COVID-19
(Coronavirus)

Phase 4

Care Homes Guidance

Stay informed on the latest developments about COVID-19 by visiting the Government of Bermuda's website ***coronavirus.gov.bm***

GOVERNMENT OF BERMUDA
Ministry of Health

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COVID-19 Guidance: Care Homes v.2.0

MINISTRY OF HEALTH, GOVERNMENT OF BERMUDA

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Application

Care homes regulated under the Residential Care Homes and Nursing Homes Act 1998, are to follow this guidance in accordance with The Public Health Act 1949, the Public Health (COVID-19) Regulations 2020, Public Health (COVID-19 Emergency Powers) Regulations 2020, Residential Care Homes and Nursing Homes Act 1999, Residential Care Homes and Nursing Homes Regulations 2001 and Code of Practice for Care Homes 2018.

Each care home is responsible to implement the guidance in accordance to their specific care home needs and circumstances. The COVID-19 Care home support can be contacted for advice on implementing the guidance.

The guidance will be updated continuously based on clinical and national developments regarding COVID-19. Care homes will be informed directly of updates to the guidance.

Contact Information

Covid Care Home support, Ministry of Health
441-278-4936
wmmatthew@gov.bm

Epidemiology and Surveillance Unit (ESU), Ministry of Health
278-6503
jdwilson@gov.bm

For more information, updates and Covid-19 resources go to:
https://www.gov.bm/coronavirus

COVID-19 Guidance for Care Homes v.2
Ministry of Health, Government of Bermuda
October 2020

Glossary

Droplet and Contact Precautions

include:

- Surgical/procedure mask (add N95 for aerosol generating procedures)
- Isolation gown
- Gloves
- Eye protection (goggles/face shield)

Essential visitors or providers include a person:

- Performing essential resident support services e.g. health care services required to maintain good health; family required to provide care.
- Visiting a very ill or palliative resident

Visitor- a person who is not an essential visitor but visits:

- To provide non-essential services
- For social reasons
- As a prospective new resident

Provider - a person who provides non-essential personal or health care services to the resident, for example hair or beauty care.

High Risk for severe COVID-19 disease

Older adults and people of any age who have serious underlying medical conditions such as:

- Asthma
- Chronic kidney disease
- Chronic lung disease
- Diabetes
- Immunocompromised
- Liver disease
- People aged 65 years and older
- People in nursing homes or long-term care facilities
- Serious heart conditions
- Severe obesity

Outbreak in a care home A single, laboratory-confirmed case of COVID-19 in a care home resident or staff member.

Outbreak area- Designated space(s) within the care home where COVID-19 positive or exposed residents are cared for and engaged in activities. Based on the size, layout or number of Covid positive/exposed residents in the home, the entire facility may be designated as an outbreak area.

Isolation separates persons who have a confirmed diagnosis of COVID-19 to prevent the transmission from an infected resident/staff/visitor to other non-infected residents, health care workers, and visitors.

Quarantine separates and restricts the movement of persons who may have been exposed to COVID-19 but do not have a confirmed medical diagnosis.

Personal Protective Equipment (PPE) is equipment worn to minimize exposure to a variety of hazards. Examples of PPE include such items as gloves, eye protection, masks, N95s, gowns, aprons

Self-monitoring means the person should monitor themselves for fever by taking their temperature twice a day and remain alert for symptoms of COVID-19 (e.g., cough, shortness of breath, sore throat, sore muscles, tiredness, gastrointestinal symptoms, loss of taste or smell)

Staff includes anyone working in the care home including but not limited to, health care workers.

Symptoms consistent with COVID-19

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Muscle pain
- Sore throat
- New loss of taste or smell
- Gastrointestinal symptoms like nausea, vomiting, or diarrhea
- Unexplained change in baseline condition

1. Residents at High Risk for Severe Disease

1.1. Respiratory infections such as COVID-19 can be easily transmitted in an institutional environment such as the care home.

1.2. The resident community in care homes is likely to be older, frailer and have complex chronic conditions, which put them at *high risk for severe COVID-19 disease.*

2. Preparedness Measures

Review and Activate Infection Control Measures

2.1. Ensure sufficient PPE is available and review staff PPE training. Ensure appropriate PPE conservation is followed. (See **Appendix 1).** Donning and doffing guidance is found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html

2.2. Update advanced directives with all residents.

2.3. Review staffing schedules, staff who work in other locations, availability of alternate staff, and emergency contact numbers for staff.

2.4. Review environmental cleaning protocols and ensure frequent cleaning of high touch surfaces. See Occupational Safety and Health Guidance at https://www.gov.bm/coronavirus-workplace.

2.5. Review communications protocols.

2.6. Develop plans to communicate with staff, residents and families on COVID-19 updates, and impact on the care home. It should include providing information on where staff can get tested if they become symptomatic or are exposed to COVID-19.

2.7. Identify if and how outbreak areas can be established in the home.

2.8. Identify and ensure the appropriate staff are trained, as required by the Ministry, for ResQwest test booking and test sampling.

Increase Physical Distancing

2.9. Modify internal activities to promote adherence to physical distancing measures (>2 meters/6 feet) for residents and among staff.

2.9.1. Communal dining can continue with physical distancing to reduce potential exposures. Dining in shifts may be required to ensure physical distancing. Environmental cleaning should occur between shifts and, as appropriate, during dining shifts.

2.10. Review use of staff common areas and staff break schedules to reduce the number of staff in break facilities at a time and to facilitate physical distancing.

2.11. Review all residents' medication administration schedules to consolidate and minimize the number of times staff need to enter a resident's room.

Visitors

2.12. Visitor restrictions and requirements are determined by the Visiting and Activity Phases as outlined **Appendix 2** and by notification from the Ministry.

2.13. Essential visitors or essential providers may be arranged with the care home during restricted visiting phases.

2.14. Essential visitors/providers, are determined by the care home and must be people needed to perform essential care/quality of life support for:

2.14.1. End of life care needs

2.14.2. Dementia care needs

2.14.3. Mental health needs

2.14.4. Physical care needs

2.15. If a person does not meet the criteria in 2.14 to be an essential visitor/provider, a request by the care home may be placed with the Ministry's COVID-19 care home support.

2.16. For all visitation phases, care homes must ensure the following are adhered to for all types of visitors and providers, unless otherwise directed by the Ministry:

2.16.1. The restrictions on the types of visitors/providers, number of visitors/providers and location of visits for each Phase are listed in **Appendix 2.**

2.17. 6 feet is maintained at all times between the resident and a visitor/provider, unless direct care is being provided

2.17.1. All visits are prescheduled with the home to ensure adequate staff and physical distancing, as determined by the care home and according to the specific restrictions at each Phase.

2.17.2. All essential and non-essential visitors and providers are screened prior to and upon arrival with the *COVID -19 Screening Tool for LTC Homes* (see **Appendix 3&4**).

