaminants from the corridor enter into the OR and contaminate the sterile field. Persons infected with COVID19 present a unique risk when AGMPs or extensive respiratory surgery are performed in the OR, as the positive pressure can have the effect of pushing these contaminants into the adjacent spaces. Even with use of laminar flow diffusers above the OR table and linear slot diffusers to create an air curtain around the sterile field, these are unlikely to contain airborne disease particles from moving. For surgery on persons infected with COVID19:
   a. When performing an AGMP (usually intubation/extubation) related to a surgery (in order of preference):
      i. Perform in an Airborne Infection Isolation Room (often outside the OR suite – in the PACU or ICU)
      ii. Utilize a negative pressure OR. Depending upon the ventilation control system, switchable positive/negative pressure systems could be created but only if independent pressure monitoring is in place to verify performance.
      - Consider an anteroom on the circulation corridor side.
      iii. Perform the AGMP in a procedure space which is neutral pressure, preferably outside of the OR suites.
      iv. Utilize a portable HEPA air scrubber inside the OR within the curtain of air, placed adjacent to the source of the AGMP, initiating this before the procedure, and operating it for approximately 30 minutes after. Prior to proceeding with use of a HEPA air scrubber, consult Facilities Management to determine an appropriate unit and calculate the clearing time
      - In general this involves turning on the scrubber just prior to intubation, leaving on for 30 minutes after intubation, and turning off prior to first incision. Keep scrubber off for the duration of the surgery. Turn the scrubber back on for extubation and leave on for 30 minutes after extubation. Keep the door closed until adequate room exchanges occur to clear ideally 99.9% minimally 99% of airborne particles, depending on the air exchanges for the room.

b. If performing oropharyngeal or nasopharyngeal surgeries of an infected patient utilize (in order of preference)
    i. A negative pressure OR with an anteroom on the circulating hallway
    ii. An Airborne Infectious Isolation Room with an anteroom (often outside the OR suite – in the PACU or ICU) which would have the services to support such a procedure.
    iii. A negative pressure OR where independent pressure monitoring exists.
    iv. Intubate in an AIIR and perform the surgery in a normal (positive pressure) OR at the end of the day when fewer cases are present (to lower the possibility of cross contamination with other patients).
    v. *Supplemental recirculating HEPA filtration system shall NOT be used in an OR throughout these procedures (and when the OR is already achieving 20 air changes per hour). The movement of additional air within the OR will greatly disturb the sterile field by introducing significant non-directional air currents. Use of the recirculating HEPA is acceptable during the AGMP portion only to reduce contaminant load during this period. Ideally the unit should be shut down and air currents allowed to settle before incisions are made.*

Appendix B: Outbreak Interventions

Concerns have been raised regarding staff not wearing PPE consistently or wearing it incorrectly. This reduces or eliminates protection, putting staff and patients at risk. Units/facilities should use the audit tools included in the table below; focusing on auditing, evaluating and targeting areas for improvements continuously in order to halt transmission of COVID-19 in the environment.

Everyone: Physical distancing is one of the key tools used to prevent the spread of COVID-19. Adherence to spatial separation of 2 metres/6 feet wherever possible, reduces your risk of coming in contact with respiratory droplets generated when an infected person coughs or sneezes.

All staff: encouraged to practice physical distancing in all situations except when providing safe clinical care doesn't allow this. In these situations, they must be wearing PPE as outlined in the PPE Supply Management and Stewardship Planning and Guidance Framework https://sharedhealthmb.ca/files/covid-19-provincial-ppe-framework-guidance.pdf.
The wearing of PPE is a supplement to other routine practices and IP&C advice, including encouragement of physical distancing wherever possible.

Infection Prevention & Control (or designate) Actions:

1. Coordinate gathering of unit outbreak data on COVID suspects/positive patient cases.
2. Confirm and declare outbreak.
3. Arrange advice from experts as necessary (e.g., Infectious Diseases physicians, Provincial Medical Officers of Health, Epidemiologists).
4. Ensure available data is reviewed critically on a regular basis by the investigation team to generate hypotheses and decisions concerning the direction of the investigation.
5. Update facility and regional leadership on the current status of the investigation.

Site Management/Leadership Actions:

1. Establish outbreak team with appropriate members and assigning functions.
2. Coordinate a communication plan.
3. Advocate for appropriate human logistical, and financial resource requirements.
4. Ensure debriefing and evaluation of outbreak occurs.

