مركز أبوظبي للصحة العامة
ABU DHABI PUBLIC HEALTH CENTRE

دائـــرة الـصـــحـــة
DEPARTMENT OF HEALTH

Circular No.(2024 / 212) تعميـم رقم

Date: 01/11/2024

التاريخ: 01/11/2024

To **All:**
Healthcare Facilities in the Emirate of Abu Dhabi

إلى جميع:
منشآت الرعاية الصحية في إمارة أبوظبي

Subject: **Updates on COVID-19 Guideline for Healthcare Professionals**

الموضوع: تحديثات على الدليل الارشادي لكوفيد-19 للمهنين الصحين

Greetings,

تحية طيبة وبعد ،،،

We would like to extend you our greetings wishing you all the best and success.

بدايةً يسرُّنا أن نتقدم لكم بخالص التحية والتقدير متمنين لكم دوام التوفيق.

In reference to the circular number (117/2023), we would like to inform all healthcare facilities that covid-19 guideline for health care professionals has been updated (attached). The guideline include updates of:

- Case definition.
- Infection control measures in healthcare facilities.

بالإشارة إلى التعميم رقم (2023/117)، نود إعلام جميع منشآت الرعاية الصحية بأنه قد تم تحديث الدليل الارشادي لكوفيد-19 للمهنين الصحيين (مرفق)، حيث يشمل التحديث على:

- تعريف الحالة.
- إجراءات مكافحة العدوى في منشآت الرعاية الصحية.

We emphasize the importance of implementing universal source control in healthcare facilities where Covid-19 outbreak detected, especially in high-risk departments such as oncology, intensive care units, dialysis, or emergency department.

كما نشدد على ضرورة تطبيق التدابير الشاملة للحد من انتشار العدوى في منشآت الرعاية الصحية التي يتم رصد تفشي لحالات كوفيد -19 فيها خاصةً في الأقسام عالية الخطورة مثل الأورام، أو العناية المركزة، أو غسيل الكلى، الرعاية طويلة الأمد، أو قسم الطوارئ.

For further enquiries, kindly contact Communicable Diseases Department ADPHC via email: responsecdd@adphc.gov.ae

لمزيد من الاستفسارات، يرجي التواصل مع إدارة الأمراض السارية بمركز أبوظبي للصحة العامة عبر البريد الإلكتروني: responsecdd@adphc.gov.ae

We hope that all will adhere to the above, for the best interest of work

آملين من الجميع الالتزام بما ورد أعلاه، لما فيه مصلحة العمل.

Thanking you for your kind cooperation

شاكرين لكم حسن تعاونكم معنا.

هذا التعميم للإجراءات التنظيمية وغير مخصص كمحتوى للنشر الإعلامي".

"This circular is designed for regulatory procedures and should not be used as content for media publication".

د. نورة خميس الغيثي

وكيل دائرة الصحة

مركز أبوظبي للصحة العامة
ABU DHABI PUBLIC HEALTH CENTRE

COVID-19 Guideline for Healthcare Professionals

Version 7

July 2024

Contents

1. Background

Coronavirus disease (Covid-19) is an infectious disease caused by SARS-CoV-2 virus. The first case was identified in December 2019 in China, which was followed by large spread causing the covid-19 pandemic. The disease causes respiratory illness ranging between mild to moderate disease. Some cases may require medical attention due to severe disease.
The purpose of this document is to provide updated guidance to Healthcare Professionals involved with COVID-19 response and management. This guideline is subject to review and further updates by ADPHC/DOH based on up-to-date scientific evidence available and recommendations.

2. Case Definition

- **Clinical criteria**

  1- Any person with at least one of the following symptoms *

  - Cough
  - Fever
  - Shortness of breath
  - Sudden onset of anosmia, ageusia or dysgeusia
  - Sore throat
  - Additional less specific symptoms may include headache, chills, muscle pain, fatigue, vomiting and/or diarrhea

  2- A person with Acute respiratory illness (ARI) or Severe Acute respiratory illness (SARI)

- **Laboratory criteria**

  Positive respiratory sample for SARS COV2 by PCR

- **Epidemiological criteria**

  - Close contact with a confirmed COVID-19 case in the 14 days prior to onset of symptoms.

***Note**: Clinicians should be alert to the possibility of atypical presentations in patients who are immunocompromised.*

Suspected case

- Any person meeting the clinical criteria.

