COVID-19 Management in Long Term Care Facilities
Directive Under the Authority of the Chief Medical Officer of Health

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1.0 Introduction

The goal of COVID-19 Management in Long-term Care Facilities (LTCF) is to, as much as possible, prevent the introduction of the virus into facility and/or prevent transmission to residents and staff within the facility.

All health care workers must follow the Public Health Order issued by the Chief Medical Officer of Health (CMOH), dated March 24, 2020, and any direction arising from that Order and directives given under the authority of the Health Protection Act (HPA).

This document provides direction to health care workers (HCWs) for the prevention and control of novel coronavirus (COVID-19) in LTCFs. The foundational documents used in the development of this guidance include the 2019-2020 Guide to Influenza Like Illness and Influenza Outbreak Control for LTCFs and Coronavirus Disease 2019 Infection Prevention and Control Guidelines for Long Term Care Settings.

This directive is based on the latest available scientific evidence about this emerging disease and may change as new information becomes available. The Public Health Agency of Canada will be posting regular updates and related documents at https://www.phac-aspc.gc.ca/.

This directive applies to all profit or not-for-profit Department of Health and Wellness funded long-term care facilities (nursing home and residential care) licensed under the Homes for Special Care Act and all Adult Residential Centres and Regional Rehabilitation Centres funded and licensed by the Department of Community Services under the Homes for Special Care Act.

This directive uses the term **resident** to include clients residing in a Long Term Care Facility, and meeting the eligibility criteria as outlined in the Service Eligibility policy https://novascotia.ca/dhw/ccc/policies/policyManual/Service_Eligibility_Policy.pdf

This directive uses the term **staff** to include compensated employees of licensed and funded long term care facilities. Employees fulfill various functions within LTCFs, such as but not limited to: direct care, support services, and administration.

This directive uses the term **essential visitors** to include health care workers not employed by the service provider, such as but not limited to: Paramedics, occupational therapists, physiotherapists, primary care providers and oxygen therapists.

**Essential visitors** will also include support service vendors such as but not limited to: Canada Post, supply deliveries, IT, regulator authorities (Office of the Fire Marshall, Nova Scotia Environment, Licensing).
2.0 Preventing the introduction of COVID-19 into the LTCF

2.1 Screening, Monitoring and Active Surveillance

- **Active screening of all staff, essential visitors** and anyone else entering the facility:
  - Document active daily symptom screening (fever (temperature of 37.8°C or greater or signs of fever), cough (new or worsening), sore throat, runny nose, headache, any new or worsening respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat, difficulty swallowing, or loss of sense of smell or taste), any new onset of atypical symptoms including but not limited to chills, muscle aches, diarrhea, malaise, or headache).
  - Screening of all staff (including temperature checks) must occur at least once daily at the beginning of shift, and twice per shift if operationally feasible. If staff become symptomatic in the workplace, they should immediately perform hand hygiene, ensure that they do not remove their mask, inform their supervisor, avoid further resident contact and go home to isolate.
  - Staff with any symptoms should be tested for COVID-19 and excluded from work.
  - Red, purple or blueish lesions, on the feet, toes or fingers without clear cause is sometimes referred to as ‘COVID toes/fingers.’ COVID toes/fingers are believed to represent a less common, late symptom of COVID-19 that occurs as a blood vessel/immune system response to the virus. It is seen primarily in children/youth but has been seen in adults. Staff must be aware of and watch for the new development of this symptom.

- **Active screening of all residents**:
  - Document active screening (at least daily, and twice per day if operationally feasible, including temperature checks) for early identification of any resident with (fever (temperature of 37.8°C or greater or signs of fever), cough (new or worsening), sore throat, runny nose, headache, any new or worsening respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat, difficulty swallowing, or loss of sense of smell or taste), any new onset of atypical symptoms including but not limited to chills, muscle aches, diarrhea, malaise, or headache).
  - Any of these symptoms will prompt immediate testing for COVID-19 and outbreak management measures.
Red, purple or blueish lesions, on the feet, toes or fingers without clear cause is sometimes referred to as ‘COVID toes/fingers.’ COVID toes/fingers are believed to represent a less common, late symptom of COVID-19 that occurs as a blood vessel/immune system response to the virus. It is seen primarily in children/youth but has been seen in adults. Staff must be aware of and watch for the new development of this symptom. It may be challenging to screen for this symptom on a daily basis however, if found, contact local Public Health to determine what action should be taken.

