August 6, 2021

Isabel Mackenzie
Seniors Advocate
Province of British Columbia
c/o Janice Chow, Director of Research
Janice.Chow@gov.bc.ca

Re: Information Request for Records of Decisions in Long-term care and Assisted Living Facilities

Dear Isobel Mackenzie,

We are responding collectively to your letter of July 15, 2021 requesting further information regarding the management of COVID-19 outbreaks in long-term care and assisted living in our respective health authority regions. Your request is for information about the broad range of decisions made to manage these outbreaks, including any direction or guidance including "*but not limited to: infection prevention and control precautions, policy/strategic direction, outbreak sites support and resourcing, contact tracing, testing, and information/data. The record of decision to include when the decision was made and, if appropriate, when it takes effect, who made the decision and under what authority*."

The date range of the outbreaks of interest spans a ten month period of time, from April 2020 until January 2021. Each outbreak had a duration of many weeks. Fraser Health, Vancouver Coastal Health and Interior Health all managed COVID-19 outbreaks using a multi-disciplinary team approach, following provincial guidelines. All health authorities reported outbreak data in a provincially consistent manner to the BC Centre for Disease Control, where data was collated. All health authorities also had operational multiple Emergency Operation Centres that maintained oversight over COVID-19 activities including outbreak response. All health authorities also had representation at multiple provincial Emergency Operation Centres and expert committees that contributed to outbreak response.

In each outbreak of interest, hundreds or thousands of decisions were made that led to outbreak control actions. It is not possible to provide a record of all these decisions given the lengthy period of time of each outbreak, the multiple team members and committees involved, and the nature of front-line outbreak response, with team members often on-site at outbreak facilities working directly with operational leaders and front-line staff. It is also not possible to identify a single person who made each decision as most decisions were made as group decisions by multi-disciplinary teams, whose membership changed over time or depending on the time of day. Decisions were also often communicated verbally, in-person or over the phone, and therefore not amenable to data capture.

We would also like to highlight that the *Public Health Act* itself, within Part 5 (emergency powers), acknowledges that certain formal decision making and order making processes required in "non emergency" contexts do not need to be followed where there is a regional "emergency" situation, as was the case with the COVID-19 pandemic during the time period under your review. We refer in particular to Section 54 – the "general emergency powers." This section authorizes any "health officer" to provide directions or orders verbally, service of the order and creation of a written record is not

required. The content of section 54 indicates that the legislature intended "health officers" and individuals supporting them to be able to act quickly once a regional "emergency" is declared, so as not to be hampered by onerous record keeping and related requirements which may reduce the ability for the quick decision making required to protect vulnerable populations.

In order to support your review of outbreak response in long term care and assisted living, we are therefore providing a number of materials that we believe are helpful and responsive to your request, and will permit an in-depth understanding of the outbreak response in each health authority:

- ***Infection Prevention and Control Requirements for COVID-19 in Long Term Care and Seniors' Assisted Living* – BC Ministry of Health**

  These provincial guidelines provided guidance and recommendations to Long Term Care (LTC) operators and health authorities for the prevention and control of COVID-19. As these guidelines were developed and updated over time based on new evidence and changing practices, we are providing copies of all versions over the period of time covering the 25 outbreaks of interest, allowing your office to understand the differences in response from April 2020 to January 2021.

- ***Infection prevention and control for COVID-19: Interim guidance for long-term care homes – Public Health Agency of Canada***

  These national guidelines were released early in the pandemic, and informed outbreak response and subsequent provincial guidance. (Initial release April 13 2020, with ongoing online updates: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevent-control-covid-19-long-term-care-homes.html)

- **Copies of Fraser Health, Interior Health and Vancouver Coastal Health "playbooks" for outbreak response**

  These documents list the guidance for decisions, actions and resources that were consistently implemented for each declared outbreak, including the *Vancouver Coastal Health COVID-19 Response Guidance for Long Term Care Facilities*, *Interior Health LTC, AL and Hospice Resource Toolkit, and* the *Fraser Health Outbreak Response Lead Checklist.* The Fraser Health document *COVID-19 Resources for Long Term Care Assisted Living and Independent Living Sites* can be found at https://www.fraserhealth.ca/employees/clinical-resources/coronavirus-information/ltc-al-il/resources#.YQsMHLoUo2w.

- **Regional Health Authority audit tools for COVID-19 prevention/control in long-term care**

  Fraser Health, Interior Health and Vancouver Coastal Health conducted audits of each long-term care facility geographically located in the region, with results informing remedial direction given to facilities and also decisions during outbreaks. Included is a copy of the audit tool used by each health authority.

- **Copy of letter sent by Vancouver Coastal Health Licensing to all Long Term Care facilities dated Nov 25 2020**

Indicating necessary actions for decreasing the risk of introduction and spread of COVID-19 in long term care facilities.

- **Copies of published peer-reviewed articles and internal reports on the long-term care outbreak response in Vancouver Coastal Health and Fraser Health, describing the approach and learnings from COVID-19 outbreak management:**

  Peer-reviewed publications
  - *Evaluation of a multisectoral intervention to mitigate the risk of SARS-CoV-2 transmission in long-term care facilities* – VCH, 2020
  - *Serological survey following SARS-COV-2 outbreaks at long-term care facilities in metro Vancouver, British Columbia: Implications for outbreak management and infection control policies* – VCH, 2020
  - *Lived experiences of frontline workers and leaders during COVID-19 outbreaks in long-term care: A qualitative study* – VCH, 2020

  Internal report
  - *Analysis of outbreak assessments and other risk factors for COVID-19 outbreaks in long-term care facilities* – FHA, 2021.

We hope that these materials are helpful to your review.

Finally, in response to your letter of July 23, 2021 requesting interviews with Medical Health Officers (MHOs); while we are not able to provide MHO interviews to answer questions about individual outbreaks, we can answer questions at the systemic level about the overall approach to COVID-19 outbreak management in BC health authorities. We would request that these questions be submitted to us in writing. Obtaining the questions from you in writing allows us to conduct the research and review required in order to ensure that a thorough and accurate response to each question can be prepared for you. We look forward to providing you with answers to your questions in writing.

Please don't hesitate to be in touch with any further questions.

