Saskatchewan Health Authority COVID-19 Response Guidance for Long Term Care Facilities

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Version 3.0

Adapted with permission from Vancouver Coastal Health

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Introduction

The goal of this document is to assist Saskatchewan Health Authority staff to respond to outbreaks of COVID-19 within long-term care (LTC) facilities, limiting transmission to residents and staff within the facility. The guidance is meant to provide a set of interventions for LTC COVID-19 outbreaks, building on existing approaches to respiratory outbreaks, available evidence on COVID-19, and current regional experience with COVID-19 control in this setting. The guidance is not prescriptive, and should be applied in the context of a specific outbreak scenario.

This document does not provide guidance for the clinical management of COVID-19 cases, nor outbreaks in assisted living facilities and other contexts.

This guidance document is based on the latest available scientific evidence about this disease, which is subject to change as new information becomes available. The Public Health Agency of Canada will be posting regular updates and related documents at www.phac-aspc.gc.ca. The Saskatchewan Ministry of Health has a healthcare professional's page with resources including posters, pamphlets and other information for health care facilities in Saskatchewan regarding COVID-19.

At this time, the evidence suggests that the incubation period for COVID-19 is 1-14 days with a median of 5 – 6 days. The period of communicability of COVID-19 has not been definitively established. For the purpose of LTC COVID-19 outbreak management, the period of communicability for individuals infected with COVID-19 is considered to begin 48 hours prior to symptom onset and considered to end 14 days following symptom onset, or 48 hours after resolution of symptoms, whichever is longer. A dry cough may persist for several weeks, so a dry cough alone as a symptom does not indicate transmissibility or warrant continuation of self-isolation.

Definitions

LTC COVID-19 OUTBREAK: Two or more individuals with laboratory confirmed COVID-19 for whom the Medical Health Officer has determined that transmission likely occurred[1] within a common non-household setting (i.e. unit/floor/facility) during a specified time period.

One individual with laboratory confirmed COVID-19 who may have acquired or transmitted SARS-CoV-2 in a non-household setting (i.e. unit/floor/facility) would trigger a public health investigation to determine whether an outbreak exists and this would be considered a sentinel event or suspected COVID-19 outbreak

OUTBREAK STAGES:

1. **Declared Outbreak:** The Medical Health Officer (MHO) declares the outbreak in a LTC facility.
2. **Concluded Outbreak:** 28 days i.e. two incubation periods with no new cases after the last date of exposure to a symptomatic lab-confirmed COVID-19 case at the LTC facility.
    a. The length of time to conclude an outbreak may be reduced or extended by an MHO. For example, a facility with 1 staff member diagnosed with COVID-19 AND zero (0) residents, may have an outbreak concluded 14 days after last exposure to the symptomatic staff member

COVID presentation definitions:

Signs and symptoms may include:

- Fever[2] (temperature of 37.8°or greater) or temperature that is above normal for that individual, OR;
- Any new or worsening respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat or difficulty swallowing), OR;
- Any new onset of atypical symptoms including but not limited to chills, muscle aches, diarrhea, malaise, fatigue, loss of taste or smell, headache, acute functional decline or acute confusion

Note that symptoms in elderly residents may be subtle or atypical and screening staff should be sensitive to detection of changes from resident baseline.

[1] Reasonable evidence that transmission likely occurred within a common non-household setting include:

- Close contact is confirmed with COVID-19 from 2 to 14 days following exposure;
- Individual with exposure to a setting where confirmed case was present and onset of symptoms consistent with incubation period of COVID-19;
- The individual has been located within a closed setting (e.g. admitted to hospital, residing at a work camp, correctional facility) for ≥ 7days before symptom onset or date of specimen collection if asymptomatic;
- No obvious source of exposure other than at the setting.