A summary of daily resident monitoring must be sent to local Public Health. A template document is found here: https://novascotia.ca/dhw/populationhealth/covid-19-documents.asp

The goal of active screening is to have a very low threshold for detection of COVID-19 cases. Recognizing that in the LTC population, clear symptoms and signs do not always present in the same way.

Testing may be appropriate in these circumstances based on clinical knowledge and judgment of these residents.

2.2 New Admissions and Re-admissions

For information about admissions and transfers of residents during a COVID-19 outbreak, refer to Section 4.4

New admissions, re-admissions and those residents returning from essential medical appointments must be screened for symptoms and potential exposure to COVID-19.

- Prior to a resident returning from a healthcare facility, the LTCF must determine if the resident has been suspected, tested, or diagnosed for COVID-19 and if so, what measures may be required.
- All admissions must be tested for COVID-19. For testing information please refer to Section 3.3.
- All admissions must complete a period of 14 days isolation (contact/droplet precautions) within the LTC facility, unless otherwise determined by Public Health.
- For those residents returning from a medical appointment, staff must perform a risk assessment to determine exposure risks during transport and while at the appointment (clinic/hospital/office).
- For greater clarity, the Order by the Medical Officer of Health (March 24, 2020) does not prevent the:
  - discharge of a COVID-19 patient from a hospital to a long-term care or residential care facility.
  - transfer of a COVID-19 patient from community to a long-term care or residential care facility; or
o return of a COVID-19 patient who has left a long-term care or residential care facility for healthcare services back to that facility after receiving treatment at a hospital.

2.3 Managing Essential Visitors
As LTCFs are now closed to visitors, accommodation should only be considered for essential visitors who are visiting very ill or palliative residents (compassionate exception), or those who are performing essential support care services for the resident (i.e., similar to a personal support worker). If an essential visitor is traveling from out of province, they need to contact local Public Health to discuss if an exemption to the requirement to isolate/quarantine may be granted and instructions on how to isolate/quarantine for remainder of time in Nova Scotia.

- Essential visitors must be limited to one person at a time for a resident (compassionate exceptions to be considered on a case by case basis)
- Essential visitors must be screened on entry for illness including temperature checks
- Essential visitors must only visit the one resident and no other residents
- Staff must support the essential visitor in identifying and appropriately using personal protective equipment (PPE)

2.4 Managing Other Visitors
Visitation to long-term care facilities is permitted provided the following measures are in place:

- Visits occur outdoors only, in designated areas on the grounds of the facility.
- Visits monitored by staff who will accompany visitors directly to the identified visiting space and who will provide personal protective equipment if necessary.
- A maximum of two visitors may attend at one time.
- Visitors must be screened for COVID-19 upon entry to the facility, must be asymptomatic, must wear a non-medical mask, and must maintain physical distancing of 2 metres. Once at the designated visiting area, the non-medical mask may be removed at the discretion of the LTC facility if physical distancing can be maintained and if the mask presents a barrier to effective communication between resident and visitor.
- Visitor information must be logged, including date and time of attendance at the facility.

Visitors are not permitted to enter the facility or grounds if they are under a requirement to self-isolate (due to travel, awaiting for results of COVID-19 testing, due to contact with a COVID-19 case, are currently ill with COVID-19, or for other reasons).
2.5 Physical Distancing
As per the Order by the Medical Officer of Health (March 24, 2020):

- All efforts to maintain physical distancing must be made. Examples of physical distancing include, but are not limited to, staggering mealtimes, maintaining physical distance of two metres or six feet, limiting group activities to less than 5 people total inclusive of staff supporting activity.
- Staff while working within the facility providing resident care are exempt from physical distancing requirements.