Sincerely,

Dr. Elizabeth Brodkin
Vice President Population Health and Chief Medical Health Officer
Fraser Health

Dr. Patricia Daly
Vice President, Public Health and Chief Medical Health Officer
Vancouver Coastal Health

Dr. Sue Pollack
Chief Medical Health Officer (Interim)
Interior Health

Dr. Bonnie Henry
Provincial Health Officer

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ANALYSIS OF OUTBREAK ASSESSMENTS AND OTHER RISK FACTORS FOR COVID-19 OUTBREAKS IN LONG-TERM CARE FACILITIES

APRIL 21, 2021

Dr. Rohit Vijh | Public Health Resident, Population & Public Health
Carmen Ng | Senior Epidemiologist, Population & Public Health
Dr. Aamir Bharmal | Medical Director, Medical Health Officer
David Thompson | Advisor, Pandemic Planning

LTC EVALUATION

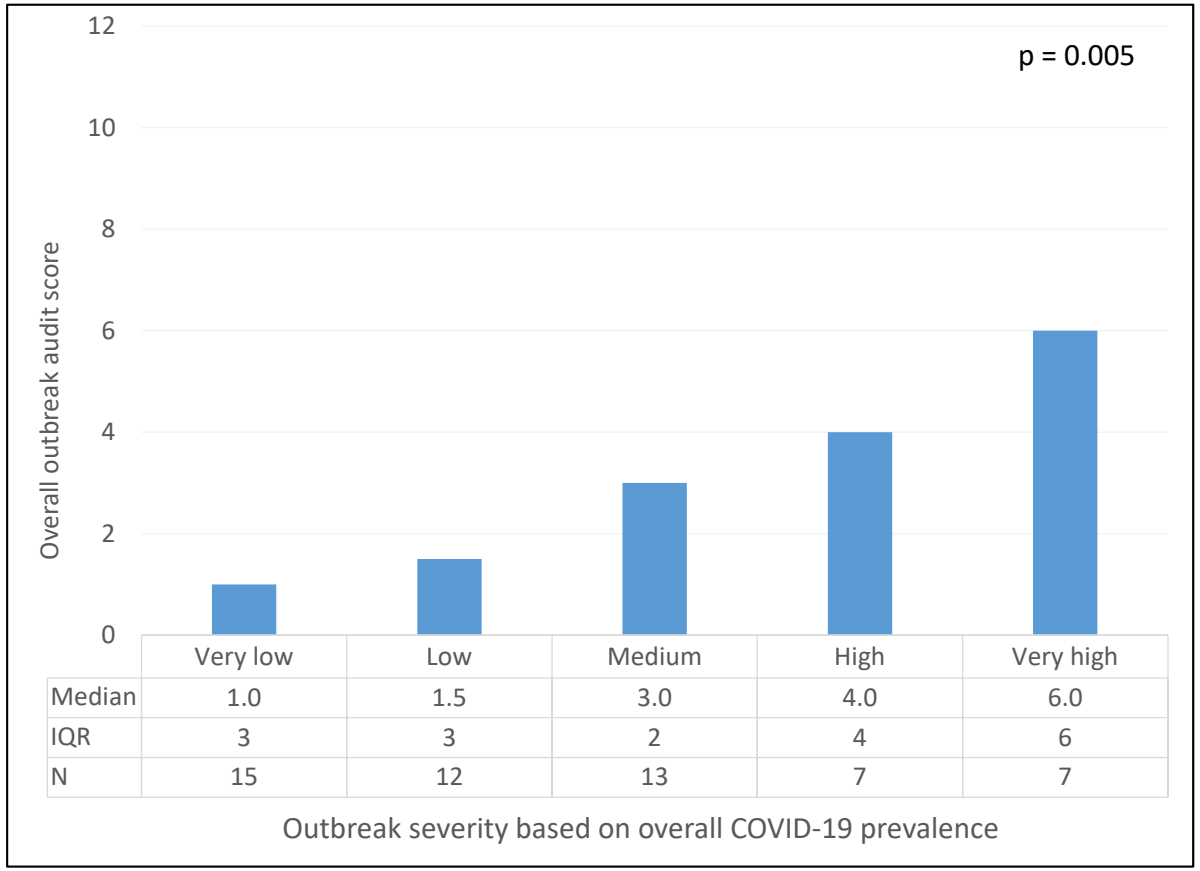
Evaluation included two components:

1. Assessment tool data from LTC outbreaks to determine the relationship between the assessment scores and outbreak severity
2. Resident and facility characteristics compared against outbreak severity

Analysis only included data prior to the revised assessment tool implemented on December 14, 2020.

ASSESSMENT TOOL EVALUATION RESULTS

- The more items in the assessment tool that are not met, the more severe the outbreak is likely to be



	Very low	Low	Medium	High	Very high
Median	1.0	1.5	3.0	4.0	6.0
IQR	3	3	2	4	6
N	15	12	13	7	7

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ASSESSMENT TOOL EVALUATION RESULTS

- Assessment tool has a strong association with outbreak severity. **The assessment tool is effective at identifying facilities which are at risk of having more severe outbreaks.**

- Assessment tool used regularly and during outbreaks identifies high risk IPC concerns to help prevent outbreaks and stop transmission during active outbreaks

PRIORITY AREAS FROM ASSESSMENT TOOL

- The following categories of items in assessment tool were associated with outbreak severity in the analysis

  - Dining area – e.g. physical distancing, scheduled cleaning, signage
  - Hallway areas – e.g. alcohol based hand rub availability, areas free of clutter
  - Housekeeping – e.g. enhanced cleaning, cleaning and IPC measures in staff rooms
  - Personal protective equipment (PPE) – e.g. availability, policies for PPE use, staff training

OTHER RISK FACTORS FOR OUTBREAK FACILITY

- LTC outbreaks with a **resident index case** had more severe outbreaks compared to outbreaks with a staff index case
- **Older facilities** were more likely to have severe outbreaks
- Resident characteristics (e.g. average LOS, % with dementia, % dependent in ADL) did not have an effect on outbreak severity in our dataset

ONGOING ASSESSMENT PROCESS

- New version of the Prevention Assessment launched December 14, 2020:
  - Incorporation of latest guidelines and best practices
  - Risk-based approach:
    - Moved from Y/N to Met, Partially Met and Fully Met
    - Added weighted scoring of elements based on risk level
  - Addition of new elements (staff break rooms, non-care areas, leadership visibility etc.)
- Routine reporting on themes from prevention assessments
- Targeted education based on identified site needs

KEY LEARNINGS AND ACTIVITIES FOR PROVIDERS GOING FORWARD

1. Prevention assessment is a reliable clinical tool in identifying risk and triggering actions to reduce transmission
2. Key Areas within the Prevention Assessment that are associated with higher transmission are the following:

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Key Areas	Elements and Risk Level	Actions for Providers
Dining	38 (M), 39 (L)	Shared dining within a unit or floor, scheduled cleaning, hand hygiene for staff and residents/tenants
Hallway	40-44 (M), 50 (M)	Ensure access to hand hygiene sink or alcohol-based hand rub, areas are free of clutter, clear separation and labelling of clean and dirty equipment/items
Housekeeping	45-46 (M), 47-48 (L), 49 (M)	Schedule enhanced cleaning, equipment and supplies for cleaning, staff break rooms require regular housekeeping and IPC measures
PPE	52-53 (H), 54 (M), 55-57 (H)	Regular monitoring & education of donning and doffing practices via audits, accessibility and availability of PPE, follow policies for PPE use

FRASER HEALTH NEXT STEPS

- Commitment to ongoing prevention assessments
- Review of risk scores in assessment tool
- Follow-up with LTC stakeholders to examine facility design

Infection Prevention and Control Requirements for COVID-19 in Long Term Care and Seniors' Assisted Living

June 30, 2020

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A. General

This document provides guidance and requirements to Long-Term Care (LTC) facilities and Seniors Assisted Living (AL) residences for preventing and controlling COVID-19.

This is based on the latest available scientific evidence about this emerging disease. Accordingly, best practices, requirements and guidance may change in the future as new information becomes available.