Probable case:

- Any person meeting the clinical criteria AND an epidemiological link,

OR

Confirmed case:

- Any person meeting laboratory criteria.

3. Collection and Handling of Clinical Specimens for COVID-19 Testing

adapted from reference laboratory

Test Category
Molecular Detection

Preparation and Collection of Specimens
Proper specimen collection is the most important step in the laboratory diagnosis of infectious diseases. A specimen that is not collected correctly may lead to false or inconclusive test results.

Nasopharyngeal and oropharyngeal swabs	Nasopharyngeal and oropharyngeal swabs are collected from adults and children five years and older
Nasopharyngeal aspirate	For children under five, a nasopharyngeal aspirate is recommended.
Tracheal aspirate	A tracheal aspirate is also recommended when it is not possible to collect a swab
Other samples	The COVID-19 virus has been detected in other sample types, such as stools and blood. However, the viral dynamics in these samples has not been fully characterized.

Shipment
Respiratory samples including swabs and UTMs should be kept refrigerated (4-8 °C) and sent to the laboratory where they will be processed within the 24-72 hours of collection. If samples cannot be sent within this period, freezing at -80 °C is recommended until samples are shipped (ensuring the cold chain is maintained).
All the samples shipment are under Biological Substances, Category B

Methods and Interpretation of Results

f confirmation of COVID-19 cases is based on detection of COVID-19 virus nucleic acid (RNA) by real time RT-PCR assays.

4. Infection control & prevention

4.1. Early recognition and source control

- Screen and triage patients entering the healthcare facility for signs and symptoms of respiratory illness.
- Verify if they have been in close contact with confirmed COVID -19 cases recently.
- Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g. waiting areas, elevators, cafeterias) to provide instructions (in appropriate languages) about respiratory etiquette, wearing surgical mask if having respiratory symptoms and how and when to perform hand hygiene.
- Universal source control is recommended in facilities who experience Covid-19 outbreak. It is also recommended to apply universal source control when outbreak occurs in high risk units within the facility such as oncology, intensive case, dialysis, or emergency department.
- Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand sanitizer with 60-95% alcohol, tissues, and no-touch receptacles for disposal, at healthcare facility entrances, waiting rooms and other patient areas.
- Use only EPA (Environment Protect Agency) approved disinfectants for low-risk reusable medical equipment and environmental surfaces with focus on commonly touched surfaces.
- Ensure staff are always implementing standard precautions with all patients in terms of the use of recommended PPE; safe waste management; cleaning and disinfection of equipment; cleaning of the environment, laundry management, etc.
- Provide instruction to visitors before they enter a patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy. visitors should minimize their time spent in other locations in the facility.
- Take measures to limit crowding in communal spaces, such as scheduling appointments to limit the number of patients in waiting rooms or treatment areas.
- If healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP and patients as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. If possible, testing should continueuntil no new cases are identified for at least 14 days

  Note: Respirators with an exhalation valve are not recommended for source control, as they allow unfiltered exhaled breath to escape.

4.2. When caring for patients with suspected/confirmed COVID-19

- Suspected COVID-19 patients should be placed in an area separate from other patients (examination room with the door closed). If not possible, group patients with similar respiratory symptoms or clinical diagnosis and based on epidemiological risk factors, with recommendedspatial separation of at least 2 meters.

- Use PPE (N95 mask, eye protection, gloves, and gown) before entering a room where a suspected or confirmed COVID-19 patient is.
- If possible, use either disposable or dedicated equipment (e.g., stethoscopes, blood pressure cuffs and thermometers).
- If equipment needs to be shared among patients, clean and disinfect between each patient use.
- Ensure that health care workers refrain from touching their eyes, nose, and mouth with potentially contaminated gloved or un-gloved hands.
- Avoid contaminating environmental surfaces that are not directly related to patient care (e.g., door handles and light switches).
- Limit transport and movement of the patient outside of the room to medically essential purposes.
    - Whenever possible, perform procedures/tests in the patient's room.
    - Consider providing portable X-ray equipment in patient cohort areas to reduce the need for patient transport.
- Perform hand hygiene before and after contact with the patient or his/her environment.