Unit/Area Staff:

1. Monitor patients for signs and symptoms consistent with COVID-19 infection.
    a. Implement Enhanced Droplet/Contact precautions immediately, if not already in place.
    b. Notify attending physician and arrange for COVID-19 testing, as appropriate.
2. Update a line list of all suspects/positive COVID cases.
3. Notify IP&C/designate of all new suspects/positive COVID cases.
4. Focus on PPE donning and removal, ensuring safe practices.

Intervention/action	Controlled spread (i.e., new cases are identified contacts)	Uncontrolled spread (i.e., new cases are beyond identified contacts)
Outbreak signage posted	X	X
Outbreak site updates - general	Bi-weekly	Daily
Outbreak site updates – new COVID positive case	As required	As required
Contact Management	Per High Risk Contact Management algorithm	Per High Risk Contact Management algorithm. Regional IP&C will advise if unit wide testing should be connected.
Documented active symptom and temperature monitoring of patients	Per High Risk Contact Management algorithm	All patients on units
Adjacent units (units next to outbreak unit) - documented active symptom and temperature monitoring of patients – twice daily		As determined by contact investigation in consultation with IPC/designate
Active staff screening – upon entry		As determined by contact investigation in consultation with Occupational and Environmental Safety and Health
Admissions	See: Guidance for Admission To, Discharge and/or Transfer from Acute Care Facilities/Units with Confirmed COVID-19 Outbreaks. Admissions from an outbreak unit: treat as Orange zone	See: Guidance for Admission To, Discharge and/or Transfer from Acute Care Facilities/Units with Confirmed COVID-19 Outbreaks. Admissions from an outbreak unit: treat as Orange zone
Minimize patient transfers to medically necessary	X	X
Cohorting Orange Zone patients (single	Place Orange patients in private rooms as	As listed in controlled spread

rooms) in one area of the unit is preferred Note: This may impact flow, however based on experiences with other outbreaks, not separating orange patients perpetuates the outbreak	soon as possible, to shorten the length of the outbreak See Guidance for admission, discharge or transfer from acute care areas with COVID-19 outbreaks	
Red Zone patients may be cohorted in the same room if required	See Accommodation & Monitoring	See Accommodation & Monitoring
Discharges to community **See: COVID-19 outbreaks**	Additional precautions as directed by sending facility, in consultation with IP&C, as appropriate	Recommend all transfers and discharges – 10 day Enhanced Droplet/Contact precautions.
Discharges or essential transfers to another healthcare facility **See: COVID-19 outbreaks**	All transfers and discharges – 10 day Enhanced Droplet/Contact precautions.	All transfers and discharges – 10 day Enhanced Droplet/Contact precautions.
Visitors stopped, with exceptions as noted	X	X
Cohort staff as much as possible. If not possible, recommended workflow is from well residents to ill residents to minimize transmission	X	X
Enhanced environmental cleaning and disinfection – frequently touched areas	X	X
Enhanced environmental cleaning and disinfection – widespread deep disinfection	Deep clean of room done when discharged or recovered (i.e., isolation room cleaning). When end of outbreak declared, clean/disinfect high touch areas/surfaces throughout unit	Deep clean of room done when discharged or recovered (i.e., isolation room cleaning). When end of outbreak declared, clean/disinfect high touch areas/surfaces throughout unit
Dedicated patient equipment or clean/disinfect/launder between use.	X	X

Note: includes slings, transfer belts, sliders, BP machines, etc.		
Education (e.g., outbreak measures, hand hygiene, PPE use)	X	X
Stop all group activities	X	X
Patients masked, as appropriate	X	X
Hand Hygiene auditing increased	X	X
Audit PPE Compliance in area: **COVID PPE Audit Tool (Facility)** **COVID PPE Donning Audit Analysis Tool (Facility)** **COVID PPE Doffing Audit Analysis Tool (Facility)** **COVID PPE Audit Tool (Community)** **COVID PPE Donning Audit Analysis Tool (Community)** **COVID PPE Doffing Audit Analysis Tool (Community)**	30 audits weekly; each tool	15 audits daily; each tool
Audit physical distancing in area: **COVID-19 PPE and Physical Distancing Compliance Scan for Health-care Leaders and Teams**	PPE - Shift reports Physical distancing - daily	PPE - Shift reports Physical distancing - daily

Change Tracking List

July 27, 2022

- Updated Discharging COVID 'Green' patients section.