2.6 Environmental Management

- Enhanced environmental cleaning and disinfection regimens are required. This includes frequent (twice daily) cleaning and disinfection of high-touch surfaces.
- Hospital-grade disinfectants with a drug identification number (DIN) must be used in accordance to the manufacturers’ instructions.
- Laundry and waste disposal protocols are as per facility routine practices.

2.7 Resident Care Equipment
Any equipment that is shared between residents must be cleaned and disinfected, as per facility routine practices, before use on or by another resident.

3.0 Identification of COVID-19

3.1 Suspect Covid-19 Outbreak
In the context of the pandemic, a single case in a resident or staff with any the following symptoms: fever (temperature of 37.8°C or greater or signs of fever), cough (new or worsening), sore throat, runny nose, headache, any new or worsening respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat, difficulty swallowing or loss of sense of smell or taste), any new onset of atypical symptoms including but not limited to chills, muscle aches, diarrhea, malaise, or headache)] in a LTCF, meets the definition for a 'suspect outbreak' and must prompt outbreak control measures associated with a suspect respiratory infection outbreak.
3.2 Notification

- The following agencies must be notified immediately when the first staff or resident exhibiting symptoms of COVID-19 is identified in a facility:
  - Public Health: **8:30 am – 4:30 pm 7 days/week** – notify local Public Health as per regular reporting process. **After hours until 10 pm**, please notify the MOH on call (through Central Zone Location – 902-473-2222). **After 10 pm**, please notify local Public Health the next day. **NOTE:** this does not apply when a COVID-19 outbreak has already been declared. Only the first staff or resident needs to be reported to Public Health immediately.
  - Placement Office in their area
  - Investigation and Compliance (Licensing) office, Continuing Care, DHW by email to the following address: DHWICO@novascotia.ca
  - Medical Director of facility

- Once an outbreak has been declared in the facility, add additional staff/residents presenting with symptoms to the Line List (section 4.2). **Do not notify Public Health immediately for additional cases.**

- During contact tracing discussions with Public Health, staff must report all facilities they have worked in during the 14 days preceding symptom onset.

- During contact tracing discussions Public Health must be notified of resident transfers during the 14 days preceding symptom onset.

3.3 Testing (also see Appendix A)

- Collect samples from up to 3 different symptomatic residents as soon as influenza-like-illness (ILI) or COVID-19 is suspected. Refer to Appendix A for detailed instructions for how to collect samples.

- Notify local PH to obtain an outbreak number to be included on lab requisitions and specimens. If for any reason it is not possible to obtain an outbreak number, please clearly indicate “Suspect COVID Outbreak” on the lab requisition.

- In the context of the COVID-19 pandemic, all cases with symptoms compatible with COVID-19 (refer to Section 2.1) in staff or residents of a LTC facility must continue to be swabbed and tested for COVID-19 even if another pathogen is identified, to detect any new entry of COVID-19 into the facility. Public Health does not need to be notified regarding swabbing of additional residents.

- While swabbing must continue for all symptomatic residents to test specifically for COVID-19, any swabs beyond the first 3 cases will not be tested for Influenza A/B and RSV.

- Upon one positive COVID-19 result, determination of additional testing will be in consultation with local Public Health. To facilitate prioritization at the lab, samples should be sent as a batch and clearly labelled with the name of the facility in addition to the patient identifiers.

Should the facility have challenges around obtaining testing materials or arranging testing of staff, support is available to assist in testing on site. Contact local Public Health.
4.0 Outbreak Control Measures

Use the measures outlined below as soon as a resident or staff exhibits any of the following symptoms: fever (signs of fever), cough (new or worsening), sore throat, runny nose, headache, any new or worsening respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat, difficulty swallowing or loss of sense of smell or taste), any new onset of atypical symptoms including but not limited to chills, muscle aches, diarrhea, malaise, or headache. Implement additional precautions upon symptom onset and continue using them until advised by Public Health. Do not wait for lab results to begin additional precautions.