[2] Note that is majority of our LTC resident population fever is usually not present

Recommendations for use of PPE when caring for residents with probable, suspect or confirmed COVID-19

The SHA has a continuous mask use policy that recommends all healthcare workers who come into contact with residents during the course of their shift must wear a face mask at all times. Additionally, it is recommended that health care workers should wear the same facemask and eye protection for repeated interactions with multiple residents for the maximum of one complete shift.

LTC Managers are advised to refer to the *CONTINUOUS and EXTENDED PPE Guidelines Continuing Care* document for additional guidance on recommended PPE usage for staff.

Monitoring of and initial response to probable or suspect COVID-19 cases (symptomatic, prior to completion of lab testing)

Monitoring for COVID-19 cases

Long-term care (LTC) staff should actively monitor residents twice daily for compatible symptoms/presentations (see 'definitions' section). Health Care workers within the SHA are also expected to comply with the Daily Fitness for Work Screening for Health Care Workforce directive Residents who meet the abovementioned case definitions are considered possible cases and should be tested for COVID-19 .

LTC staff should test residents experiencing mild ILI or respiratory symptoms, as well as fever without a known cause, and residents experiencing atypical symptoms. COVID-19 cases in the LTC population are known to occur in residents with mild or atypical presentations.

Initial steps for suspect cases

If symptom criteria are met for a resident, the LTC facility should:

- **Follow** Droplet/Contact Plus[3] precautions and use appropriate personal protective equipment (which includes a gown, mask, eye protection, and gloves) to deliver care to the respective resident, including the collection of the specimens for testing
- **Place** the resident in isolation within their room, to the extent possible
- **Personal protective equipment (PPE) requirements**: Staff who are entering the room of a patient awaiting COVID-19 testing must follow Droplet/Contact Plus[3] precautions including using appropriate PPE and engaging in thorough hand hygiene
- **Notify** leaders in resident care for the LTC facility (Director of Care and/or Medical Director)

Test resident (see below)

[3] For Droplet/Contact Plus, staff would wear gowns, gloves, and procedure mask with eye protection. Setup PPE station outside of room. Post signage. Where AGMP's are considered, place patient in a room with hard walls and door; ensure the door is closed. Where available place patient in a negative pressure room. The PPE requirement for AGMP's include an N95 respirator with eye/facial protection.

Testing suspect cases for COVID-19:

- **Obtain** specimen for COVID-19 testing. Refer to the Saskatchewan.ca/covid-19 website under the Testing, Screening, Treatment and Medical Directives section for Health Care providers:
- The specimen should be obtained as soon as possible after symptom onset. Mindful of the chance of false negative test results early in the disease process, specimens may need to be collected again 48 hours after symptom onset.
- Label requisition with *"STAT LTC"* to ensure prioritized testing
- Transportation of specimens should be prioritized and expedited as rapid detection of COVID-19 in LTC is a priority.

Additional steps LTC facility should initiate with a probable or suspect case of COVID-19:

- **Cleaning**: Inform housekeeping of the need for enhanced cleaning[4].
- **Food service**: Meals for symptomatic resident awaiting test results should be provided in their room during isolation.
- **Notify** the following:
- *Resident's primary care provider*: Direct LTC facility to notify resident's usual primary care provider to determine if further assessment and treatment is indicated.
- *Resident's family / substitute decision-maker / next-of-kin*: Direct LTC facility to notify family of illness and testing being done.
- *Facility Medical Director*: ensure facility medical director is aware of pending test result
- **Continue** active monitoring of all residents for fever and symptoms twice daily. LTC facility should maintain an increased level of surveillance of other residents who fit the above mentioned presentations.
- **Continue** the Daily Fitness for Work Screening for all LTC staff. LTC facility should be on alert for staff who fit the abovementioned presentations
- Staff who screen as '*Unfit to work*' should be excluded from the facility and referred for testing as per the Daily Fitness for Work Screening for the Healthcare Workforce: LTC Guidelines and Principles.
- Advise the staff to identify themselves as long-term care staff when being assessed for testing.
- **Documentation of resident and staff monitoring:** LTC facility should maintain a line list of symptomatic residents (see Appendix A) and a separate line list of symptomatic staff (see Appendix B).