Use this document in conjunction with BC's Personal Protective Equipment (PPE) Framework.

Note: Seniors' Assisted Living residences are advised to apply the measures outlined in this document for their facilities to the greatest extent possible.

Key Sources of Provincial COVID-19 Guidance & Information

Provincial guidance and information specific to COVID-19 can be found at:

- British Columbia Centre for Disease Control (BCCDC) – COVID-19 Information for Health Professionals: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care
- BCCDC – COVID-19 Information for the Public: http://www.bccdc.ca/health-info/diseases-conditions/covid-9
- BCCDC – Guidance for Long-Term Care & Assisted Living Facilities: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/clinical-care/long-term-care-facilities-assisted- living
- Office of the Provincial Health Officer – COVID-19 Orders, Notices and Guidance: https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the- provincial-health-officer/current-health-topics/covid-19-novel-coronavirus
- Government of British Columbia – COVID-19 Provincial Support and Information: https://www2.gov.bc.ca/gov/content/safety/emergency-preparedness-response- recovery/covid-19-provincial-support

Facility operators must maintain awareness of data about the local and regional spread of COVID-19.

About COVID-19

Coronaviruses are a large family of viruses found mostly in animals. In humans, they can cause diseases ranging from the common cold to more severe diseases such as Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS). The disease caused by this new coronavirus has been named COVID-19. While many of the characteristics of COVID-19 are still unknown, mild to severe illness has been reported for confirmed cases.

Individuals over the age of 70 and especially when these individuals have underlying chronic medical conditions are most at risk of a serious or fatal illness after contracting COVID-19. These same individuals living in congregate LTC and AL settings are at greater risk still due to their daily care needs.

COVID-19 is most commonly transmitted through droplets produced when a person infected with COVID-19 coughs or sneezes. The virus in these droplets can be inhaled or enter through the eyes, nose, or mouth of another person if they are in close contact with the person who coughed or sneezed. The virus can also enter a person's body from touching something with the virus on it and then touching one's eyes, mouth or nose before performing hand hygiene. Preventing transmission of COVID-19 is essential to minimizing the risks for vulnerable individuals residing in care homes and assisted living residences.

Health care workers (HCWs) are responsible for taking reasonable care to protect their own health and safety and the health and safety of other people in their workplace. In the context of COVID-19, this means HCWs are responsible for their own personal self-care, which includes frequent hand washing and staying home when sick.[1]

An essential practice requirement for HCWs relates to providing care and services that promote and maintain the safety and well-being of clients and families in addition to attention to personal safety and job stressors.

In addition to adhering to the guidelines outlined in this document HCWs are required to draw on their foundational knowledge, skills and abilities as well as their entry to practice competencies[2] to:

- Adhere to health and safety standards
- Demonstrate effective infection prevention and control practices
- Implement preventative measures to mitigate harm

Operators are responsible to ensure adequate and ongoing engagement and training for HCWs on updated infection prevention and control requirements per the BCCDC guidelines for Long Term Care and Seniors Assisted Living facilities.

Note: Staff who have any questions or concerns regarding their possible exposure or symptoms are advised to call their local Public Health unit and/or their Workplace Health and Safety department for assessment and advice. Information regarding risk assessment of HCWs exposed to COVID-19 while at work as well as guidance to support decision-making on return to work for HCWs with symptoms of COVID-19 is available online: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/testing-and-case-management-for-healthcare-workers

Key Terms

- **Client:** Refers to a person in care in a Long-Term Care facility or an individual living in an Assisted Living residence.
- **Incubation Period:** Current evidence suggests that the incubation period for COVID-19 is up to 14 days. The incubation period is the time from when a person is first exposed until symptoms appear. A close contact is likely to develop COVID-19 illness during this time.
- **Infectious Period:** For people with mild to moderate cases of COVID-19, the end of their infectious period is 10 days after the first onset of symptoms. After this time, a COVID-19 patient is unlikely to be infectious. The infectious period may be longer for people with more severe illness who require hospitalization.
    - A residual dry cough may persist for several weeks. The individual is not considered to be infectious, as long as all other symptoms have resolved (e.g., temperature is back to normal without the use of fever-reducing medication; improvement in respiratory, gastrointestinal and systemic symptoms).
- **Period of Isolation**: The Period of Isolation is the length of time a person must avoid situations where they could come in contact with others in order to reduce the likelihood of passing COVID-19 on to others. In outbreak situations, where some symptomatic clients may not be tested, the period of isolation is at the discretion of the Medical Health Officer.
- **Health Care Worker (HCW):** The term "HCW" includes, but is not limited to, anyone working in LTC facilities and AL residences, such as registered nurses, licensed practical nurses, care aides, dieticians, allied health professionals, food service and environmental support staff.

Note: The policies contained herein also apply to volunteers.

[1] https://www.worksafebc.com/en/about-us/covid-19-updates/health-and-safety
[2] https://www.health.gov.bc.ca/library/publications/year/2014/HCA-Core-Competency-Profile_March2014.pdf

B. Personal Protective Equipment (PPE)

PPE Supply

During the COVID-19 pandemic, PPE supplies are in historically high demand. During the COVID-19 pandemic, PPE will be prioritized for HCWs who provide essential services and who are at greatest risk, as outlined in BC's Personal Protective Equipment (PPE) Framework (the PPE Framework). The PPE Framework highlights the clinical, ethical, and operational structures and principles that must be applied to effectively manage PPE in the context of a pandemic and critical supply shortages.

PPE supply and demand volumes are determined by the Provincial Health Services Authority (PHSA) Supply Chain and health authority operational leads across the province. If PPE resources become depleted, resource allocation decisions will be determined based on the stages outlined in the PPE Framework. At each stage, there are required actions that need to be taken to extend the provincial supply.

PPE supply and demand volumes are determined by the Provincial Health Services Authority (PHSA) Supply Chain and health authority operational leads across the province. If PPE resources become depleted, resource allocation decisions will be determined based on the stages outlined in the PPE Framework. At each stage, there are required actions that need to be taken to extend the provincial supply. During COVID-19, LTC and AL operators requiring PPE have direct access through established Health Authority supply contacts. Supply requests are assessed based on need and urgency and filled accordingly. Distribution mechanisms may vary across health authorities.

Surgical/procedural masks are effective at capturing droplets, the main transmission route of COVID-19. For this reason, surgical/procedural masks in conjunction with eye protection provide adequate protection for HCWs caring for clients with COVID-19.

During the COVID-19 pandemic, all persons working in a Long-Term Care facility or Seniors Assisted Living residence should wear a surgical/procedure mask for the full duration of their shift.