4.3. When performing an aerosol-generating procedure in patients with COVID-19

- Ensure that healthcare workers performing aerosol-generating procedures (i.e. open suctioning of respiratory tract, high flow nasal oxygen, non-invasive ventilation, intubation, bronchoscopy, cardiopulmonary resuscitation) use PPE, including gloves, long-sleeved gowns, eye protection, and fit-tested particulate respirators (N95 or equivalent, or higher level of protection). (The scheduled fit test should not be confused with user seal check before each use.)
- A negative pressure rooms is required, when performing aerosol-generating procedures, with minimum of 12 air changes per hour or at least 160 litres/second/patient in facilities with natural ventilation or HEPA filters.
- Avoid the presence of unnecessary individuals in the room.
- Perform procedures on COVID-19 cases at the end of the daily schedule whenever possible.

4.4. Healthcare Facilities - information, instructions, and training

Healthcare Facilities should provide information, instructions and training on occupational health and safety, including:

- Provision of adequate training for HCWs including refresher training on infection control measures and PPE donning & doffing.
- Ensuring an adequate patient-to-staff ratio.
- Ensure that all those involved in collection and transportation of specimens should be trained on safe handling practices and spill decontamination procedures.
- Ensure that laboratories in health care facilities adhere to appropriate biosafety practices and transport requirements, according to the type of organism being handled.
- Monitoring HCWs compliance with standard precautions and providing mechanisms for improvement as needed.
- Cleaners and other subcontractors should be included in the above-mentioned training/education.

5. Contact tracing

- Close contacts should self- monitor for symptoms, and get tested immediately if they develop any symptoms.
- Home quarantine is not required for contacts.
- High-risk contacts (age above 50, have chronic disease or people of determination) are recommended to test and monitor symptoms for 7 days. Those who develop symptoms should seek medical care for clinical assessment and management plan.

6. Case management

6.1. Criteria for admission:

In general, the admission criteria are:

• if there is evidence of pneumonia **in high risk patient** regardless of the oxygen saturation

• severe and critically ill patients

• presence of other medical/surgical/psychiatric indications for hospital admission unrelated to COVID19 in infected patient

6.2. SARS-Cov2 Severity Spectrum: *(based on NIH covid-19 guidelines)*

Asymptomatic or Pre-symptomatic Infection: Individuals who test positive for SARS-CoV-2 using a virologic test (i.e., NAAT), but who have no symptoms that are consistent with COVID-19.

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnoea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

* In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.

6.3. High risk for progression to severe COVID-19:

Certain underlying medical conditions increase risk for severe COVID-19 illness in adults and multiple conditions are associated with more severe COVID-19 illness.

- Age above 65 years.
- Diabetes mellitus
- Obesity (BMI ≥30 kg/m2 or ≥85th percentile in children)
- Cardiovascular disease or hypertension
- Chronic kidney disease
- Chronic lung diseases
- Chronic liver diseases
- Sickle cell disease
- Neurodevelopmental disorders or conditions that confer medical complexity
- HIV (human immunodeficiency virus)
- Pregnancy
- Cancer
- Solid organ or hematopoietic cell transplantation
- Immunocompromised or on immunosuppressive medications

Other conditions in children:

- Congenital or acquired heart disease
- Neurodevelopmental disorders
- Positive pressure ventilator

6.4. Clinical Management and Treatment for confirmed COVID 19 cases (Adults)

Asymptomatic COVID-19	
No risk factors	Supportive management if needed
With risk factors	Sotrovimab monoclonal antibodies

Mild to Moderate COVID-19 (O2 > 94%)	
No risk factors	Symptomatic and supportive management
With risk factors	Paxlovid, OR, Sotrovimab monoclonal antibodies OR, Remdesivir for a total of 3 days*
*if patient has COVID-19 pneumonia, give remdesivir for total of 5 days	

Severe COVID-19 (O2 < 94% but not on mechanical ventilation)	
All patients	Remdesivir Dexamethasone
receiving dexamethasone and who have rapidly increasing oxygen needs and systemic inflammation	Add PO Barcitinib or IV Tocilizumab

Critical COVID-19 and mechanical ventilation or ECHMO	
All patients	Dexamethasone OR, equivalent Corticosteroids (preferable methylprednisolone) AND PO Barcitinib OR IV Tocilizumab

For management of covid-19 in pediatrics, refer to SKMC department of infectious diseases

6.4.1. COVID-19 medications

A. Antivirals

Remdesivir:

Remdesivir is a nucleotide prodrug of an adenosine analogue. It binds to the viral RNA-dependent RNA polymerase and inhibits viral replication by terminating RNA transcription prematurely. Remdesivir has demonstrated in vitro activity against SARS-CoV-2.