[4] All resident room surfaces especially those that are horizontal and frequently touched, should be cleaned at least twice daily and when soiled, in addition to facility cleaning protocol for droplet/contact precautions. Additionally all surfaces or items, outside of the patient room, which are touched by or in contact with HCWs such as computer carts, medication carts, charting desks or tables, computer screens, telephones, touch screens should be cleaned at least daily and when soiled

Positive COVID-19 test result in either a resident or staff

Public Health is notified of all new lab-positive COVID-19 cases by the lab performing the test, and will investigate all positive cases.

A single lab-confirmed COVID-19 case is considered a sentinel event or suspected outbreak in the LTC facility unless otherwise directed by the MHO and the presence of two or more individuals with laboratory confirmed COVID-19 where transmission is likely to have occurred is considered a confirmed COVID-19 outbreak.

In long-term care facilities, due to the risk of adverse outcomes in residents, the outbreak control measures would be similar for both suspected and confirmed outbreaks.

Outbreak control measures

1. **Isolate or exclude** the COVID-19 positive case:

   For **Positive RESIDENT:** Ensure that Droplet/Contact Plus[3] precautions are in place for the confirmed positive COVID-19 resident

   - Maintain in-room isolation for the confirmed positive COVID-19 resident for 14 days from symptom onset or 48 hours after symptoms have resolved, whichever is longer. Discuss with outbreak lead before discontinuing precautions.
   - Where shared rooms exist, the well resident(s) in the room should be moved into a private room.
   - Exposed roommate(s) should not be transferred to any other shared room for 14 days from last exposure.
   - If unable to isolate COVID-19 case in private room, ensure minimum two meters of separation are maintained between bed spaces with privacy curtains drawn. Please note that this is the option of last resort.
   - Provide resident(s) with separate toileting (commode); remove toothbrushes and denture cups from washroom.

   For **Positive STAFF:** Exclusion of positive staff from work duties is recommended

   - Self-isolation at home for 14 days from the onset of symptoms or until 48 hours post symptom resolution, whichever is longer. Note that a dry cough may persist for several weeks, so a dry cough alone does not warrant continuation of self-isolation. Employee Health/Public Health will advise.
2. **Implement** extended use of eye protection (face shields) in addition to continuous masking for all staff on the affected unit. The use of eye protection by healthcare workers to minimize infection transmission of coronaviruses including COVID-19 is supported by evidence.
3. **Identify** any resident close contacts (with assistance of Public Health, Infection control) and place on Droplet/Contact Plus precautions. Monitor for symptoms twice daily for 14 days.
4. **Complete** Resident Monitoring form for residents who are identified as a close contact (see Appendix C) to outbreak lead (IPAC or Public Health) daily.