4.1 Signage

- Signage must be posted at all entrances and exits throughout the facility to advise staff and essential visitors, that an outbreak has been declared in the unit/facility.
- Signage must include instruction for cleaning hands when entering and exiting the facility, reminders that ill visitors must not visit, and that visitor restrictions are in effect e.g. non-essential visits must be postponed

4.2 Line Listing

Public Health will support the development of a line list. Update the line list daily and send to Public Health. A template document (residents and staff) can be found here: https://novascotia.ca/dhw/populationhealth/covid-19-documents.asp. There should be regular communication between the facility and Public Health to monitor the progress of the outbreak.

4.3 Cohorting of Staff and Residents

Residents

For symptomatic residents, asymptomatic lab-confirmed cases and their close contacts, restrict contact as much as possible. Isolation measures for individual cases may be lifted at the direction of Public Health. Public Health determines this based on when a positive case is no longer considered infectious, or a contact has completed the mandatory self-isolation period.

Measures include:

- Placing residents in private rooms, or if that is not possible, placing symptomatic residents/lab-confirmed cases with other symptomatic residents/lab-confirmed cases. If this is not possible, maintain a two-meter distance between residents with symptomatic/lab-confirmed cases and others. Use of partitions, like curtains, must be used if available.
- Serving meals in the resident’s room, or floor/unit/ward.
- Further restricting participation in any group activities.
- Implementing droplet and contact precautions when providing direct care to the resident or when within 2 metres of the resident.
• Posting visible signage on the resident’s door or in the resident’s bed space that indicates the resident requires droplet and contact precautions. The sign should not disclose the resident’s confirmed or suspect diagnosis.
• Ensuring the resident wears a mask when a staff or an essential visitor is in the room.

For all residents:

• Minimize contact between residents on affected floors/units/wards with unaffected areas.
• Remind patients/residents to wash hands thoroughly and immediately report any symptoms.
• Cancel or reschedule appointments that do not risk the health or well-being of the resident until the outbreak is declared over.
• Reinforce hand hygiene and respiratory hygiene practices.

Staff

• Cohort staff as strictly as possible e.g. staff working with symptomatic residents must avoid working with residents who are well.
• Practice strict hand hygiene between residents at all times.
• Staff working within facilities experiencing a COVID-19 outbreak must not work at a non-outbreak facility.
• If dedicated staff for sick residents is not available, staff must first work with the well/asymptomatic and then move on to care for the ill/symptomatic and avoid movement between floors and units where possible.

For LTC facilities experiencing staffing issues as a result of a COVID-19 outbreak, the following approach is supported in consultation with Public Health.

  o Cohorting of staff/staffing assignments must be reviewed to maximize the utilization of existing staff. Ensure as much as possible that unexposed staff work with unexposed residents, and exposed staff work with exposed residents.
  o As a second measure, exposed staff may continue to work under ‘work quarantine/work isolation’ measures described below.
  o As a last resort, external staff may be deployed to work in the facility, with strict attention given to cohorting.
  o If external staff are required to manage and outbreak, the following approaches are to be taken:
    o Prior to returning to work in a facility that is not experiencing an outbreak, staff complete 14 days of self-isolation.
    o If this is not possible due to staffing pressures in the non-outbreak facility, exposed staff may return to work by following the work quarantine/isolation measures described below.
Work-quarantine (work-isolation) is implemented for staff who are asymptomatic but have had a high-risk exposure.

- Work-quarantine is implemented for staff who are deemed critical, by all parties, to continued operations, and it is therefore unfeasible to exclude the worker for the 14 days of quarantine following a high-risk exposure.

- All requirements must be met:
  - Staff is asymptomatic
  - Staff completes regular twice daily screening of temperature and symptoms
  - Staff must immediately leave the workplace if symptoms develop and self-identify to OHS or supervisor
  - Staff must wear a mask during their shift
  - Appropriate PPE must be worn when interacting with patients
  - Proper hand hygiene must be followed
  - Staff must not work in another facility
  - Self-isolation measures must be maintained outside of the workplace
4.4 During Outbreak: Admissions and Transfers

- There should be no new admissions, transfers or outside medical appointments during an outbreak; however, this may not always be feasible.