Food and Drug Administration approved the antiviral drug Remdesivir for use in adult and pediatric patients 28 days of age and older weighing at least 3 kilograms for the treatment of COVID-19 requiring hospitalization

Dosage Recommendations:

The treatment dose for admitted COVID19 patients on oxygen is 200 mg loading dose on day 1 followed by 100 mg once-daily for 4 days.

For early patient in the outpatient not requiring oxygen, the dose is 200 mg loading dose on day 1 followed by 100 mg once-daily for 2 days.

Administration:

IV infusion.

Monitoring:

- A baseline of:

1. CBC

2. Renal and liver functions

Common Side effects:

- Hypotension, anaphylactic shock, diarrhoea, constipation, nausea and vomiting.

- Elevated liver function tests (AST, ALT), phlebitis and headache.

- Remdesivir is co-formulated with sulfobutyl ether β-cyclodextrin (SBECD), so there is a theoretical risk of accumulation in renal failure promoting further renal injury, similar to intravenous voriconazole. Especially if creatinine clearance is < 50 ml/minute

Drug-Drug Interactions with other anti-covid-19:

No interaction documented so far.

Paxlovid

Paxlovid is a combination of Nirmatrelvir, a SARS-CoV-2 main protease (Mpro: also referred to as 3CLpro or nsp5 protease) inhibitor, and ritonavir an HIV-1 protease inhibitor and CYP3A inhibitor.

It has FDA and MOHAP emergency use authorization for the treatment of mild-to-moderate coronavirus disease 2019 (COVID-19) in outpatient adults and paediatric patients (12 years of age and older weighing at least 40 kg) with positive results of direct severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death.

- **Limitations of Authorized Use**
  - PAXLOVID is not authorized for initiation of treatment in patients requiring hospitalization due to severe or critical COVID-19
  - Drug to drug interaction

- **Dosage and Administration**

PAXLOVID is nirmatrelvir tablets co-packaged with ritonavir tablets.

Nirmatrelvir must be co-administered with ritonavir.

Initiate PAXLOVID treatment as soon as possible after diagnosis of COVID-19 and within 5 days of symptom onset.

Administer orally with or without food.

Dosage: 300 mg nirmatrelvir (two 150 mg tablets) with 100 mg ritonavir (one 100 mg tablet), with all three tablets taken together twice daily for 5 days.

Missed dose: If <8 hours since dose was due, the missed dose should be administered as soon as possible, and normal dosing schedule should resume. If ≥8 hours since dose was due, the dose should be skipped, and dosing should resume at the next scheduled administration time. Do not double the dose to make up for a missed dose.

Dose reduction for moderate renal impairment (eGFR ≥30 to <60ml/min) to PAXLOVID is 150 mg nirmatrelvir and 100 mg ritonavir twice daily for 5 days

PAXLOVID is not recommended in patients with severe renal impairment (eGFR <30ml/min)

No dosage adjustment is needed in patients with mild (Child-Pugh Class A) or moderate (Child-Pugh Class B) hepatic impairment.

PAXLOVID is not recommended for use in patients with severe hepatic impairment

- PAXLOVID is not authorized for pre-exposure or post-exposure prophylaxis for prevention of COVID-19.
- PAXLOVID is not authorized for use longer than 5 consecutive days.

- **Contraindications**
  - History of clinically significant hypersensitivity reactions to the active ingredients (nirmatrelvir or ritonavir) or any other components.
  - Co-administration with drugs highly dependent on CYP3A for clearance and for which elevated concentrations are associated with serious and/or life-threatening reactions.

- Co-administration with potent CYP3A inducers where significantly reduced nirmatrelvir or ritonavir plasma concentrations may be associated with the potential for loss of virologic response and possible resistance.

- **Warnings and Precautions**

The concomitant use of PAXLOVID and certain other drugs may result in potentially significant drug interactions.

Hepatotoxicity: Hepatic transaminase elevations, clinical hepatitis, and jaundice have occurred in patients receiving ritonavir.

HIV-1 Drug Resistance: PAXLOVID use may lead to a risk of HIV-1 developing resistance to HIV protease inhibitors in individuals with uncontrolled or undiagnosed HIV-1 infection.