2.17.3. All essential and non-essential visitors and providers are asked to tell the care home if they develop fever or symptoms consistent with COVID-19 within 14 days of their visit.

2.17.4. All essential and non-essential visitors and providers are signed in on arrival and departure. They should use their own pen or be signed in/out.

2.17.5. All essential and non-essential visitors and providers only visit the approved resident and no other residents. This includes consideration for the roommates of a resident if the visit must occur in their room. A dedicated indoor visiting space may be useful if space permits

2.17.6. Use of the resident/visitor bathroom facilities is discouraged.

2.17.7. Children under 16 are not permitted as essential visitors.

2.17.8. The resident's right to decline a visitor is respected.

2.17.9. Staff must support the visitor or provider in appropriate use of PPE:

a. All essential and non-essential visitors and providers must wear a mask while visiting a resident that does not have COVID-19. In non-outbreak homes a cloth mask brought by the visitor is sufficient.

b. All essential and non-essential visitors and providers in contact with a resident who has COVID-19 or suspected COVID-19, must use PPE as required for droplet and contact precautions (see **Appendix 5**).

2.17.10. All essential and non-essential Visitors and providers are guided in performing hand hygiene when they arrive.

2.17.11. If it is necessary to enter the building, it should be through a separate entrance.

2.18. Care homes are responsible for advising residents' family and friends of the visiting restrictions and requirements.

2.19. Where possible, visitors are encouraged to keep in touch with loved ones by phone or video chat or other technologies, as available.

2.20. Care packages from families/friends are encouraged. Labelled packages, in a wipe-able wrapping, should be left in a designated spot outside of the care home and wiped off using disinfectant wipes before being brought into the facility. Remind family/friends that if they are ill with cough, sneezing, or runny nose they should not prepare/send packages).

2.21. Families with strong objection to the visiting restrictions should be given the option to relocate their loved one.

Resident Activities & Engagement

2.22. When Covid-19 is present in the community, restrictions are in place on resident activities and day care services in accordance with the Visitor and Activity Phases in **Appendix 2**. This guidance must be read with the restrictions and requirements and any other guidance or notice issued by the Ministry.

2.23. Homes are to provide meaningful engagement and activities for residents with existing staff when external activity providers are unable to work in the home based on the Activity and Visiting Phase (see **Appendix 2**).

2.24. For activities, where possible, residents are grouped into **social pods** with dedicated staff members for all activities and engagement including dining. This is to protect spread of an outbreak prior to receiving a positive test. Pods should take into account resident friends and preferences and be limited to a maximum of 6 residents.

2.25. When external activities and visits are restricted (See Phases in **Appendix 2**):

2.25.1. The home needs to consider cultural and religious practices and determine acceptable alternatives

2.25.2. Residents who wish to go outdoors should remain on the home's property and are to maintain safe physical distancing

2.26. Residents who leave the home have the following precautions in place:

2.26.1. Residents, and persons they are leaving the home with, are educated by staff on proper Covid-19 precautions when outside the home. This includes screening to help ensure residents are not visiting people with symptoms, in self isolation or quarantine.

2.26.2. Residents are screened upon re-entry to the home (they do not require isolation or testing unless presenting with symptoms).

2.26.3. Residents wear a mask at all times when not in the home.

2.27. Residents whose leave includes an overnight stay follow the above precautions and, upon return to the care homes, are put under 14 days of modified quarantine which includes:

2.27.1. Twice per day active screening – if any symptoms are present this would trigger a suspected case and the required actions outlined in the Guidance.

2.27.2. No indoor visitation

2.27.3. Twice per day monitoring for symptoms

2.27.4. Avoidance of common areas however if not possible, residents are to wear a mask.

2.27.5. Limited contact with other residents

2.27.6. No participation in group activities

2.27.7. Frequent hand washing

2.27.8. Adherence to respiratory etiquette

2.27.9. Maintaining physical distancing

2.28. Residents in quarantine must remain on the property at all times.

2.29. Ensure any quarantining takes into consideration the detrimental physical, emotional and social impacts on the residents.

2.29.1. Alternative options for support should be considered, e.g. exercise programs for the room, one on one programs, use of technology to allow visual and auditory contact with family and friends, distracting activities that meet the needs of individual residents.

2.29.2. Consider cultural and religious practices and determine acceptable alternatives.

2.29.3. Consider alternative measures to be taken for residents with cognitive disabilities (e.g. increase one on one programs, use of preventative wandering barriers, dedicate resident time for sensory stimulation activities)

Day Care Programming

2.30. Day care programs for non-residents are not authorized when a home is in outbreak and during Phase 1 and 2 of the Visiting and Activity Phases (see **Appendix 2**).

2.31. Care homes are responsible to assess the risk and requirements for re-opening their day care program and adapt their services and total number of clients they can serve accordingly when authorized under the Visiting and Activity Phase 3.

2.32. The Covid-19 Guidance for Care homes applies to day care services within a care home. In addition, the following is required to be in place for day care when authorized to operate:

2.32.1. Dedicated direct care staff for the day care clients, i.e. these staff are not working with residents in the home.

2.32.2. Day care clients are in a space separate from residents and this separation can be maintained.

2.32.3. The space used for day care services is maintained in accordance with IPC guidance to decrease risk of transmission.

2.32.4. Physical distancing requirements, unless personal care or support is being provided, are maintained and total number of clients reflect this criteria.

2.32.5. PPE requirements in the Covid-19 Guidance for Care Homes, are upheld for day care clients and staff.

2.32.6. Daily client screening and monitoring is in place.

a. A person who fails the screening cannot return to the program until they are 48hours symptom free and have a negative COVID-19 test result.

2.32.7. Any suspected case of COVID in the care home can result in the closure of the day care service. Any suspected case of COVID in a day care client can result in closure of the day program.

2.32.8. All clients (and their carers, as appropriate) are informed of the risks to attend day care services, the policies in place regarding screening and attendance, and if the service must cease.

2.32.9. Transportation services both for attending and during the day program are considered with regard to risk reduction.

2.32.10. The care home's day care policies, procedures and practices are updated to uphold these criteria.

Active Screening

2.33. The Nurse-in-Charge/Administrator must ensure all people entering the home are screened (See **Appendix 3 &4)**. These procedures are to be applied 7 days a week and 24 hours a day. This includes all staff, providers, all types of visitors and any person providing delivery or maintenance services that must enter the facility.

Staff

2.34. Staff screening must include twice daily (at the beginning and end of the day or shift) temperature checks and symptom screening.

2.35. Any staff showing symptoms of COVID-19 must not be allowed to enter the home. They must go home immediately to self-isolate and contact their health care provider for assessment and nasal swab testing.