5. **Continue** to actively monitor all residents and staff twice daily for fever and any signs and symptoms of illness.
   - Implement Droplet/Contact Plus precautions for symptomatic residents and test for COVID-19. Testing should be considered for any resident, even those with mild or atypical symptoms.
   - Exclude any symptomatic staff as per the Daily Fitness for Work Screening.
6. **Serve** meals for the confirmed positive COVID-19 resident last on unit/floor.
7. **Provide** non-urgent care to the confirmed positive COVID-19 resident last on unit/floor.
8. **Continue** enhanced cleaning for entire unit/floor.
9. **Notify** non-facility staff, professionals, and service providers of the outbreak and assess their need to visit the LTC facility. Visits should be postponed unless:
   - It is to provide an essential therapeutic service that cannot be postponed without adversely affecting the health of the residents.
   - Provide essential services (i.e. Maintenance, etc.) to maintain the safe operation of the facility.
10. **Communicate** with families of residents of the outbreak (provide a customized PDF copy of LTC COVID-19 outbreak template letter on SHA letterhead – see Appendix D for an example). Consult with outbreak lead/IPAC/MHO and SHA communications regarding any media releases or requests.
11. **Submit line lists and discuss** outbreak with designated outbreak lead within the SHA (IPAC or Public Health) daily.
12. **Restrictions** to visitors and family presence will be determined by the MHO.
13. **Encourage** diligence in hand washing and use of alcohol-based hand sanitizer for all patient/residents/staff.
14. **Alert** inventory (PPE supplier) that additional hand hygiene products, gloves, gowns, eye protection, and masks may be required.
15. **Close** facility to admissions and transfers. Any request for admission or readmission must be discussed with the MHO, their designate or the outbreak lead (IPAC or Public Health). Transfers of residents from an outbreak unit to another unit or LTC facility is not to occur until the outbreak is declared over.
16. **Cancel** all group activities and non-essential services (e.g. hair salon, pet therapy, worship)
17. **Ensure** LTC facility staff are not actively working in other healthcare settings. Cohort staff to the outbreak unit. Staff continuing to work on the outbreak unit are not to work in any other unit/facility until the outbreak is declared over.
18. **Restrict** staff movement throughout facility (no staff coverage between units/floors).
19. **Establish** a facility outbreak team including but not limited to: Director of Care (DOC)/leadership, environmental services, laundry, nursing, food services, scheduling. Regular communication within the team is advised to discuss resident cases and infection control measures until outbreak is declared over.
20. **If two or more positive COVID-19 cases are identified:**

- Isolate all residents in their rooms and implement Droplet/Contact Plus precautions when providing care .

- Isolate all confirmed positive COVID-19 residents in private rooms or they may be cohorted to the same room.
- Consider cohorting COVID-19 residents within the facility.
- Serve meals to all residents using in-room tray service.
    a. Where in-room meal service is not possible for some residents due to safety concerns such as where choking hazards exist or feeding required, the dining room can be used as long as the number of people present in the space is minimized, 2 meter distance between those present is maintained AND all those present are asymptomatic and not considered a close contact to a case.
- Continue enhanced cleaning of floor and/or neighbourhood (consider expanding to include the entire facility).

Additional Measures

The section below highlights additional outbreak control measures that should be implemented in the event of a COVID-19 outbreak in an LTC.

Contact tracing

The MHO, Public Health staff, Employee Health and Infection control, working with the LTC, must identify anyone who have had close contact with the confirmed COVID-19 positive case in the 48 hours prior to symptom onset and while the case was symptomatic (e.g. taking meals together, face-to-face conversations, provided care and other close contact).

Residents who have had close contact with a case will be considered to be exposed and should be isolated in their room on Droplet/Contact Plus precautions and monitored twice daily for fever and symptoms of illness for fourteen days after last exposure. Exposed residents should not be transferred to any other room, Long Term Care or personal care home during this time.

Employee Health/Public Health will contact all staff that test positive for COVID-19 and a detailed contact tracing interview will be performed to identify anyone who may have had close contact in the 48 hours prior to symptom onset and while the case was symptomatic.

Staff who have had close contact with a case will be directed to self-isolate and self-monitor for symptoms for fourteen days following last exposure and will be followed by Employee health/Public Health. Refer to the Interim Guidance: Risk Classification for Asymptomatic HCWs with Potential Exposure to Covid-19 Patients/Residents/Clients in Healthcare settings

Expanded Testing During Outbreak

All residents and staff should be tested upon notification of a COVID-19 positive resident or staff member.

- In order to facilitate immediate outbreak measures, testing of resident and staff contacts will be implemented as per outbreak management procedures with remaining residents and staff tested in phased approach as determined by the MHO, their designate or outbreak lead.
- A negative test does not rule out the potential for the individual to still be incubating illness.

- Residents and staff who initially tested negative may need to be re-tested if they develop symptoms.
- Re-testing residents and staff who continue to be asymptomatic is not recommended.