  - Surgical/procedure masks should be changed if the masks become wet, damaged or visibly soiled.
  - Surgical/procedure masks should be removed just prior to breaks or when leaving the facility. Staff should always follow droplet and contact precautions when entering COVID-19 units or rooms on droplet and contact precautions (i.e., rooms where clients diagnosed with confirmed or suspected COVID-19 have been admitted).
  - PPE for droplet and contact precautions includes gloves, gown, eye protection and a surgical or procedure mask.
- If an airborne precautions sign is posted, wear an N95 respirator.
  Use of a fit-tested N95 respirator is only required when performing aerosol-generating medical procedure (AGMPs) on a person with suspected or confirmed COVID-19.
  - In LTC and AL settings, AGMPs on clients suspected or confirmed to have COVID-19 should only be performed when medically necessary to reduce the need for N95 respirators.
  - If an AGMP is performed, ensure the fewest number of staff necessary to perform the procedure are present.
  - Nasopharyngeal (NP) and throat swabs can be performed using droplet and contact precautions with surgical/procedure masks and eye protection, and do not require the use of an N95 respirator.
- Always use PPE in combination with frequent hand washing using plain soap and water or an alcohol-based hand rub with a minimum of 70% of alcohol content.
- The employer must train, test and monitor staff compliance to ensure vigilant donning (putting on), wearing and doffing (removing) of PPE.
- Monitor and safely secure PPE stock to prevent theft and loss, while still ensuring staff can access PPE when needed.
- Wherever possible, PPE should be accessible and available at the point-of-care with each client.

Use of PPE During the COVID-19 Pandemic

- Extending the use of PPE conserves the overall PPE supply and supports the continued safe delivery of care in the context of critical global supply shortages during the COVID-19 pandemic.

- Extend the use of individual PPE items in accordance with the stages outlined in the Personal Protective Equipment (PPE) Framework.
- Extended PPE use can include:
    - Wearing the same surgical/procedure mask and eye protection for repeated, close contact encounters.
    - Wearing the same eye protection, gown and mask for repeated close encounters where there is a known diagnosis of COVID-19 for all the clients being cared for.
    - Cleaning and disinfecting eye/facial protection when visibly soiled, and at the end of each shift: http://www.bccdc.ca/Health-Professionals- Site/Documents/COVID19_EyeFacialProtectionDisinfection.pdf
    - Maximizing the number of services delivered during a single client interaction.
    - Minimizing the number of times staff enter/leave the client area during their shift.
    - Minimizing the number of different staff who care for clients with confirmed or suspected COVID- 19.
    - Designating staff to specific units or cohorts of clients, whenever feasible. These changes can be planned and implemented before COVID-19 is detected in a facility.
    - Performing aerosol generating medical procedures (AGMP) only when necessary to preserve N95 respirators.
- When using PPE always:
    - Change gloves in between clients, accompanied by hand hygiene between each glove change.
    - Doff old PPE and don a new set when moving from clients with COVID-19 to those not diagnosed with COVID-19.
    - Change surgical or procedure mask if the mask becomes wet, damaged, or soiled or when leaving the facility.
    - Practice hand hygiene after removing each individual piece of PPE, and before putting on new PPE.

Signage to Guide PPE Use

- Post signage for routine droplet and contact precautions outside the room/space of clients who are suspected of having or have been diagnosed with COVID-19: https://www.picnet.ca/resources/posters/precaution-signs/
- Post signage on how to extend the use of PPE during the COVID-19 pandemic throughout the facility: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/infection- control/personal-protective-equipment
- Post signs at appropriate locations with instructions on how to put on (don) and take off (doff) PPE: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/infection- control/personal-protective-equipment
- Post signs at appropriate locations on how to wear a surgical (or procedure) mask: http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_SurgicalMaskPoster.pdf
- Post instructions at appropriate locations on how to clean and disinfect eye and facial protection: http://www.bccdc.ca/Health-Professionals- Site/Documents/COVID19_EyeFacialProtectionDisinfection.pdf

C. Visitors

Health authorities and facility operators shall continue to support visitors for essential visits and allow family/social visits within established criteria, supported by a detailed plan and process as outlined below. The Ministry of Health acknowledges the need to support operators to ensure safe visitation with adequate staffing.

A written plan must be developed in accordance with the practice requirements. The plan must be available for Licensing or the Assisted Living Registry if requested. A visitor list, with contact information, will be maintained as per BC CDC IPC COVID-19 Guidance for LTC and Seniors AL.

Essential Visits

Essential visits include:

- Visits for compassionate care, including critical illness, palliative care, hospice care, end of life, and Medical Assistance in Dying;
- Visits paramount to the patient/client's physical care and mental well-being, including as follows:
    - Assistance with feeding;
    - Assistance with mobility;
    - Assistance with personal care;
    - Communication assistance for persons with hearing, visual, speech, cognitive, intellectual or memory impairments;
    - Assistance by designated representatives for persons with disabilities, including provision of emotional support;
- Visits for supported decision making; and
- Police, correctional officers and peace officers accompanying a patient/client for security reasons.

Essential visits shall be limited to one visitor per patient/client within the facility at a time (except in the case of palliative/end of life care). A visitor who is a child may be accompanied by one parent, guardian or family member.

Health Authority or Facility staff will determine if a visit is essential.

Family and visitors can request an immediate review of the decision and shall be provided the ability to speak with an administrator or administrator on call; or a formal review of a decision through the health authority Patient Care Quality Office (PCQO).

Family/Social Visits

As part of their ongoing efforts to keep residents safe, operators will complete an initial and then monthly review of their current practices to ensure for themselves, residents, and families that there is full compliance against the current practice requirements set out below. Any gaps identified should be addressed.

As part of implementing additional measures to allow family/social visits, operators will engage with residents, their families, and care providers on both the current status of IPC practice in the home and the proposed next steps that will now include processes for visitors. There will be ongoing engagement to ensure residents and families understand the individual and collective risks and their collective accountability and commitment to adhere to agreed guidelines to minimize those risks for both residents and visitors who may be older and/or have underlying health conditions. This engagement will strive to ensure an ongoing shared approach to establishing and then maintaining the challenging balance of safety and quality of life that will require the continued collaboration and mutual accountability of residents, families and their care givers through the coming 12 plus months.

Practice Requirements:

These practice requirements are intended to support residents, families, staff, administrators and managers, boards or owners of LTC homes and Seniors AL residences to provide the opportunity for social visits and to provide guidance about how they can collectively work together to minimize the risk of COIVD-19 transmission in these facilities.

These practice requirements may be updated as required with renewed direction from the Ministry of Health and Provincial Health Officer. This document replaces earlier infection prevention and control guidance that was set out in the following documents:

- Infection Prevention and Control Novel Coronavirus (COVID-19): Interim Guidance for Long-Term Care and Seniors Assisted Living (BC CDC IPC COVID-19 Guidance for LTC and Seniors AL, May 19,2020).

- Infection Prevention and Control Novel Coronavirus (COVID-19): policy communique providing updated guidance for essential visits (Ministry of Health May 12,2020)

Family/social visits are intended to support the emotional well-being of clients/residents and are limited to a **single** designated visitor per client and must be booked in advance according to the practice requirements below.

The shared approach to establishing and maintaining the balance of benefits and risks will be informed by the following core practices:

1. Social visits will only be allowed if there is no active COVID-19 outbreak at the care home/residence and will cease immediately if an outbreak is declared, and the facility goes into active outbreak management. Visits will resume immediately when the outbreak is declared over with lessons learned applied to ongoing practice.