2.36. The home's charge nurse / administrator must follow up on all staff who have been advised to self-isolate.

Current Residents

2.37. Care homes must conduct daily active screening, including temperature checks, of all residents, at least twice daily (at the beginning and end of the day) to identify if any resident has symptoms of COVID-19 (see **Appendix 3&4).**

2.38. Residents with symptoms (including mild respiratory symptoms or atypical symptoms i.e. unexplained change in baseline condition) must be isolated and **nasopharyngeal sample tested** for COVID-19.

New Admissions and Re-admissions

2.39. Patients transferred from a hospital or new admissions to a care home must be tested for COVID-19 just prior to discharge from the hospital or home, and results received, prior to transfer/admission.

2.40. On admission/readmission, all new residents:

2.40.1. Must be screened for symptoms and potential exposures to COVID-19.

2.40.2. Must be placed in quarantine under droplet and contact precautions for 14 days

a. An initial negative result does not rule out the potential for incubating illness and all residents

2.40.3. Must be tested for COVID-19 (**nasopharyngeal sampling**) on or after Day 14.

a. If test results are negative on or after Day 14, the resident may be released from quarantine.

b. If test results are positive on or after Day 14, the resident must be isolated under droplet and contact precautions until two negative tests are obtained at least 24 hours apart.

Summary of Required Precautions

Activity	**Precautions**
Preventing spread from staff or essential visitors who may be asymptomatic/pre-symptomatic while working in or visiting the care home.	Use a surgical/procedure mask at all times during shift or visit. For staff who are taking breaks, the surgical/procedure mask may be removed but a minimum two meter (6 feet) distance should be maintained from others.
Before providing care to a resident	Staff must determine the precautions and PPE required.
Providing care to residents with suspect or confirmed COVID-19, including collection of nasopharyngeal swabs	High Contact (increases risk of transfer of virus/other pathogens to the hands and clothing) <u>Droplet and Contact Precautions</u>, including: • Surgical/procedure mask • **Isolation gown** • Gloves • Eye protection (goggles/face shield)
	Low Contact (unlikely to provide opportunity for transfer of virus/other pathogens to the hands and clothing) • Surgical/procedure mask • **Plastic Apron** • Gloves • Eye protection (goggles/face shield)
Providing suctioning (or other aerosolizing procedure) to resident with suspect or confirmed COVID-19	Droplet and Contact precautions **plus** use of N95 respirator. Manage in single room with door closed. Keep the number of people in the room during the procedure to a minimum.

3. Testing for COVID-19

3.1. Care homes are to implement a very low threshold for COVID-19 testing. **Nasopharyngeal swabbing and testing is conducted on every symptomatic resident and staff member in the care home**.

3.1.1. If there are no screening supplies, residents will be put in isolation with droplet precautions and staff will isolate at home as required by ESU

3.2. For outbreak prevention, monthly whole care home buccal screening of all residents and staff, regardless of symptoms, is to occur.

3.2.1. Buccal swab sampling is used for whole care home screening of asymptomatic residents and staff.

3.2.2. If there is limited screening supplies, whole care home testing will sample 50% of residents and 50% of staff, as directed by ESU.

3.3. Care homes are responsible for booking tests, ordering and verifying their kits, obtaining samples, delivering their samples and initiating required actions as a result of test results.

3.3.1. For details on each step see the testing process diagram in **Appendix 6**

3.3.2. Only care home staff certified for COVID-19 specimen collection may collect samples from staff or residents.

3.3.3. Care home must have designated staff trained in using the ResQwest system to book tests for their home.

3.3.4. Test results are sent to the care home, the care home's medical consultant and residents/staff's personal GP, as logged in the ResQwest system.

3.4. Consent is obtained for all residents and staff for testing and monthly buccal screening.

3.4.1. For residents that refuse testing and buccal screening, they must wear appropriate PPE (mask, gloves and gown/apron) while in the public areas of the care home.

3.4.2. Staff who refuse to test or buccal screen must wear full PPE at all times.

3.5. For information on outbreak testing, refer to the Outbreak Guidance section below.

Mandatory Reporting

3.6. COVID-19 is a notifiable disease as per the *Public Health (Communicable Disease) Order 2020* [1] *and the Public Health Act 1949*[2]

3.7. The care home must contact the Epidemiology and Surveillance Unit (ESU) in the Ministry of Health at **441-278-6503** or jdwilson@gov.bm to report a staff member or resident suspected/confirmed to have COVID-19. The ESU will provide advice on what control

[1] Bermuda Laws online. Retrieved from http://www.bermudalaws.bm/laws/Annual%20Laws/2020/Statutory%20Instruments/Public%20Health%20(Communicable%20Disease)%20Order%202020.pdf

[2] Bermuda Laws Online. Available at http://www.bermudalaws.bm/laws/Consolidated%20Laws/Public%20Health%20Act%201949.pdf

measures should be implemented to prevent further spread and how to monitor for other possible infected residents and staff members.

4. Staff Exposure/Staff Illness

4.1. All staff who have been advised to self-monitor for 14 days from an exposure must report to their supervisor in the care home.

4.2. Anyone with symptoms compatible with COVID-19 must not go to work, must self-isolate, report their symptoms to the care home and their physician, and get tested.

4.3. Staff who test positive for COVID-19 must report their illness to their manager /supervisor. Staff who test positive must have 2 negative COVID-19 tests at least 24 hours apart before returning to work.

4.4. The manager/supervisor must promptly inform the ESU of any cases or clusters of staff including part-time/casual staff who are absent from work.

4.5. If COVID-19 is suspected or diagnosed in a staff member, return to work should be determined in consultation with their health care provider and the ESU.

4.6. Symptomatic or suspected staff are not tested in the care home but at the government symptomatic testing site or their private GP. They should not go to a public testing site.

4.6.1. Testing for symptomatic staff is scheduled via the ResQwest System, either by their GP or through the ESU case management. They must state they are symptomatic.

4.7. For details on work self-isolation please see the Work-Self-Isolation section below.

Limiting Work Locations

4.8. Care home employers and employees must comply with staffing restrictions issued under the Residential Care Home and Nursing Homes Amendment Regulations 2020. All care homes will be notified on staffing restrictions, or changes to restrictions, under this regulation.

4.9. When staffing restrictions are in place care homes must:

4.9.1. Work with staff, contractors, and volunteers to limit their work location to the care home to minimize risk to residents and other staff of exposure to COVID-19.

4.9.2. Staff, contractors and volunteers must discuss with their employer if they have other work locations and the COVID-19 status of those locations.

5 Outbreak Guidance

5.1. Outbreaks are declared in collaboration between the home and ESU.

5.2. A single, laboratory confirmed case of COVID-19 in a resident or staff member is managed as an outbreak.

5.3. If a new admission or re-admission tests positive, it may not be necessary to declare an outbreak if they have been in isolation under contact and droplet precautions since entering the care home.

5.4. Early identification of cases associated with care homes and rapid implementation of outbreak control measures are essential to preventing spread within the home.