Review recent admissions and transfers

Provide a list of all residents transferred **OUT** of the facility (to other Long Term care homes, Personal care homes or acute care sites) going back to 14 days prior to onset of symptoms in the first positive case to Public Health. Public Health will follow up and determine if any isolation, monitoring or testing is advised.

Provide a list of all residents admitted or transferred **IN** to the facility (from other Long Term care homes, Personal care homes, community or acute care sites) in the 14 days prior to onset of symptoms in the first positive case to Public Health. Public Health will follow up.

COVID-19 related deaths

All deaths that occur during a COVID-19 outbreak regardless of symptoms should be swabbed and tested for COVID-19.

In non-outbreak scenarios, an unexpected death in a resident with symptoms suggestive of COVID-19, the recommendation is to collect appropriate swabs. The rationale for testing in these scenarios is to ensure that otherwise atypical presentations that may not have been identified are captured and early control measures implemented.

Where unexpected deaths in the absence of symptoms consistent with COVID-19 or in cases where death was anticipated and imminent such as in palliative patients, a risk-based approach should be used. The decision to test or not can be made in consultation with the MRP or Public Health.

Facility animals/pets during COVID-19 outbreaks

There is limited information on animals and COVID-19. . Infection with COVID-19 has been seen in both cats and dogs but it is unknown if they can spread COVID-19 to people. During a COVID-19 outbreak, the following precautions should be implemented:

- Ill residents and close contacts should avoid contact with animals/pets.
- All staff and residents should practice hand hygiene before and after touching animals, their food or supplies.
- Individuals at higher risk for severe COVID-19 illness should avoid contact with animals that have been exposed to an ill person.

Return to work

Employee Health/Public Health will follow-up all staff infected with COVID-19 and determine when they are permitted to return to work. In general, staff can return to work 14 days after the onset of symptoms or 48 hrs after symptom resolution, whichever is later. A dry cough may persist for several weeks, so a dry cough alone does not warrant continuation of self-isolation.

Employee Health/Public Health will not release, to the employer, the personal health information of employees.

Resident admission or transfer during COVID outbreak

Admissions/transfers into the outbreak unit are **suspended** until the outbreak is declared over. Any transfers or admissions that are urgently required must be discussed on a case by case basis with the MHO, their designate or outbreak lead. **Transfer of residents from an outbreak unit to other LTCFs or units** is not to occur until the unit/facility in outbreak is declared over.

For transfers to acute care: Residents who require urgent medical attention that cannot be met in the home should wear a mask if possible during transport. The LTC facility should notify the Emergency Department at the receiving facility to coordinate medical management of the resident. Staff must notify the Emergency Department regarding the resident's infection status. Staff must inform EMS and the receiving facility of the following:

i. Reason for transfer to acute care
ii. Coming from LTC facility with ongoing COVID-19 outbreak
iii. If resident is symptomatic or not or if a known COVID-19 case or not
iv. If the resident is a close contact or not (i.e. Roommate to a COVID case)

In addition to routine practices, HCWs involved in transporting the resident should wear PPE for Droplet/Contact Plus.

For transfers from acute care back to a LTC facility under COVID-19 precautions: Acute care site should contact the MHO or their designate to discuss the transfer.

Readmission of a COVID-19 case back to the LTC may be considered on a case by case basis – contact the MHO or the outbreak lead to discuss.

Schedule outbreak management meeting with LTC facility

Multidisciplinary outbreak management teams are part of IPAC Canada's Standards for Infection Prevention and Control programs. In order to facilitate communication and coordination of outbreak control measures, an outbreak management team should be established when an outbreak is declared.

Access provincial LTC COVID-19 surge plan if required

During an outbreak, demands on the facility to provide care to residents may supersede the LTC's resources and ability to provide safe and appropriate care. In particular, staffing may be an issue due to exclusion of COVID-19 positive staff from the facility.