- **Adverse Reactions**

Adverse events (incidence ≥1% and ≥5 subject difference) were dysgeusia, diarrhoea, hypertension, and myalgia

- **Drug Interactions**

  - Co-administration of PAXLOVID can alter the plasma concentrations of other drugs and other drugs may alter the plasma concentrations of PAXLOVID.
  - Consider the potential for drug interactions prior to and during PAXLOVID therapy and review concomitant medications during PAXLOVID therapy.

- **Pregnancy and lactation Considerations:**

Adverse events were observed following exposure to Nirmatrelvir in some embryo-fetal developmental toxicity studies, ritonavir has a low level of transfer across the human placenta and is the preferred pharmacologic booster in pregnancy, therefore, if pregnant patients have mild to moderate symptoms, especially patients with one or more additional risk factors (eg, BMI >25, cardiovascular disease, chronic kidney disease, diabetes mellitus)

Paxlovid should not be withheld when the potential benefits outweigh the possible risks.

Ritonavir is present in breast milk; excretion of nirmatrelvir is unknown, the decision to breastfeed during therapy should consider the risk of infant exposure, the benefits of breastfeeding to the infant, and the benefits of treatment to the mother

B. Immunomodulators

Tocilizumab

The current evidence supported the use of IL6 receptor blockers in these categories of patients to reduce mortality and need of mechanical ventilation.

If patient meet the above criteria then Tocilizumab should be given in combination with corticosteroids, not as single agent.

The suggested dose is 4- 8 mg/kg of actual body weight (maximum dose 800 mg) as a single intravenous dose over 1-hour infusion, a second dose can be given after 12 to 48 hours if clinically required.

Administration: Dilute in 100 ml of 0.9 % saline, allow diluted solution to reach room temperature, infuse over more > 60 minutes using dedicated line (Do Not infuse if opaque particles or discoloration visible same)

Sarilumab: Is another IL6 that can be used in cytokine storm. If used, the suggested dose is 400mg IV infusion over 1 hour once

Barcitinib

Baricitinib. an inhibitor of Janus kinase 1 (JAK1) and JAK2, may be used as a combination with corticosteroids for hospitalized adults with severe COVID-19, who require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) with a recommended dose of 4 mg once daily for 14 days or until hospital discharge, whichever happens first.

Baricitinib has an Emergency Use Authorization by FDA for the above indication.

Baricitinib may be considered in people who meet the above criteria, and who cannot have tocilizumab.

When there is clinical deterioration despite treatment with tocilizumab, it may be appropriate to add Baricitinib.

Baricitinib is contraindicated in pregnancy and breastfeeding

Adult Dose for COVID-19

4 mg orally once a day Duration of therapy: 14 days or until hospital discharge, whichever occurs first

Dose adjustment based on renal function

- Mild renal dysfunction (eGFR 60 to less than 90 mL/min/1.73 m2): 4 mg orally once a day
- Moderate renal dysfunction (eGFR 30 to less than 60 mL/min/1.73 m2): 2 mg orally once a day
- Severe renal dysfunction (eGFR 15 to less than 30 mL/min/1.73 m2): 1 mg orally once a day
- ESRD or acute kidney injury (eGFR less than 15 mL/min/1.73 m2): Not recommended.

C. Monoclonal Antibodies (MAB)

Pre-Exposure Prophylaxis

Evusheld is approved under emergency use authorization for pre-exposure prophylaxis among non-infected individuals and who are not a contact of COVID-19 case. Eligible groups include adults and children above 12 who weigh at least 40 kg and:

- unvaccinated individuals due to severe adverse reaction to the available vaccines. Or,
- Those with immunocompromised conditions or taking immunosuppressant medications who may not mount sufficient immune response.

Dosage and Administration:

Evusheld is given as two separate consecutive intramuscular injections (IM)

- Dosing for individuals who did not receive Evusheld previously:

Initial dose: 300 mg of tixagevimab and 300 mg of cilgavimab administered as two separate consecutive intramuscular injections.

- Dosing for Individuals Who Initially Received 150 mg of Tixagevimab and 150 mg Cilgavimab
  - if Initial dose ≤3 months prior: 150 mg tixagevimab and 150 mg cilgavimab.
  - Initial dose >3 months prior: 300 mg tixagevimab and 300 mg cilgavimab.