Triggering an Outbreak Assessment

5.5. As soon as one resident or staff presents with new symptoms compatible with COVID-19, the care home must immediately report to ESU to conduct an outbreak assessment.

5.6. All symptomatic staff and residents are tested for COVID-19. This includes deceased residents who were not previously tested.

5.7. There is a low threshold to test residents and staff; even one compatible symptom, and or an unexplained change in baseline, may lead to testing.

5.8. **Symptomatic people are tested by nasopharyngeal sampling**.

5.8.1. If there are no testing supplies and if instructed by ESU, residents will be put in isolation with droplet precautions and staff will isolate at home.

For an Ill Resident:

5.9. Place the symptomatic resident under contact and droplet precautions in a single room, if feasible.

5.10. Roommates of the symptomatic resident are to be tested at this time.

5.11. Further testing within the care home is assessed, in collaboration with ESU, using a risk-based approach based on exposures.

For an Ill Staff / Visitor/Provider:

5.12. The staff/visitor/provider must self-isolate immediately at home and be tested by **nasopharyngeal sampling.**

5.13. Symptomatic or suspected staff are not tested in the care home but at the government symptomatic testing site or their private GP. They should not go to a public testing site.

5.14. Testing for symptomatic staff is scheduled via the ResQwest System, either by their GP or ESU case management. They must state they are symptomatic.

Outbreak Management

Specimen Collection and Testing for Outbreak Management

5.15. Once an outbreak is declared, any additional compatible illness in residents is to be managed as a probable case and presumed COVID-19, while waiting for their testing results.

5.15.1. All symptomatic people will get a full viral panel conducted in addition to the COVID-19 test.

5.16. In the context of a confirmed outbreak, and in consultation with ESU, the following testing is required:

5.16.1. Initial test- occurs for the whole care home (all residents and staff) when declared in outbreak.

5.16.2. Second test- are necessary for those who test negative during the initial test. The purpose is to reduce the risk of false negatives.

a. 7 days after the initial test- all staff and residents who tested negative or missed the initial get a second test.

b. Staff and residents who missed the initial test and test negative under 5.16.2.a, get their second test 7 days later.

5.16.3. After 5.16.2.a and b are completed, all those who tested negative resume monthly buccal screening (as outlined under Section 3 of this Guidance).

5.16.4. If a person tests positive, they are exempted from the routine monthly buccal screening.

a. Positive persons are tested 6 weeks from their onset of symptoms, or their positive test date.

b. If this test is negative they must have a second negative test result within 24hours to declare them COVID-19 negative.

Assessing for Individual Cases

5.17. Once an outbreak has been declared, all visitors and providers who were in close contact with the infected individual(s), must be identified and tested. This involves:

5.17.1. Assessing for illness in those who had exposure to the case(s) in the 14 days prior to illness onset to identify potential source cases.

5.17.2. Assessing for illness in those who had exposure to the case(s) while the case(s) was infectious and not in isolation, i.e. 2 days before until 14 days after onset of symptoms or negative test results.

Outbreak Control Measures

5.18. Consider all residents in the outbreak area to be either infected or exposed and potentially incubating.

5.19. Continue monitoring of all residents and staff for new symptoms.

5.20. Report regular updates on ill residents or staff to the ESU.

5.21. Quickly identify, initiate droplet and contact precautions, and test for COVID-19 any resident with symptoms compatible with COVID-19 (including atypical symptoms) and assess for expansion of outbreak areas.

5.22. **No new resident admissions are allowed** into the outbreak areas until the outbreak is declared over.

5.23. **No re-admission of residents** who were not part of the outbreak into the outbreak areas until the outbreak is over;

5.24. Re-admission of residents who were part of the outbreak line list may be considered with a risk assessment/discussion.

5.25. If residents are taken by family out of the home, they may not be readmitted until the outbreak is over.

5.26. When there is an active COVID-19 case in a care home, the care home reverts to Phase 1 for Visiting and Activities (see **Appendix 2** and section 2 of the Guidance). All essential visitors and providers must be informed of the outbreak status and risk of transmission.

5.27. For activities and engagement at the home, including dining, residents are to be cohorted, if and when an outbreak occurs, see Cohorting section.

5.28. Any delivery or maintenance person not required to enter the home for an essential service, is not to enter the home.

5.29. For residents that leave the home for an essential out-patient visit, for example, dialysis, the home must provide a surgical mask for the resident. If tolerated, the mask must be worn while out of the home and the resident should be screened upon their return.

5.30. Review infection prevention and control practices including proper PPE use, and hand hygiene with all staff including kitchen and housekeeping staff.

5.31. Ensure EMS and hospitals are informed when COVID-19 positive or exposed residents are to be transferred from the home.

5.32. Maintain ongoing assessment of contingency plans for procurement of essential supplies (e.g., stock rotation, ordering, alternatives, etc.).

Cohorting

5.33. Cohort or "group together" all residents and staff in the outbreak area as much as possible.

5.34. Residents are cared for in groups of 6 or less, within each cohort, with a consistent assignment of staff.

5.35. Resident cohorting includes one or more of the following:

- 5.35.1. COVID-19 positive residents with COVID-19 positive residents;
- 5.35.2. COVID-19 negative residents with COVID-19 negative residents;
- 5.35.3. Exposed residents with other exposed residents and vice versa.

5.36. Use respite and palliative beds/rooms and other rooms as appropriate to help maintain isolation of affected residents/cohorts.

5.37. Staff cohorting can include:

5.37.1. Designating staff to **either** ill **or** well residents, exposed **or** unexposed residents.

5.37.2. Assigning staff who test positive and are asymptomatic (if on work self-isolation) to positive or exposed residents.

5.37.3. Assigning staff who test negative to negative residents.

5.37.4. Assigning unexposed staff to unexposed residents.

5.38. Resident activities (including dining) are geared to each cohort and group.

5.39. Cleaning must take place after each group activity/dining shift.

5.40. Intermingling of the groups must be avoided.

5.41. Residents in isolation or quarantine must remain on the property of the care home, unless necessary for essential health care.

5.42. If cohorting and consistent assignment is not possible, the alternative is to discontinue all communal activities/gatherings for the duration of the outbreak; where possible provide in-room food service.

5.43. In smaller care homes or in homes where it is not possible to maintain physical distancing of staff or residents between each cohort, all residents or staff should be managed as if they are potentially infected, and staff should use droplet and contact precautions.

5.44. Ensure any quarantine/ isolation of residents takes into consideration the detrimental physical, emotional and social impacts on the residents as outlined for quarantined residents under Resident Activities & Engagement.

Work Self-Isolation

5.45. Used in exceptional circumstances for asymptomatic staff critical to operations, but who are advised to self-isolate (either from travel, high-risk exposure, or testing positive).