- The return of a hospitalized resident must be discussed with Public Health to consider the resident's past COVID exposure, testing history and disease status. This information will determine if and where within a facility the resident should be placed and the public health measures to be implemented.

- For those residents returning from a medical appointment, staff must perform a risk assessment to determine exposure risks during transport and while at the appointment (clinic/hospital/office).

- All admissions must be tested for COVID-19 (refer to Section 3.3) and complete a period of 14-day isolation/quarantine within the LTCF, unless otherwise determined by Public Health.

If transfer to the hospital or another facility is necessary, notify the hospital/other facility and Emergency Health Services (EHS) of the outbreak situation. If the resident requiring transfer is a known case or is symptomatic, EHS should be notified prior to pick-up that the resident will require droplet/ contact precautions

4.5 Discontinuation of Precautions for COVID-19 positive Residents and contacts

Precautions should remain in place for residents until there is no longer a risk of transmission of the illness. Precautions may be lifted a minimum of 10 days after the onset of the initial symptom, provided the resident is afebrile (off antipyretics) and has improved clinically. For asymptomatic residents, precautions may be lifted a minimum of 10 days following laboratory confirmation of COVID-19.

Note: Residents who have signs and symptoms of any respiratory illness must be managed with the appropriate additional precautions (droplet and contact).

During outbreak situations, removal of precautions on individual residents should be part of the ongoing management and discussion with public health.

4.6 Declaring the Outbreak Over

The outbreak will be declared over through direction from Public Health. Generally, an outbreak will be declared over when two maximum incubation periods (2x14 days) have passed after the last day anyone could have been exposed to an infectious person in the facility. For a staff case this would mean 28 days after break in contact with the facility (last shift worked). For a resident this would be 28 days after the last resident case has been deemed recovered (and therefore no longer infectious, typically 10 days after symptom onset).
Appendix A

Important Laboratory Information

Diagnosis of respiratory viruses depends on the collection of high-quality specimens, their rapid transport to the lab and appropriate storage. See sections below for specific laboratory requirements.

Viral Collection Kits

- Viral collection kits are available at local/regional hospital labs. The preferred swab is nasopharyngeal, however, given limited supplies we have validated an alternative Aptima multi test swab for nares and throat specimen. This swab should NOT be used for nasopharyngeal sampling (NPS).
- The viral collection kits contain two swabs. In addition to the regular swab that was used in the past, the kit contains a smaller caliber, more flexible swab with a flocked head that should make collecting a nasopharyngeal sample easier.
- Nasopharyngeal – Collection instructions may be found in Appendix B. Also see video: https://www.youtube.com/watch?v=TFwSefezIHU. During this procedure, adhere to droplet and contact precautions.
- Throat/nares – Use the Aptima Swab for this collection (see video: https://vimeo.com/397169241 and collection instructions found in Appendix C.) During this procedure, adhere to droplet and contact precautions.
- Ensure the swab has not expired, as specimens received in expired containers will not be processed.

Testing Information

- Nasopharyngeal or throat/nares swabs for COVID-19 testing should be obtained as soon as a respiratory outbreak is suspected in patients that satisfy the screening criteria or are contacts of confirmed cases of COVID-19. Residents who initially test negative but develop worsening symptoms should have swabs repeated.
- If residents present with new symptoms after the outbreak has ended, repeat testing is appropriate.
- Ensure the lab specimen and the requisition indicates the name of the facility involved and the outbreak number from Public Health. If an outbreak number is not available, clearly indicate “Suspect COVID outbreak” on the requisition.
- You must notify the local PH office whenever there is a possible outbreak; do NOT delay notifying PH while awaiting the results of swabs. Ensure your lab requisition indicates the “Name of Facility”, “Suspect COVID Outbreak” and “Public Health Outbreak Number” if provided by Public Health.
- COVID testing services are available at the QEII Health Sciences Centre (QEII).
- Outbreaks in LTC should be communicated with the laboratory and Public Health, and the swabs be shipped as soon as possible.
Specimen Collection and Handling