If the LTC has commenced its outbreak response plan but demands for resources (HR or otherwise) have escalated beyond the site's capacity, consider suggesting to Operational and Medical Directors of the impacted LTC facility to activate STAGE 1 of the Provincial LTC COVID-19 Response Plan, to request support for the facility.

The Provincial LTC COVID-19 Response Plan can mobilize different strategies including local staff redeployment, agency staffing, financial incentives, and volunteers, in support of contracted, as well as SHA owned and operated, sites.

Post-outbreak debrief

After the conclusion of an outbreak, consider a debrief meeting with the LTC facility to evaluate the management of the COVID-19 outbreak and make recommendations to further COVID-19 outbreak management guidance.

Long-term care (LTC) staff should continue to actively monitor residents at least once daily for compatible symptoms/presentations (see 'definitions' section) despite the outbreak being declared over in order to recognize if illness is reintroduced into the facility. Health Care workers within the SHA are also expected to comply with the Daily Fitness for Work Screening for Health Care Workforce directive. Residents who meet the abovementioned case definitions are considered possible cases and should be tested for COVID-19 via a nasopharyngeal swab (NP) swab.

Appendix A – Patient/Resident Line List

Resident COVID-19 Line list **Outbreak #**

Case Definition:

Case Identification			**Update daily with all symptoms in past 24 hours**											**Complications**		**Specimens**		**Vaccine/Medications**			
Recovered	Name and location	Baseline Temp	Date	Onset Date	Highest temperature	Cough (Dry (D)/Wet (W))	Runny nose (R) Nasal congestion (C) Sneezing (S)	Sore throat (S) Hoarse voice(H)	Headache	Myalgia (muscle pain)	Chest congestion	Malaise (M) Chills (C)	Other S&S	Hospitalization (d/m/y)	Death (d/m/y)	Date specimen collected (d/m/y)	Results/organism	Influenza vaccine (d/m/y)	Antibiotic (d/m/y)	Tylenol	Other antipyretic
	Case#:			Day 0																	
				Day 1																	
	Name:			Day 2																	
				Day 3																	
				Day 4																	
				Day 5																	
				Day 6																	
	Sex: M/F			Day 7																	
	Age:			Day 8																	
				Day 9																	
	HSN:			Day 10																	
	Room #:			Day 11																	
				Day 12																	
				Day 13																	
				Day 14																	
				Day 15																	

Comments/Diagnosis/Med History:

☐Wanderer/Non-compliant with precautions

Appendix B – Staff Member Line List

Staff COVID-19 outbreak line list

Name and HSN	Role (e.g. LPN, housekeeping)	Onset date	Temperature	Cough (Dry (D)/Wet (W))	Runny nose (R) Nasal congestion (C)	Sore Throat (S) Hoarse voice (H)	Headache	Myalgia	Others i.e. malaise	Hospitalization	Date tested	Results	Floors/areas worked prior to symptom onset	Date(s) Excluded from work	Return to work date
Case # Name HSN (if available)															
Referred to Occupational Health/811 for assessment and testing? ☐Yes ☐No Comments:															
Case # Name HSN (if available)															
Referred to Occupational Health/811for assessment and testing? ☐Yes ☐No Comments:															
Case # Name HSN (if available)															
Referred to Occupational Health/811 for assessment and testing? ☐Yes ☐No Comments:															

Appendix C – Resident Close Contact tracking form

Resident is identified as having close contact with a COVID case. Isolate of droplet/contact plus precautions and monitor for signs and symptoms for 14 days