5.46. "Work self-isolation" means continuing to work (where appropriate) while using appropriate PPE and active self-monitoring, including taking their temperature twice daily to monitor for fever, and immediately self-isolating if symptoms develop**.** See **Appendix 8.**

5.47. Staff under work self-isolation must be known to the head nurse / administrator.

5.48. Staff must follow self-isolation guidance outside of the workplace, i.e. in the home and wider community.

5.49. During work, full PPE must be worn at all times.

5.50. 2 negative COVID-19 tests obtained 24 hours apart must be obtained for clearance from work self-isolation.

Communications

5.51. Care homes must keep staff, families and residents informed about the COVID-19 status in their home.

5.52. Signage in the care home must be clear about COVID-19, including signs and symptoms of COVID-19, and steps that must be taken if COVID-19 is suspected or confirmed in staff or a resident and if the home is currently in outbreak.

5.53. Communicate with ESU throughout the outbreak, including regarding newly symptomatic residents or staff, residents transferred to hospital and resident deaths.

Declaring the Outbreak Over

5.54. A home is declared outbreak free when there has been no positive tests for 28days after the last positive test was received.

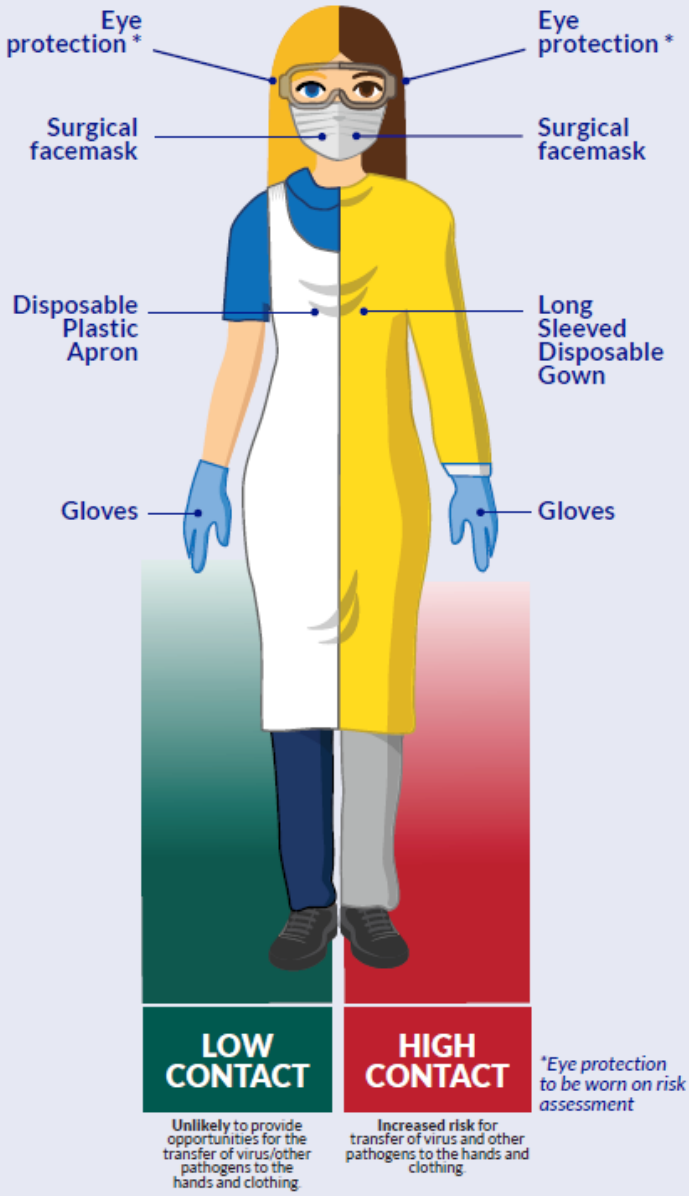
5.55. If a new case or cases are detected after this 28-day recovery period has been achieved, then this is a new outbreak and the care home manager notifies ESU and implements outbreak measures.

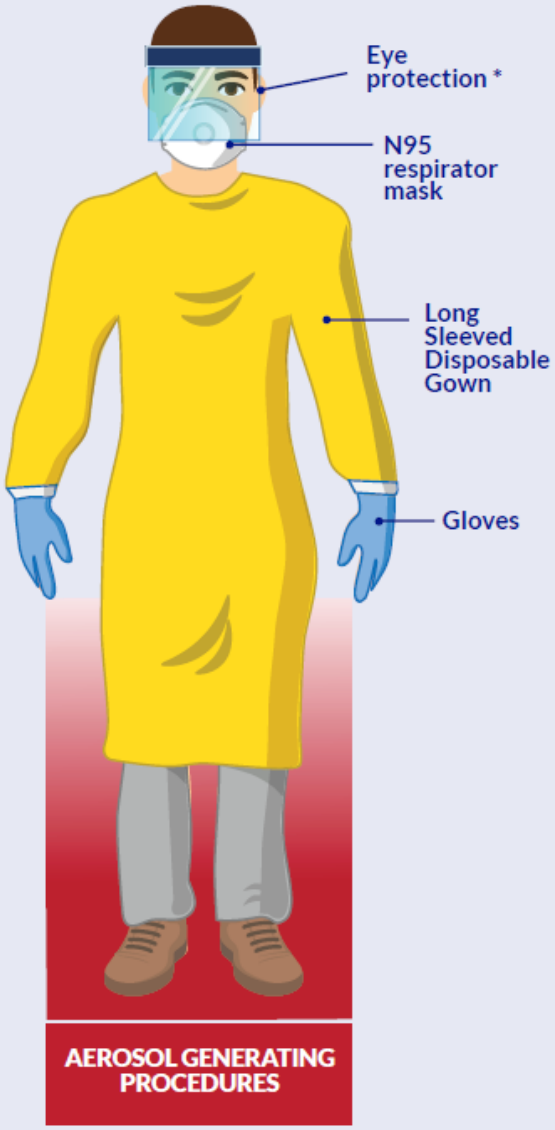
Appendix 1: Safe PPE

COVID-19
Safe PPE

Care of patients with respiratory symptoms/suspected/confirmed COVID-19

Hand Hygiene First in **All** Cases





Stay informed on the latest developments about COVID-19 by visiting the Government of Bermuda's website coronavirus.gov.bm

GOVERNMENT OF BERMUDA
Ministry of Health

page 1

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Appendix 2: Care home Visiting and Activity Phases

The high vulnerability setting of care homes requires restrictions on visitors and non-essential staff during Covid-19. At the same time, these are residents' homes and quality of life and care are essential. Homes are encouraged to maximize available opportunities for visiting and engagement during all phases for resident wellbeing.

The table below outlines the visiting phases. The visiting phases and associated restrictions and requirements, found in the Covid-19 Guidance: Care Homes will be continuously reviewed and updated based on updated COVID outbreak prevention and management standards and national developments.