2. Social visits will be scheduled in advance between the visitor and facility. The number of visitors within a visiting group should be limited to effectively support physical distancing practices while supporting meaningful social connection with the resident. As part of the engagement the facility will establish a family friendly process for scheduling and facilitating visits.

3. Care homes/residences will safely provide the location(s) for visits as soon as possible. Residents will meet their visitors in the designated location(s). The location(s) of social visits occurring at LTC home or seniors AL residence should be introduced as soon as possible but once the preparation at a site level is completed. The three key locations are as follows:
    a. Outdoor location(s) dedicated to visiting (seasonally when the weather permits)
    b. Indoor designated location(s) (summer and especially fall/winter)
    c. Individual single-client room (focused on limited mobility of an individual resident)

4. If individuals residing in multi-bed rooms are unable to attend in the settings outlined above, appropriate visitation requires careful consideration. Visitation in multi-bed rooms would be an exceptional circumstance based on, and taking into consideration, the needs and requirements of everyone in the shared room. This circumstance requires careful planning and facilitation with the care team, families and residents.

5. Visitors should receive advance guidance on the process and guidelines for social visits. Operators will identify details about the location(s) and processes for visiting on their websites, inform residents and families in writing/by email. For outside and designated facility visits, operators will ensure adequate signage and mark suitable locations as required to help families and residents to have a safe and successful visit.

6. All visitors shall be screened for signs and symptoms of illness, including COVID- 19, prior to every visit: http://www.bccdc.ca/health-info/diseases-conditions/covid-19/about-covid-19/symptoms Visitors with signs or symptoms of illness, as well as those in self-isolation or quarantine in accordance with public health directives, shall not be permitted to visit.

7. Visitors shall be instructed when to perform hand hygiene, respiratory etiquette and safe physical distancing. All visitors are required to bring and wear a mask. When visiting with a client on 'Droplet & Contact Precautions' all visitors shall be instructed on how to put on and remove any required PPE. If the visitor is unable to adhere to appropriate precautions, the visitor shall be excluded from visiting.

8. Care homes/residences must be able to safely provide oversight for these visits, including adequate staffing to provide pre-screening, screening on arrival, providing information on IPC for the visit, monitoring the visit, monitoring leaving of the residence. Visitors shall go directly to the patient/client they are visiting and exit the facility directly after their visit.

9. Any furniture and surfaces in the visit area will be sanitized as per BC CDC IPC COVID-19 Guidance for LTC and Seniors AL at the end of each visit. Time should be allowed for sanitizing visitor areas and supporting residents to move to and from the visiting area between visits.

Social Activities & Outside Appointments

LONG-TERM CARE FACILITIES:

- Residents are advised to limit their external activities and outside appointments to essential only (i.e., medically necessary).
- If clients must leave the facility for medically necessary care or treatment (e.g., hemodialysis treatment):
  - Call the medical facility and the transportation service (e.g., HandyDART, taxi or SNT hospital transfer service) ahead of the appointment to discuss necessary precautions.
  - Clients with confirmed or suspected COVID-19 who need urgent medical attention should wear a surgical or procedure mask when leaving their room or space. Droplet and contact precautions must be maintained during client transport. See Client Transfer of this document for further information.
  - Clients returning from an outpatient medical appointment (e.g., hemodialysis and cancer treatment) do not require 14-day isolation upon arrival at the facility. Staff must complete a PCRA to assess the risk posed by returning clients and determine appropriate control measures. See Point of Care Risk Assessment for more information.
  - When possible, clean mobility aids, such as wheelchairs, canes and walkers before exiting the client's room/space and upon returning from the appointment.

ASSISTED LIVING RESIDENCES

- Assisted Living clients can engage in social and external activities that are aligned with general public health guidance.
- Current information suggests that older people with chronic health conditions are at higher risk of developing more severe illness or complications and should take the measures to protect themselves including avoiding large gatherings and stay away from other people who are ill. They should maintain safe physical distance at all times and wear a non-medical mask when in enclosed spaces such as transit or stores where safe physical distances cannot be maintained.

Hairdressing and Other Personal Services

All service providers must follow the WorkSafeBC protocols for personal services returning to operation, including mask use for both service providers and clients, excellent hand hygiene and the cancellation of services if the service provider or client has symptoms. Additionally, all operators or facilities are asked to retain a list of every resident who has received services and when these services are provided.

Hairdressers and other personal services providers working onsite will develop and submit safety plans to the director of the facility, who will confirm the feasibility of the plan and work to determine the starting date. These plans will need to follow the guidelines within this document and should be posted in the service area prior to services being resumed.

D. Infection Prevention & Control Practices for COVID-19

In order to prevent or control transmission of COVID-19 in LTC and AL settings the following Infection & Control Practices (IPC) are required:

Screening

Passive Screening (Signage)

- Post signs at all facility entrance outlining the current visitor restrictions in place: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/clinical-care/long-term- care-facilities-assisted-living

- Post signs in multiple languages at all entrances reminding people not to enter if they are sick or if they are required to self-isolate in accordance with Public Health directives: http://www.bccdc.ca/Health-Info-Site/Documents/COVID19_DoNotEnterPoster.pdf
- Post signs in multiple languages reminding people within facilities with COVID-19 symptoms to wash their hands, put on a surgical or procedure mask and self-identify to reception or a health care provider: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/signage- posters

Facility Entry Points

- Limit the number of entry points into the facility.
- Develop and implement an appropriate script and process for active COVID-19 screening at building entry points (see Appendix A of this document).
- Actively screen at all building entry points seven days a week, 24 hours a day.
- Maintain a list of all staff and facility visitors, seven days a week, 24 hours a day.
- Ensure all visitors are actively screened as per the Practice Guidelines.
- During business hours, post a staff member at all entry points to actively screen every person who enters the building for symptoms of COVID-19. This includes actively screening all staff entering the building before the start of their shift.
- Outside of regular business hours, the administrator must develop and implement a comparable process to ensure that everyone entering the building is actively screened.
- Develop a script and implement a process for managing individuals who do not comply with screening.
- Increase protections for screeners by installing physical distancing supports, including spacing markers on the floor (2 metres apart) and transparent barriers that prevent droplet transmission without interfering with communication between the screeners and others.