- Repeat dose:

300 mg of tixagevimab and 300 mg of cilgavimab every 6 months. Repeat dosing should be timed from the date of the most recent EVUSHELD dose, and based on the assessed epidemiological situation of Covid-19 and continued risk of exposure.

Warnings and Precautions:

- Hypersensitivity Including Anaphylaxis: observe for clinical signs and symptoms of anaphylactic reaction. In case of occurrence provide supportive medical management.
- Clinically significant bleeding disorder: Evusheld must be administered with caution in presence of thrombocytopenia or coagulation disorders.
- Cardiovascular Event: although no causal relationship established between Evusheld and cardiovascular events, precautions and close monitoring must be considered prior to administration. Discuss risk and benefits among individuals with cardiovascular risk factors or history. Individuals must seek medical attention if they develop signs and symptoms of cardiovascular event.

Contraindications:

Evusheld is contraindicated among individuals with history of anaphylactic reaction to the treatment or any of its components.

Post administration monitoring:

We emphasize importance of post administration observation for one hour, particularly for people with coagulation abnormality or cardiovascular risk factors. Follow-up shall continue through teleconsultation, once weekly for 1 month after administration.

Treatment

Sotrovimab used for treatment of **mild-to-moderate** coronavirus disease 2019 (COVID-19) in adults and paediatric patients (12 years of age and older weighing at least 40 kg) with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death. (see 6.3. for high risk conditions)

Sotrovimab is not authorized for patients who are hospitalized due to COVID-19 or require oxygen therapy due to COVID-19.

Dosage: It is a single dose of 500 mg to be given as soon as possible after positive results of direct SARS-CoV-2 viral testing and within 10 days of symptom onset.

Must be diluted and administered as a single intravenous infusion over 30 minutes.
No dosage adjustment is required on renal impairment, during pregnancy or while lactating.

7. Discharge Criteria:

COVID-19 patients can be discharged from the hospital when medically stable with no hospital care being needed for other reasons.

- No fever for more than 24 hours without the use of antipyretics and improved respiratory complaints
- Patient is maintaining oxygen saturation more than 94% on room air for at least 24 hours (or arrangements have been made for home Oxygen therapy requiring low flow Oxygen less than 4 L/min, including patient on long-term Oxygen therapy prior to COVID pneumonia)
- Improved or static inflammatory markers
- Improved or static chest imaging
- Individuals who are medically stable but didn't complete required isolation duration, can be discharged and advised to complete isolation at home with full adherence to infection control measures

8. Prevention and Control of COVID-19 spread in Long Term Care (LTC) and Home Care Services

8.1. Monitoring residents in LTC and home care patients

- Patients should be screened daily for any symptoms of Covid-19. Consider atypical symptoms in older age groups and symptomatic residents should be tested for COVID 19 immediately. Retesting need to be considered if initial test is negative and symptoms persist.
- The clinical status and vital signs of all patients should be monitored at least three times per 24-hour period, including daily temperature measurements and oximeter.
- It is important to comply with wearing mask while providing care for residents and homecare patients.

8.2. PCR testing for COVID 19 in LTC and home care services

- Symptomatic patients should be tested for COVID 19 immediately. Retesting need to be considered if initial test is negative and symptoms persist.
- Symptomatic health care workers should be restrained from caring the patients and should tested for COVID 19. Work restriction is required until symptoms resolve.

8.3. In case of an outbreak of COVID 19 in Long Term Care Facility

Outbreak in LTC refers to detection of more than one case of COVID-19 in long term care facility. Strong infection prevention and control measures must be monitored and applied.

Testing Residents:

- All residents should be tested for SARS-CoV-2 immediately.
- Continue repeat viral testing of all previously negative residents, generally every 3-5 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result.

Testing Healthcare Personnel (HCP):

- All staffs should be tested initially and continue repeat viral testing of all previously negative residents generally, every 3 to 5 days, until the testing identifies no new cases of SARS-CoV-2 infection among HCP for a period of at least 14 days since the most recent positive result.

Testing escorts

- Must be tested every 3-5 days for a period of at least 14 days since the most recent positive result.

Visitors

- universal masking should be applied for all visitors to minimize risk of infection. Facilities are recommended to request evidence of negative tests no older than 48 hours prior to entry.