Essential visitors (family/friends and external health care providers) are authorized at any phase with restrictions and requirements.

Phase 1	Essential visitors allowed with restrictions and requirements Non-essential visitors allowed only by telephone, internet and through closed windows and doors.
Phase 2	Essential visitors allowed with restrictions and requirements OUTDOOR in-person non-essential visitors allowed with restrictions and requirements. Visits must remain on care home property.
Phase 3	INDOOR in-person essential and non-essential visitors for residents allowed with restrictions and requirements.
Phase 4	Unrestricted in-person visiting – precautions to be determined.

The Care home Outbreak Management Team is responsible to assess and identify the visitation phase for all homes and if and how a home can progress to a new phase. Homes will be notified of the current phases and any changes applicable. This decision must ensure:

- Care home visiting phases lag behind the general community's reopening by a minimum of 4 weeks and dependent on community COVID rates.

- Care homes do not advance through any phase of reopening or relax any restrictions until all residents and staff have received a base-line test, and the appropriate actions are taken based on the results in accordance with the COVID 19 LTC Guidance.

- Homes prior to moving to a new phase of visitors, especially those that experienced an outbreak, are adequately preventing transmission of COVID-19 through adherence to PPE and IPC guidance, have adequate staffing in place and adequate PPE supplies for all staff, residents, and visitors. See TABLE 2 below for more detail on the standard and criteria used.

Restrictions on the number, type and location of visitors, providers and activities are listed in TABLE 3.

TABLE 2: Criteria for moving between Phases

Standard	Criteria
Change in visitor phases – to lag behind national re-opening.	• Date & stage of most recent national re-opening • National COVID19 status/prevalence
Testing- all current staff and residents have received testing and results.	• All residents and staff tested • Date of test and results
COVID19 status	28 days free of COVID19
Staffing levels and ratios- Care needs are being met while oversight and support can be provided to manage visitors and protect residents as required.	• Level of care of residents • NAs: residents • RN: residents • Administrative and management oversight. • Staffing exemptions (type & #) and impact on oversight. • Ability to cohort in small groups with dedicated staff
IPC – Demonstrated staff and. Management knowledge and implementation of existing guidelines	• All staff (including appropriate management) are trained in PPE use for themselves and visitors • Demonstrated ability to implement and monitor adherence to IPC guidance.
PPE supplies- Demonstrated ability to maintain and manage PPE supplies.	• Adequate supplies for staff and visitors • Evidence of ability to manage supplies
Communication with families- Demonstrated willingness and ability to community and enforce with families on restrictions and requirements for visiting.	Management maintains clear and effective communication with families on COVID19 related procedures to ensure compliance.
Physical environment- Suitable space and design to ensure required IPC requirements for visiting (6ft)	• Separate entrance and exit available • Outdoor space with physical distancing available • Indoor space with physical distancing available • Demonstrated ability for management to assess and manage visitors in accordance with requirements.

Resident need for Phase 1 essential visitors	• Discussion and decision on the risk and need by the care home with the resident and their relevant persons has occurred.
	• The need is determined as essential due. To:
	  ○ End of life – as determined by the resident's physician
	  ○ Dementia- provide support to ensure appropriate care is provided.
	  ○ Mental Health- to help support residents experiencing challenges e.g. depression or anxiety.
	  ○ Physical care needs – essential healthcare to address or avoid risk to resident health.

TABLE 3: Visiting Phases- Restrictions and Requirements:

These restrictions and requirements must be read in conjunction with the general provisions included within this Covid-19 guidance for Care homes.

	Phase 1	**Phase 2**	**Phase 3**
Type or visitor/provider	• Essential visitors only • Essential providers only • No one under 16 years of age	• Essential and non-essential visitors and providers • No one under 16 years of age	• Essential and non-essential visitors and providers • No one under 16yrs of age indoors.
Number of visitors in total allowed per resident	2 named persons	2 named persons	No restrictions
Number of visitors at one time per day	1 essential visitor/provider per resident at a time per day	• 1 essential indoor visitor per resident at a time per day • 2 non-essential outdoor visitors if from the same household	1 essential or non-essential visitor or provider at a time per resident per day
Location of visits	• On site • Essential- indoor and outdoor • Non-essential visitors allowed - through closed doors, windows	• On site • Essential – indoor & outdoor • Non-essential- through closed doors and window OR outdoor visiting	• On and off site, including overnight. • Essential and non-essential visitors & providers- indoor & outdoor based on home and room layout.
Length of visits	Max 30min	Max 30min	Max 30 min
Activities	• In house activity providers and activities (on care home property) only. • No day care services	• In house activity providers and activities (on care home property) only. • No day care services	• External activity providers • External activities • Restricted day care programs

Appendix 3: COVID-19 Screening Tool Example for Care Homes

At a minimum, the following questions should be used to screen individuals for COVID-19 before they are permitted entry into the home. The tool is not intended to be used to screen new/re-admissions in the absence of other clinical and detailed admission assessments. **In emergency situations, emergency first responders should be permitted entry without screening**

Name of person:
Date:
Contact information:

Screening Questions

1. Do you have any of the following symptoms or signs?

New or worsening cough	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Runny nose, sneezing or nasal congestion (in (absence of underlying reasons for symptoms such as seasonal allergies and post nasal drip)	☐ Yes	☐ No
Hoarse voice	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Loss of smell or taste	☐ Yes	☐ No
Nausea/vomiting, diarrhea, abdominal pain	☐ Yes	☐ No
Unexplained fatigue/malaise	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No

2. Have you travelled outside of Bermuda or had close contact with anyone that has travelled outside of Bermuda in the past 14 days? ☐ Yes ☐ No

3. Do you have a fever? (37.8 C or greater) ☐ Yes ☐ No **TAKE TEMPERATURE.**

4. Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19? ☐ Yes – go to question 5 ☐ No – screening complete

5. Did you wear the recommended PPE according to the type of duties you were performing (e.g., goggles, gloves, mask and gown or N95 with aerosol generating medical procedures (AGMPs)) when you had close contact with a suspected or confirmed case of COVID-19? ☐ Yes ▫ No

Results of Screening Questions:

*• If the individual answers **NO to all questions from 1 through 4 and they do not have a fever**, they have passed and can enter the home. They need to wear a mask to enter the home and should be told to self-monitor for symptoms and be reminded about required re-screening at the end of their day/shift/visit or when they leave the home.*

*• If the individual answers **YES to any question from 1 through 3**, they have not passed and **cannot** enter the home. They should go home to self-isolate immediately. Staff/Essential visitors should be told to contact a healthcare care provider to discuss their symptoms and/or exposure and seek advice on testing.*

*• If the individual answers **YES to question 4 and YES to question 5, and they do not have a fever**, they have passed and can enter the home. They need to wear a mask to enter the home and should be told to self-monitor for symptoms and be reminded about required re-screening at the end of their day/shift/visit or when they leave the home.*