Appropriate specimen types common in LTCFs:

- Nasopharyngeal swab
  - The procedure for obtaining a nasopharyngeal swab is the same as for routine ILI swabs. **The exception is that during this procedure you must adhere to droplet and contact procedures.**
  - An instructional video is available at: [https://www.youtube.com/watch?v=TFwSefezIHU](https://www.youtube.com/watch?v=TFwSefezIHU).
  - Collection instructions found in **Appendix B**.

- Throat/nares swab
  - An instructional video is available at: [https://vimeo.com/397169241](https://vimeo.com/397169241).
  - Collection instructions found in **Appendix C**.

Labeling of Specimens:

- Ensure specimen label (and requisition) includes two unique identifiers. One identifier must be the resident’s legal name along with the date of birth and the other can be the provincial health card number/registered health card equivalent, medical record number, passport number or private insurance policy number.

- Ensure specimen container has not expired. Specimens in expired containers will not be processed by the lab.

Filling in the Requisition – Complete All Parts and Add the Following:

- Ensure specimen requisition (and label) also includes the same two unique identifiers.
- Ensure the collection date & time are indicated.

- Indicate that the test is for COVID-19 (tests for influenza will be at the discretion of Public Health).

- Indicate if the specimen is part of an outbreak. Write “Name of Facility”, “Suspect COVID Outbreak” and “Public Health Outbreak Number” if provided by PH.

- Ask results to be copied to the MOH and to the resident’s family physician and/or medical director.

Shipping Specimens:

- Specimens must be collected and transported to the QEII laboratory or the local/regional hospital laboratory as soon as possible and within 24 hours.

- Specimens must remain at 4°C and be shipped as soon as possible.

COVID Result Inquiry:

- Results for COVID testing should be available from 24 hours after receipt of the specimen in the QEII laboratory.

- All results should be available in SHARE portal.

- QEII laboratory testing site: Central Lab Reporting 902-473-2266.
Appendix B

INSTRUCTIONS FOR THE COLLECTION OF A NASOPHARYNGEAL SWAB FOR RESPIRATORY VIRUSES

<table>
<thead>
<tr>
<th>Container</th>
<th>Store Before Collection</th>
<th>Store After Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasopharyngeal Swab Collection kit</td>
<td>Room Temperature</td>
<td>*Refrigerate</td>
</tr>
</tbody>
</table>

**HOW TO COLLECT THE SAMPLE or view online** [http://www.youtube.com/watch?v=TFwSezTh4lU](http://www.youtube.com/watch?v=TFwSezTh4lU)

1. Use the swab supplied with the viral transport media.
2. Explain the procedure to the patient.
3. When collecting the specimens, wear eye protection, gloves, gown and a mask. Change gloves and wash your hands between each patient.
4. If the patient has a lot of mucus in the nose, this can interfere with the collection of cells. Either ask the patient to use a tissue to gently clean out visible nasal mucus or clean the nostril yourself with a cotton swab (e.g. Q-Tip).
5. How to estimate the distance to the nasopharynx: prior to insertion, measure the distance from the corner of the nose to the front of the ear and Insert the shaft _approximately 2/3 of this length_.
6. Seat the patient comfortably. Tilt the patient’s head back slightly to straighten the passage from the front of the nose to the nasopharynx to make insertion of the swab easier.
7. Insert the swab provided along the medial part of the septum, along the floor of the nose, until it reaches the posterior nares; gentle rotation of the swab may be helpful. (If resistance is encountered, try the other nostril; the patient may have a deviated septum.)
8. Allow the swab to sit in place for 5-10 seconds.
9. Rotate the swab several times to dislodge the columnar epithelial cells. **Note**: Insertion of the swab usually induces a cough.
10. Withdraw the swab and place it in the collection tube.
11. Refrigerate immediately.
12. Remove gloves.
13. Wash hands.
15. Transport to the laboratory.