June 28, 2022

- Updates to physical distancing & eye protection

June 9, 2022

- Removed Discharging COVID "Green" Patients section

June 1, 2022

- Updates to document to align with existing guidance • Changes to Non-COVID group activities

March 21, 2022

- Changes to the following sections: Contacts Tracing and Management, Deaths, Outbreaks, Leaves and Passes, Celebrations

March 1, 2022

- Change in isolation time from 14 to 10 days
- Removed restrictions around non-vaccinated residents
- Added instructions that visitors are not to enter common service areas

Dec. 14, 2021

- Updates to align with guidance for celebrations, Gatherings and Services (https://sharedhealthmb.ca/files/covid-19-ipc-guidance-for-celebrations.pdf)

Nov. 17, 2021

- Removed information re: contact management of vaccinated patients

Sept. 29, 2021

- Changed the period of time a patient is considered recovered from 90 to 180 days following the date of the positive COVID test.

Aug. 19, 2021

- Removed "Precautions may be discontinued 14 days from last exposure" for asymptomatic COVID-19 suspect patients from the "Duration of Droplet/Contact Precautions, with Airborne Precautions for AGMPs" sub-section of Orange/Red Zone.

June 17, 2021

- Updates to "New COVID-19 Positive Case" section

June 8, 2021

- Updated recovered laboratory-confirmed COVID-19 cases information for Symptomatic persons
- Added contact tracing/management section
- Added community and new COVID-19 positive case sub-section to orange and red zone areas

- Added information to Duration of Droplet/Contact Precautions, with Airborne Precautions for AGMPs section
- Added information to Deaths section
- Added discharging COVID "Green" patients section
- Removed Appendix (Temperature Monitoring Form) and replaced with link to Daily Patient/Resident Screening Tool

Feb. 22

- Added table of contents (pg. 1)
- Added information for managing recently vaccinated patients (pg. 3)
- Added guidance for recovered COVID-19 cases (pg. 3)
- Added exceptions for admitting patients to red units (pg. 5)
- Added additional cohorting information (pg. 5)
- Added section on deaths (pg. 8)
- Updated PPE requirements across all zones (pg. 11)
- Added additional guidance for leaves/passes (pg. 13)
- Added additional guidance for faith based gatherings (pg. 15)
- Updates to table in Appendix C (pg. 24)
-

Nov. 18

- Updated "Recovered Laboratory Confirmed COVID-19 cases" to include **"**Patients may have chronic respiratory symptoms and/or a post-viral cough, which do not require maintenance of enhanced precautions for COVID-19" (Pg. 2)

Nov. 16

- Updated Entrance Screening points information to include factors that raise the index of suspicion should also be included (pg. 1)
- Added Recovered Laboratory-Confirmed COVID-19 cases section (pg. 2)
- Updated Orange and Red Zone precautions (pg. 3)
  - establish twice daily symptom and temperature checks
  - Precautions for patients/residents transferred from facility that is experiencing an outbreak
- Laboratory Specimens/Tests (pgs. 3 + 4)
  - COVID serology updates
  - Steps to prevent leaking when NP swabs are collected
- Duration of Droplet/Contact Precautions, with Airborne Precautions for AGMPs (pg. 5)
  - Added refer to Testing and Clearance document for details on removing precautions
- Added Discharging COVID-19 suspect patients section (pg. 6)
- Mother Child, added link to Interim Provincial Obstetric Anesthesia Guidelines for Pregnant Women (pg. 6)
- Outbreaks – added information on when an outbreak should be declared (pg. 7)
- Prevention measures
  - Cleaning: added Common staff areas should be targeted for enhanced daily cleaning and disinfection (breakrooms, unit desks). (pg. 8)

- Staff break rooms: added Regular (daily) scans of breakroom areas using the COVID-19 PPE and Physical Distancing Compliance Scan for Healthcare Leaders and Teams (pg. 9)
- Leaves passes: added restriction on patient passes during level RED (Pg. 11)
- Added appendix B – temperature monitoring form (Pg. 18)
- Added appendix C – Outbreak interventions (pg. 19)

September 10, 2020

- Updated Accommodation & Monitoring section (p2)
  - Identified contacts and those who meet the exposure criteria require a documented temperature and COVID-19 symptom check twice daily
- Updated Lab Specimens/Tests section (p3)
  - Note: Patients can be infected with more than one virus at the same time. Coinfections with other respiratory viruses in people with COVID-19 have been reported. Therefore, identifying infection with one respiratory virus does not exclude COVID-19 infection, and vice-versa.
- Updated Duration of Droplet/Contact Precautions, with Airborne Precautions for AGMPs section (p4)
  - To discontinue precautions for a patient who is COVID-19 positive consult IP&C/designate. 10 days from symptom onset and 72 hours while asymptomatic must have passed, whichever is longer. Where patients with confirmed COVID-19 infection have been cohorted and one has recovered, this patient may be moved into the Green Zone a required.
- Updated Personal/Other Items section (p7)
  - Requirements outlined by Zone
- New section – Leaves and passes p 9/10