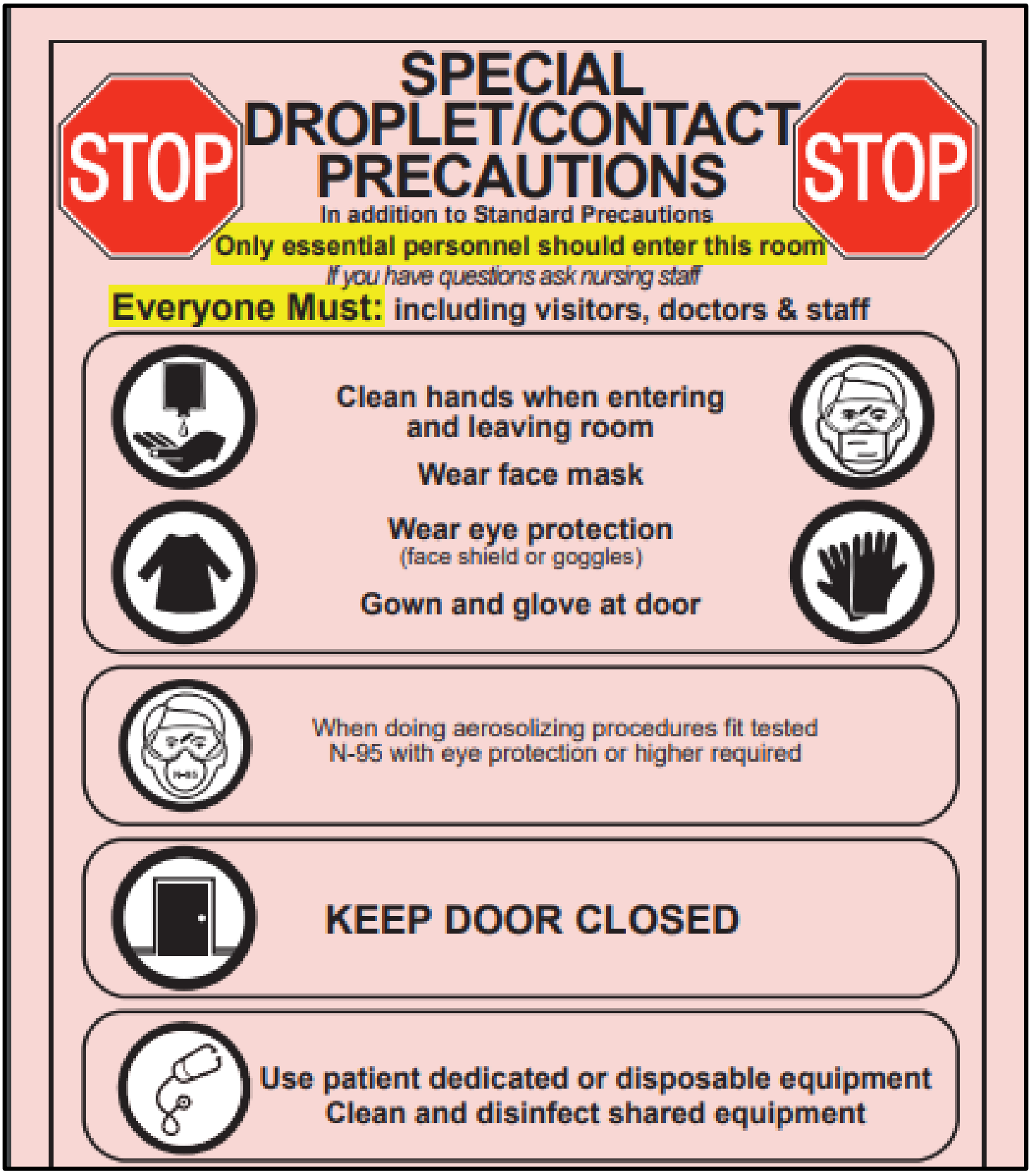
*• If the individual answers **YES to question 4 and NO to question 5**, they have not passed screening and **cannot** enter the home. They should go home to self-isolate immediately. Staff/Essential visitors should be told to contact a healthcare provider to discuss their symptoms and/or exposure and seek advice on testing.*

Appendix 4: Summary for Active Screening for Care homes

	Staff, Essential Visitors*, and Anyone Entering the Home	Current Residents of the Home	Resident Admissions and Re-Admissions to the Home
Who does this include?	Staff working at the care home, a person performing essential services and a person visiting a very ill or palliative resident.	Residents currently living in the home.	Residents newly admitted and residents who are being re-admitted.
What are the screening practices?	Conduct active screening twice daily (at the beginning and end of the day) to identify any symptoms including temperature checks.	Conduct active screening of all residents, at least twice daily (at the beginning and end of the day) to identify any symptoms, including temperature checks and atypical symptoms.	Screen all new admissions and re-admissions for potential exposure to COVID-19 and identify any symptoms, including temperature checks and atypical symptoms, Place all new residents in quarantine for 14 days on arrival at the LTCF regardless of a negative COVID-19 test result.
What if someone screens positive?	Staff, essential visitors, and those attempting to enter the home who are showing symptoms of COVID-19 must not be allowed to enter and should go home immediately to self-isolate and be tested for COVID-19.	Residents with symptoms of COVID-19 must be isolated under droplet and contact precautions and tested.	

*Essential visitors include a person performing essential services including family providing care services, and other health care services. Requirements for active screening of visitors excludes emergency first responders who should, in emergency situations, be permitted entry without screening.