**MAKE SURE THE SPECIMEN LABEL INCLUDES**
- Patient’s legal name and date of birth
- Patient’s Health Card Number or another unique identifier (as determined by healthcare provider)
- Date and time of collection

**MAKE SURE THE REQUISITION FORM INCLUDES**
- Patient’s legal name
- Patient’s Health Card Number or another unique identifier (as determined by healthcare provider)
- Date and time of collection
- Patient’s date of birth
- Physicians full name, address and physician registration number

**Note:** If the specimen and requisition are not labelled correctly, the specimen will not be processed.

**DELIVER THE SPECIMEN**

Delivery of sample(s) to the regional laboratory should occur within 4 hours from time of collection. *If transportation is delayed beyond 4 hours, the specimens should be refrigerated and transported to the laboratory using a cooler with ice packs. Transport logistics needs to be maximized to ensure that specimens are received by the QEL laboratory within 24 hours.*
During limited supply of Viral Transport Media for Nasopharyngeal collections, the following alternate instructions for the collection of Throat and Nares with the Aptima® Multitest Swab Specimen Collection Kit.

**INSTRUCTIONS FOR THE ALTERNATE COLLECTION OF A THROAT AND NARES SWABS FOR COVID-19**

<table>
<thead>
<tr>
<th>Container</th>
<th>Specimen Source</th>
<th>Store Before Collection</th>
<th>Store After Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aptima® Multitest Swab Specimen Collection Kit</td>
<td>Throat and Nares to be collected from the single swab. DO NOT USE this swab for Nasopharyngeal collection</td>
<td>Room Temperature</td>
<td>*Refrigerate</td>
</tr>
</tbody>
</table>

**HOW TO COLLECT THE SAMPLE (see video link)**

1. Explain the procedure to the patient.
2. When collecting the specimen, wear eye protection, gown, gloves, and a mask. Change gloves and wash your hands between each patient. Partially open the swab package and remove the swab. Do not touch the soft tip or lay the swab down. Have the patient tilt their head backwards, open their mouth, and stick out their tongue. Use a tongue depressor to hold the tongue in place. Do not hold the shaft below the score line.
3. Hold the swabs, placing the thumb and forefinger in the middle of the shaft covering the black score line. Do not hold the shaft below the score line.
4. Without touching the sides of the mouth or tongue, use the swab to swab the posterior oropharynx. Using the same swab, ask the patient to tilt his/her head back. Insert the swab approximately 1-2 cm into each nostril. Rotate the swab inside of the nostril for 3 seconds, covering all surfaces.
5. While holding the swab in your hand, unscrew the tube cap (foil top). Do not spill the tube contents. Immediately place the swab into the transport tube so the black score line with the top edge of the tube and carefully break the shaft. The swab will drop to the bottom of the vial. DO NOT FORCE THE SWAB THROUGH OR DO NOT PUNCTURE THE FOIL CAP.
6. Discard the top portion of the shaft. Tightly screw the cap onto the tube.
7. Refrigerate immediately.
8. Remove gloves and wash hands.
9. Attach completed requisition and transport to the laboratory.

**MAKE SURE THE SPECIMEN LABEL INCLUDES**
- Patient’s legal name and date of birth
- Patient’s Health Card Number or another unique identifier (as determined by healthcare provider)
- Date and time of collection

**MAKE SURE THE REQUISITION FORM INCLUDES**
- Patient’s legal name and date of birth
- Patient’s Health Card Number or another unique identifier (as determined by healthcare provider)
- Date and time of collection
- Physicians full name, address and physician registration number

**Note:** If the specimen and requisition are not labelled correctly, the specimen will not be processed.

**DELIVER THE SPECIMEN**

Delivery of sample(s) to the regional laboratory should occur within 4 hours from time of collection. *If transportation is delayed beyond 4 hours, the specimens should be refrigerated and transported to the laboratory using a cooler with ice packs. Transport logistics needs to be maximized to ensure that specimens are received by the QEII laboratory within 24 hours.*