Active Screening of Staff

- Staff must actively self-monitor for symptoms related to COVID-19, such as new or worsening cough, sneezing, runny nose, fever, sore throat, difficulty breathing, or episodes of vomiting and/or diarrhea.
    - Staff must take and record their temperature twice daily.
    - Staff must avoid the use of fever-reducing medications (e.g., acetaminophen, ibuprofen) as much as possible because these medications can mask early symptoms of COVID-19.
    - If a staff member feels that their personal health has worsened in any way, they should re-check and record their temperature, and inform their supervisor.
    - Please see the BCCDC's guidance for How to Self-Monitor for further information: http://www.bccdc.ca/Health-Info-Site/Documents/Self-monitoring.pdf
    - Please refer staff to their health care provider, 8-1-1, their local public health unit, or the COVID-19 BC Support App and Symptom Self-Assessment Tool if they have questions about their health status.
- Staff must not come to work if they are experiencing acute respiratory or gastrointestinal symptoms (e.g., new or worsening cough**, sneezing, runny nose, fever, sore throat, difficulty breathing, or episodes of vomiting and/or diarrhea). ** Cough that is not due to seasonal allergies or known pre-existing conditions.
- If symptoms develop, the staff member must self-isolate at home and must report their illness to those responsible for Workplace Health and Safety in their place of work.
- At the onset of each shift, supervisors must ensure adequate screening has taken place with each staff member.
- If a staff member develops symptoms related to COVID-19 while on duty, they must perform hand hygiene, continue to wear their surgical or procedure mask, inform their supervisor to arrange for replacement, safely transfer care as soon as possible and go directly home to self-isolate.
- Please see the BCCDC's guidance on return to work for HCWs for further information: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/testing-and-case-management-for-healthcare-workers

Screening of Visitors

- All visitors shall be screened for signs and symptoms of illness, including COVID- 19, prior to every visit: http://www.bccdc.ca/health-info/diseases-conditions/covid- 19/about-covid-19/symptoms. Visitors with signs or symptoms of illness, as well as those in self-isolation or quarantine in accordance with public health directives, shall not be permitted to visit.
- All visitors must sign-in when entering the facility (see Appendix B of this document).

Screening of Clients/Residents

- Conduct enhanced, active screening of clients for new-onset of respiratory or gastrointestinal symptoms.
- All clients should be monitored for new or worsening cough, sneezing, runny nose, fever, sore throat, difficulty breathing, or episodes of vomiting and/or diarrhea, at least once per day. See 'Presentation Definitions' below.

Presentation Definitions

Clients who meet the following presentation definitions are considered possible cases and should be tested for COVID-19 via a nasopharyngeal (NP) swab:

1. **Influenza-like illness (ILI):**

   New or worsening cough with fever (>38°C) or a temperature that is above normal for that individual and one or more of the following:

   - Sore throat,
   - Arthralgia (joint pain),
   - Myalgia (muscle pain),
   - Headache,
   - Prostration (physical or/and mental exhaustion).

2. **Respiratory infection:**

   Includes new/acute onset of any of the following symptoms*:

   - Cough** (or worsening cough),
   - Fever,
   - Shortness of breath,
   - Sore throat,
   - Rhinorrhea (runny nose).

3. **Fever of unknown cause:**
   - Fever (> 38°C) or a temperature that is above normal for that individual without other known cause. This does not include fevers with a known cause, such as urinary tract infection.

4. **Other atypical symptoms associated with COVID-19:**

   Includes, but not limited to:

   - Diarrhea,
   - Nausea/vomiting
   - Increased fatigue,
   - Acute functional decline,
   - Loss of smell and/or taste.

If a client is suspected of having COVID-19:

- Increase formal monitoring to at least twice daily (see Section C: Outbreak Protocol of this document).
- Implement Droplet and Contact Precautions (see Section 8: Respiratory Protection) and complete a Point of Care Risk Assessment (see Section 7: Point of Care Risk Assessment).
- Place the client in a single room, if possible (see Section 10: Placement and Accommodation).
- Post droplet and contact precautions signs on the door of the client's room: https://www.picnet.ca/resources/posters/precaution-signs/
- Notify client care leaders for the facility (e.g., Director of Care, Medical Director, Site Manager).
- Test the client for COVID-19 via a nasopharyngeal (NP) swab.
- Inform housekeeping of the need for enhanced cleaning in the client's room.
- Provide meals within the client's room while awaiting test results, if possible.
- Notify the client's primary care provider to determine if further assessment or treatment is required.
- Notify the client's family, substitute decision maker or next of kin about the potential need to set or modify orders from the primary care provider.
- Ensure the facility's Medical Director or Site Manager is aware of the pending test result.
- Ensure the facility's Medical Director or Site Manager is aware of the client's goals of care.
- Setup a PPE station outside of the client's door.
- Ensure all staff entering the client's room follow droplet and contact precautions, including using appropriate PPE and practicing rigorous hand hygiene.
- Maintain an increased level of surveillance of other clients who fit the Presentation Definitions (see above).
- Maintain an increased level of surveillance for any staff who fit the Presentation Definitions (see above).
- Maintain a Line List of all clients with symptoms (see Appendix E).
- Maintain a Line List of all staff with symptoms (Appendix F).

Hand Hygiene

- Post signs and posters around the facility to promote and guide proper hand washing by clients, staff and visitors: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19- care/signage-posters
- Alcohol-based hand rub with at least 70% alcohol content should be freely available to clients, staff and visitors at all facility entry and exit points, common areas, client units, and at point-of-care in the client's room.
- Ensure sinks are well-stocked with plain soap and paper towels for hand washing. Please note that antibacterial soap is not required for COVID-19.
- Ensure other supplies, including disinfecting wipes, tissues and waste bins are available as required at point-of-use.
- Teach all clients to perform hand hygiene where physically and cognitively feasible.
- If clients are unable to perform hand hygiene, help them clean their hands.
- Promote and reinforce the importance of diligent hand hygiene and proper hand hygiene technique with staff on an ongoing basis.
- Staff, clients and visitors must perform diligent hand hygiene at the following moments:
  - When hands are soiled,
  - Before and after touching others,
  - After using the toilet,
  - Before and after handling food and eating,
    - After personal body functions, such as oral care,
    - Before and after handling medications,
    - After sneezing or coughing,
    - When entering or leaving client rooms.
- In addition, all staff must clean their hands:
  - At the beginning of the work day,

- Before preparing or serving food,
- After removing each individual piece of PPE, and before putting on new PPE,
- Before and after contact with a client or their environment, even if gloves are worn,
- Before performing an aseptic procedure,
- Before moving from a contaminated to a clean body site during the care of the same client,
- Before assisting clients with feeding or medications,
- After contact with body fluids,
- Immediately after removing gloves.

Respiratory Hygiene

Respiratory hygiene is also known as 'respiratory etiquette' and 'coughing etiquette'.

- Post signs and posters around the facility to encourage and guide clients, staff and visitors on proper respiratory hygiene.
- Ensure an adequate supply of tissues and lidded, non-touch waste baskets are available for use by clients, staff and visitors.
- Teach clients how to perform respiratory hygiene (e.g., coughing into their elbow, using tissues, disposing tissues into a proper waste bin, performing hand hygiene immediately after) where physically and cognitively feasible.
- Promote and reinforce the importance of diligent respiratory etiquette with staff on an ongoing basis.

Source Control and Physical Distancing

Administrative and engineering controls help protect clients and staff from exposures to infectious agents, including COVID-19.

- Assess all areas of the building including the physical plan and the types of client care activities undertaken in each of the areas to determine what administrative and engineering controls are required for your facility.

Physical Distancing

- Enforce a minimum of two meters of safe physical distance between staff, clients and visitors, including in hallways and all communal areas.
- Post signs to promote and encourage safe physical distancing by staff, clients and visitors at all times: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/signage-posters
- Instruct staff, clients and visitors to avoid physical greetings (e.g., shaking hands, hugging) and non- essential touching of others.
- Re-organize shared facility spaces to maintain a safe physical distance of at least two metres between people.
- Reinforce the importance of physical distancing with staff, clients and visitors on an ongoing basis.

