What is the evidence for a 14 day isolation period upon move-in to a continuing care environment during the COVID-19 pandemic?

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Key Findings:

No evidence was found as rationale for the 14-day isolation period on resident transition to LTC. This requirement likely arose from evidence that active monitoring for 14 days is sufficient to identify symptom onset in 99% of COVID-19+ cases (1).

No alternatives were found in Canada to a 14-day isolation period on transition of a resident into LTC. A rapid review of viral shedding and the need for isolation recommends a minimum 10-day isolation period, with additional consideration for high risk groups (36). The Centers for Disease Control and Prevention (2) in the US is considering decreasing the standard 14-day quarantine period to 7-10 days in recognition that the general two-week quarantine rule is onerous for many people and most of the benefit of quarantine to public health could be gained with a more flexible and contextual approach. Implications for changes in Public Health Agency of Canada's (PHAC) policy on quarantine or duration of isolation for admission to LTC are not yet established.

The Canadian policies at the provincial government levels align with the PHAC's recommendation of 14 days of isolation (14). Most jurisdictions across Canada follow guidelines requiring a resident to have a negative test on admission, and 14 days of self-isolation with contact and droplet precautions (4, 17).

However, a few jurisdictions stratify the level of precaution or need for isolation by community transmission (3, 5). For example, the Province of Alberta's (5) Operational and Outbreak Standards for LTC recommends the following safety precaution: for residents with low or unknown risk of exposure, twice daily symptom checks for 14 days; for residents with medium risk, continuous use of a mask for 14 days while out of resident room; for residents with high risk, quarantine for 14 days.

Best practices on transition to LTC to support residents' well-being

Some Canadian policies state the importance of protecting resident well-being on transition to LTC but provide little guidance on how to ensure this is done. For residents who might find self-isolation challenging (e.g. those with cognitive challenges), Government of New Brunswick (18) recommends taking efforts to ensure adequate staffing level and support residents' individualized care plan.

Residents in LTC who have cognitive impairments will have difficulties understanding the need for isolation and absence of families and friends, and complying with isolation procedures (31). There is little guidance for long-term care facilities on how to support safe isolation of those living with cognitive impairments, while maintaining the human dignity and personhood of the individual. Strategies need to be developed to have an isolation care planning that is effective, safe, and compassionate (31).

Maintaining connections between residents and their families should be supported under safety, socio-emotional, and ethical grounds (39). Several provinces and international jurisdictions designate Essential Family Caregivers (EFCs), who are present not for social visits but to provide services and brought into the facilities under the same specific protocols as staff (39, 49, 50, 51).

Category:	Infection Prevention and Control
	Administration
Subject:	Facilities
	Self-Isolation
	Long Term Care
	Health Planning
	Elderly
Population:	Aged (80+)
Clinical Setting:	Long Term Care
Priority Level:	Level 5 completed within 2 weeks

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