Case Identification			Update daily with all symptoms in past 24 hours												Complications		Specimens		Vaccine/Medications			
Recovered (d/m/y)	Name and location	Baseline Temp	Date		AM temperature	PM temperature	Cough (Dry (D)/Wet (W))	Runny nose (R) Nasal congestion (C)	Sore throat (S) Hoarse voice(H)	Headache	Myalgia (muscle pain)	Chest congeion	Malaise (M) Chills (C)	Other S&S	Hospitalization (d/m/y)	Death (d/m/y)	Date specimen collected	Results/organism	Influenza vaccine (d/m/y)	Antibiotic (d/m/y)	Tylenol (Dose/frequency)	Other antipyretic
	Case#:			Day 0																		
				Day 1																		
	Name:			Day 2																		
				Day 3																		
				Day 4																		
				Day 5																		
	Sex: M/F			Day 6																		
	Age:			Day 7																		
				Day 8																		
				Day 9																		
	HSN:			Day 10																		
				Day 11																		
	Room #:			Day 12																		
				Day 13																		
				Day 14																		
				Day 15																		

Comments/Diagnosis/Med History: ☐**Wanderer/Non-compliant with precautions**

Appendix D – LTC Outbreak Communication Letter

Date:______________________________

Dear Residents, Families, and Staff:

We are writing to notify you that there is an outbreak of COVID-19 at _________________________. An outbreak of COVID-19 is declared in a long-term care facility when two or more residents or staff are diagnosed with COVID-19 by lab testing and it appears that the spread of illness occurred within the long term care home.. The Saskatchewan Health Authority (SHA) is working with________ to resolve the outbreak and take steps to protect the health of all residents and staff.

The current practice when responding to a COVID-19 outbreak is to isolate resident cases of COVID-19 in their rooms, and require staff cases to isolate at their respective homes and not attend work. All residents and staff will be tested for COVID-19 and monitored closely for signs and symptoms of illness.
.

Outbreak control measures have been put in place at ______________________. This may result in some residents being confined to their rooms, including during mealtimes. There will also be restrictions to group activities, and non-essential services. These precautions prevent the spread of respiratory illnesses, and are standard approaches already used in care facilities during seasonal influenza outbreaks. Visitor restrictions may be necessary and will be determined by the Medical Health officer.
COVID-19 is a respiratory illness. It can spread through droplets when a person coughs or sneezes, or touching the virus with your hands then touching your face before washing your hands. Symptoms of COVID-19 may be mild or severe. These may include fever, cough, fatigue, runny nose, sore throat, nausea, vomiting or diarrhea. More severe symptoms can include difficulty breathing or chest pain. While most people will experience mild illness, older adults and people with pre-existing medical conditions are at higher risk for severe illness.

For further information on COVID-19 visit the Government of Saskatchewan information page (https://saskatchewan.ca/covid-19) or call 8-1-1.

Sincerely,

Medical Health Officer
Saskatchewan Health Authority

Summary of updates, changes to SHA Covid-19 Response Guidance for LTC Version 3.0

Summary of Updates, additions and changes to the SHA Covid-19 Response Guidance for LTC document	
September 25 2020 Version 3.0	• Updated LTC outbreak definition wording to align with the Communicable Disease control manual outbreak definitions(pg. 2 & pg. 5) • Updated the Covid-19 presentation definitions including acute functional decline or acute confusion (pg. 2) • Transportation of specimens should be prioritized and expedited as rapid detection of Covid-19 in in LTC is a priority (pg. 4) • Further direction provided regarding shared rooms (pg. 5). • New – implement extended use of eye protection along with continuous masking for all staff while on the outbreak unit with the identification of one case. (pg. 5) • Restrictions to visitors will be determined by the MHO (pg. 6) • Establish facility outbreak team (pg. 6) • Combined the 2 sections describing outbreak control measures when there is 1 case and when there are 2 or more cases (pg. 6) • New – Expanded testing during an outbreak – residents and staff (pg. 7) • New – Review recent admissions and transfers (pg. 8) • New- Facility animals/pets during Covid-19 outbreak (pg. 8) • Updated Appendix D the Outbreak communication letter • Removed Appendix E LTC letter to staff regarding work restrictions (not necessary with the Public health order in place regarding staff cohorting.