Engineering Controls

- Ensure the availability of single rooms with private toilets. If single rooms are not available, use physical partitions to establish at least two meters of physical distance between clients.
- Properly maintain building ventilation systems.
- Install physical barriers, such as clear partitions at reception desks and sneeze guards in food service areas.
- Hand hygiene sinks, liquid soap dispensers, paper town holders, hand sanitizer dispensers and no- touch waste bins with lids, plus related supplies and consumables, should be readily available throughout the facility.
    - Hand sanitizer dispensers should be available in hallways at the entry to each client room or suite, in communal areas, and at point of care for each client.

Administrative Controls

- Train staff on the proper selection and use of PPE.
- In accordance with an Order from the Provincial Health Officer, assign staff and restrict staff movement between facilities and residences, unless otherwise permitted by a Medical Health Officer.
- Prevent all individuals who are sick from entering the building.
- Train staff and clients on appropriate infection prevention and control measures. Monitor for compliance and take immediate corrective action when needed.
- Wherever possible, re-organize work processes within the facility to designate teams of staff to specific units or cohorts of clients. If dedicated teams or staff for ill client areas are not an option, staff must first work with well clients, before moving on to work with ill clients.

Staff Movement

The movement of staff between facilities and residences can promote the transmission of COVID-19 and increase the risk of infection for clients, staff and visitors.

By law, regional health boards, Medical Health Officers, operators, contractors, staff, educational institutions, students and volunteers must comply with all Orders from the Provincial Health Officer. As of this writing, the Provincial Health Officer has issued the following Orders relating to staff assignment and inter-facility/residence staff movement:

  - Movement of Long-Term Care Facility Staff (March 27, 2020): https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/covid-19-pho-order-movement-health-care- staff.pdf
  - Long-Term Care Facility Staff Assignment (April 15, 2020): https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the- provincial-health-officer/covid-19/covid-19-pho-order-long-term-care-facility-staff- assignment.pdf
- Please refer to the respective Orders from the Provincial Health Officer for all required actions and relevant details, including the Medical Health Officer's role in assessing local circumstances, making decisions about the assignment of staff, and exemptions.

Point of Care Risk Assessment (PCRA)

A Point of Care Risk Assessment is a risk assessment focusing on a series of fundamental questions that must be asked before every client interaction to determine whether an individual is at risk of being exposed to a potential hazard.

The 5 questions to be answered during a PCRA are:

1. Is the hazard present in the situation?
2. What is the health status of the client?
3. What type of task am I doing?
4. Where am I doing my task?
5. What action do I need to take?

The PCRA helps the care provider decide what actions are required to protect against exposure to, for example, respiratory infections. The PCRA is based on the care provider's informed judgment (i.e., knowledge, skills, reasoning and education) about care needs, the clinical situation, how a facility has been designed, the implementation of engineering and administrative controls, and the proper use of PPE. A PCRA will determine whether PPE is necessary. Overreliance on PPE can result in a false sense of security.

- Prior to every client interaction, staff must complete a PCRA to assess the risks posed by a client, situation or procedure to themselves, other care providers, other clients and visitors.

See Appendix C of this document for a Point-of-Care Risk Assessment Tool to assist with evaluation.

Cleaning and Disinfection

- Identify which staff are responsible for cleaning client care equipment and inform them about all required duties.
- Dedicate reusable equipment and supplies specifically to individual clients with suspected or confirmed COVID-19 infections.
- If dedicating equipment and supplies to an individual client is not possible, all reusable equipment that is shared between multiple clients must be cleaned and disinfected with a hospital grade disinfectant first.
- Items that cannot be easily cleaned and disinfected should not be shared among clients.
- Discard all single-use items into no-touch waste bins after use.
- Always follow the manufacturer's instructions for dilution, contact times, safe use and materials compatibility of all cleaning products.

a) Environmental Cleaning

Cleaning products and disinfectants that are regularly used in hospitals and health care settings are effective against COVID-19: http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID-19_MOH_BCCDC_EnvironmentalCleaning.pdf

- Clean and disinfect high-touch surfaces at least twice a day and when visibly soiled. High touch surfaces include, but are not limited to, doorknobs, countertops, handrails, phones, light switches, bathroom fixtures, sinks, toilets, bedside tables and outsides of paper towel dispensers.
- Disinfectants should be classed as a hospital grade disinfectant, registered in Canada with a Drug Identification Number (DIN) and labelled as effective for both enveloped and non-enveloped viruses.
- Clean visibly dirty surfaces before disinfecting, unless otherwise stated on the product instructions.
- Follow product instructions for dilution, wet contact time and safe use (e.g., use of PPE and proper ventilation).
- Floors and walls should be kept visibly clean and free of spills, dust and debris.
- For COVID cohort areas/units, change the mop solution after every client room. If using a microfiber mop system, follow standard procedures - changing mop solutions between client rooms is not required.
- For COVID cohort areas/units, dedicate cleaning implements and supplies to the area/unit. This includes the housekeeping cart, mop and mop bucket. If this is not possible, clean and disinfect all items and transfer them to another cart before leaving the COVID-19 area/unit.
- Remove items from all areas that cannot be easily cleaned and disinfected (e.g., plush cushions).
- Follow the facility's normal protocol for daily cleaning of client rooms/space and terminal cleaning of client rooms/space after discharge, transfer or discontinuation of Droplet and Contact precautions.
    - Wash bedside privacy curtains and clean the entire room/bed space area, including all touch surfaces (e.g., overhead table, grab bars, handrails, shelves, bedside chairs or benches, windows, overbed light fixtures, message or white boards, outsides of sharps containers).
    - Remove personal items following discharge, transfer or death of a client. Clean and disinfect items prior to returning to family members, storage or donation.
- Do not remove additional precaution signs until the client's personal hygiene and the environmental cleaning of their space have been completed.
- Practice diligent hand hygiene when entering and leaving each room/unit.
- Dedicate cleaning staff to specific units or areas whenever feasible. When this is not possible, cleaning staff should provide service to non-COVID rooms/units first and COVID-19 rooms/units last.
- The facility operator must monitor all environmental cleaning and disinfection practices for compliance.