Appendix 5: Droplet/Contact Precautions Poster

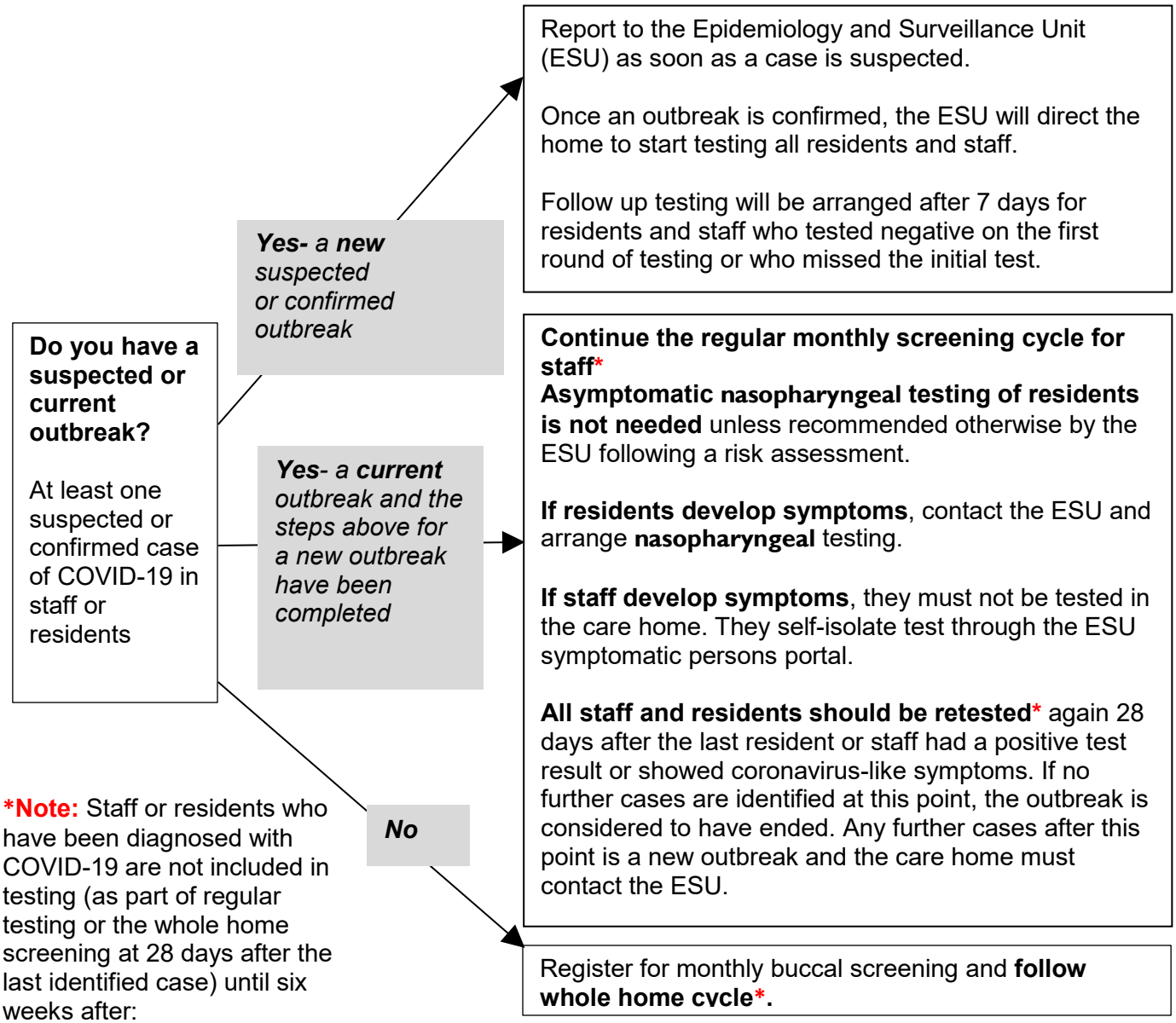


Appendix 6: COVID-19 Testing/Buccal Screening Process

TESTING STEPS	ACTIONS BY CARE HOME
BOOKING TESTS • Residents and/or staff are booked into the ResQwest system. •For monthly buccall screening book 5-7 days before scheduled test date. •Symptomatic testing (**nasopharyngeal sampling)** book immediately	• Make reservations under your care home's name in ResQwest. • Ensure sufficient PPE for testing/screening • Prepare workflow and testing/screening station • Arrange for cooler, ice and transport of specimens on testing day.
GETTING KITS •Order testing and screening kits from: Tammy Gibbons tngibbons@gov.bm; 705-0610 •Homes receives email notifying kits are ready to collect	• Order kits- include total number and type needed. • Collect kits from Ministry of Health front desk no less than one day prior to testing date (bring bag to carry tests) • Communicate testing plan to all staff and residents • Obtain signed consent forms for all residents. • Have a plan for staff and residents who refuse testing.
VERIFYING KITS • Kits include: Specimen bag, Specimen tube, Swab, Label, Reservation Form, Chain of custody form	• Check correct demographics and number of kits were provided. • Check kits are complete with no leakage from specimen tubes • Prepare record template and work stations for easy registration and workflow • Prepare residents and explain process as many times as needed before testing/screening day
TESTING DAY •Testing/screening is conducted and completed in time for specimens to be delivered by 4pm on the same day.	• Prepare staff and residents for testing/screening • Check in each person via ResQwest as tested/screened • Follow instructions, collect and package the sample from each person tested/screened • Place form in exterior pocket of specimen bag. • Ensure tops are on specimen bottles are secure and samples placed on ice, upright in a cooler. (Home to provide cooler and ice).
DELIVERY OF SPECIMENS •Specimens delivered to Hamilton Health Centre **before 4 pm** •Lab Contact: Sakina Usher, 278-6474 or 300-0513; salusher@gov.bm	• Specimens are transported in the cooler with ice, ensure they remain upright. • Complete the chain of custody form and deliver with specimens.
RECEIVING RESULTS •Results will be emailed within 72 hours of the delivery of specimens.	• Take appropriate action if the result is positive or inconclusive. • Results are mailed to the persons indicated in the ResQwest booking.

Appendix 7: Testing flow chart

COVID-19 Testing in care homes



***Note:** Staff or residents who have been diagnosed with COVID-19 are not included in testing (as part of regular testing or the whole home screening at 28 days after the last identified case) until six weeks after:

- Their initial onset of symptoms

Or

- Their positive test result (if asymptomatic)

If they develop new symptoms, they should be retested immediately.

Appendix 8: Work Self Isolation PPE

Resident/ Cohort	Symptomatic Resident: Confirmed or Suspect Case	Asymptomatic Resident: Contactsofa Case (e.g., roommate, tablemate,friend)	Asymptomatic Resident: Not Exposed to a Case	Comments
Who Should Provide Care?	Preferred option Exposed but asymptomatic staff exposed to ill residents in affected area.	Exposed but asymptomatic staff exposed to ill residents in affected area.	Asymptomatic staff not exposed to ill residents in affected area. Alternate option: Exposed but asymptomatic staff.	
Precautions When Providing Direct Care	Routine Practices plus Droplet/Contact Precautions.	Routine Practices plus Droplet/ Contact Precautions.	Routine Practices, unless whole area/facility under outbreak precautions use Routine Practices plus Droplet/Contact precautions.	
What PPE is Required?	Procedure Mask at all times. Add eye protection, gloves, and gowns for direct care.	Procedure Mask at all times. Add eye protection, gloves, and gowns for direct care.	Ideally, exposed staff are not providing care to asymptomatic residents outside of the affected area. If required, to wear Procedure Mask at all times* and as per Routine Practices.	Gloves are to be changed between residents; between soiled and aseptic tasks on same resident. Hand hygiene performed between glove use.
Staff Screening and Monitoring	Screen twice per shift for respiratory symptoms including Temperature checks. This applies to everyone entering and leaving the facility.			All staff who develop symptoms are to immediately report symptoms to their supervisor/occupational health and safety representative and should not be in the workplace.