- Please see the BCCDC's information sheet for environmental service providers for further information: http://www.bccdc.ca/Health-Info-Site/Documents/Environmental_Service_Providers_Health_Care.pdf

b) Laundry

- Soiled laundry from clients with COVID-19 should be handled using routine laundering practices.
- Do NOT shake dirty laundry.
- Place dirty laundry directly in a linen bag without sorting. Do not overfill bags. Do not compress bags or try to remove excess air.
- Contain wet laundry before placing it in a laundry bag (e.g., wrap in a dry sheet or towel).
- Consider placing a bag liner in the hamper that is either disposable (can be thrown away) or can be washed.
- Clean and disinfect hampers or carts used for transporting laundry regularly using hospital grade disinfectant that has a Drug Identification Number (DIN).
- Proper hand hygiene must be practiced when entering and leaving each room/unit.
- Wash items in accordance with the manufacturer's instructions. Use the warmest water settings allowed and dry items completely.
- Store clean laundry in designated areas.
- Maintain clear separation between clean and dirty laundry.

c) Waste Management

- Waste from clients with COVID-19 should be handled using routine procedures.
- Proper hand hygiene must be practiced when entering and leaving each room/unit.
- Waste that is normally considered biomedical should be disposed in the usual biomedical bag or container.
- If a bag is punctured or has waste spilled on the exterior, it should be placed into a second biohazard bag.
- Sharps should be placed in sharps containers, per usual practice.
- All bags should be securely closed for disposal. Do not compress bags or try to remove excess air.
- Waste should be transported using clearly defined transport routes within the health care facility.
- Removal of waste should be scheduled at designated times from designated locations when possible.
- Clean and disinfect carts used for transporting waste regularly using hospital grade disinfectant that has a Drug Identification Number (DIN).

d) Food Service, Delivery and Pick Up

- If there are suspected or confirmed cases of COVID-19 in the facility, serve clients individual meals in their rooms while ensuring adequate monitoring and supervision of those clients.
    - If in-room meal service is not possible, serve asymptomatic clients first, clean the dining area, then serve symptomatic clients.
- Food services staff should not enter dedicated COVID-19 cohort units or rooms with clients with suspected or confirmed COVID-19. Leave food trays outside the unit/room and notify client care staff.
- Use regular, reusable food trays, dishes and utensils for all clients. Disposable dishes are not required to stop COVID-19.
- Staff must clean their hands prior to delivering food trays.
- Staff must clean their hands after leaving client areas, units or floors when delivering and picking up food trays.

- Gloves are not required when delivering or picking up food trays. If gloves are worn, staff must change gloves prior to leaving COVID-19 units. Proper hand hygiene must be performed after removing gloves.
- Do NOT bring food carts into client rooms.
- Do NOT transport food on carts that have used dishes on them (i.e. carts used to deliver meals cannot be used to pick up used dishes at the same time).
- Regularly clean and disinfect carts used for transporting food between meal service and after picking up used dishes.
- Clean and disinfect cart handles before entering and after leaving each client area, unit or floor.
- Where communal dining is provided, maintain physical distancing between clients.
    - Implement a staggered dining schedule to support physical distancing and reduce the number of individuals in the dining area at any given time.
    - Remove self-service food items and shared food containers (e.g., water/coffee/cream/milk dispensers, salt and pepper shakers) from communal areas.
        - Dispense shared food items for clients, while maintaining a minimum of two metre distance as much as possible.
        - Provide single-use condiment packages (e.g., salt, pepper, sugar, ketchup and mustard) directly to clients from bulk food containers.
    - Pre-place utensils and cutlery for clients prior to seating.
    - Ensure alcohol-based hand rub with at least 70% alcohol content is available in shared dining rooms.
    - Remind clients to perform hand hygiene before handling or eating food.

e) Dishwashing

- Manage dishes/utensils in the same manner, regardless whether a client is on routine or additional precautions.
- Use commercial dishwashers with hot water and commercial grade detergents to clean dishware.
- Regularly clean and disinfect carts used for transporting food between meal service and after picking up dirty dishes.
- Clean hands before handling clean dishes or utensils.
- Maintain separation between dirty and clean dishes in the dishwashing area at all times.
- Clean and sanitize the entire dish room, including all dirty and clean dish buckets, at the end of the day.

Placement and Accommodation of COVID-19 Clients

- Immediately place any client identified as being exposed to COVID-19 or any client with new-onset respiratory or gastrointestinal symptoms (e.g., new or worsening cough, sneezing, runny nose, fever, sore throat, difficulty breathing, or episodes of vomiting and/or diarrhea) in a single room with a private toilet and sink.
    - If a single room is not available, maintain a physical separation of two meters between the bed space of the ill client and all roommates. Where available, close the privacy curtains.
- Implement contact and droplet precautions and use appropriate PPE when in direct contact with the client.
- Post signage outside the client's room/space indicating the required precautions: https://www.picnet.ca/resources/posters/precaution-signs/
- Set up a PPE station outside of the client's room.
- Post signs with instructions on how to put on and remove PPE inside and outside of the client's room.

- Restrict the client to their room or bed space, including during meals and any other clinical or social activities, unless absolutely necessary.
- Provide a designated commode chair for the client's use.
- Designate reusable equipment to the client with suspected or confirmed COVID-19, if possible.
- For long term care facilities with clients sharing rooms, move roommates of clients with symptoms related to COVID-19 to a new private room for isolation, then monitor the roommates for symptoms. If a new private room is not available, maintain a physical separation of two meters between all beds in the current room and close any privacy curtains.
- In the rare circumstances where a client with COVID-19 symptoms must leave their room, they should wear a surgical or procedure mask (if tolerated) or use tissues to cover their mouth and nose.
    - Assist clients in performing hand hygiene.
    - Encourage clients to use respiratory hygiene.
    - Clients should minimize touching surfaces or items outside of their room.
    - Immediately clean and disinfect any surfaces touched by the client while outside of their room.
- Identify and assign specific floors or units within the facility just for clients with confirmed COVID-19.
    - Long term care clients with suspected COVID-19 should only be cohorted with other clients with suspected COVID-19.
    - Designated COVID units should not be located close to vulnerable clients (e.g., clients with compromised immune systems or underlying health conditions).
    - Cohorting of clients who are confirmed to have COVID-19 should only be considered once other infectious etiologies (causes) have been ruled out.
- Dedicate teams of staff to care for clients with suspected or confirmed COVID-19, wherever possible.
- To minimise the risk of the transmission of infection in the building, consider re-organizing the work flow to limit the movement of staff between units/floors.
- Provide training for staff in how to care for COVID-19 clients.

Client Transfer

- Clients with confirmed or suspected COVID-19 infection should stay in their room unless there is essential need for movement and/or transport. Transfer within and between buildings should be avoided unless medically indicated.
- Moving clients who are on CPAP or BiPAP within a facility should be avoided.
- Clients with suspected or confirmed COVID-19 who require urgent medical attention and transfer to an acute care facility should wear a surgical or procedure mask, if tolerated.
- Call the receiving unit, physician and/or Medical Health Officer (or designate) to review and discuss the transfer.
- Notify the BC Ambulance dispatch and the receiving institution about the client's known or suspected COVID-19 status ahead of transport.
- Provide the client with clean clothing or a clean hospital gown for the transfer.
- Instruct and assist the client in performing hand hygiene.
- Remind the client to practice respiratory hygiene.
- Remind the client to avoid touching surfaces outside of their room/space.
- Clean wheelchairs and transport stretchers before exiting the client's room/space.
- Ensure clients and staff are at least two meters away from the transferring client.
    - Staff who are within two meters of the transferring client must follow routine practices, and droplet and contact precautions.
- Clean and disinfect all high touch surfaces, such as doorknobs, push buttons or handrails, touched by the client after leaving their room/space.

- Screen new or returning clients for symptoms related to COVID-19 before their transfer to the facility.
- When transfers must happen, transfer all outgoing and incoming clients directly to their room or space.
- Criteria for determining clients who need to undergo 14-day isolation upon arrival at the facility (e.g., new clients, clients returning from an inpatient admission or a community visit) should be at the discretion of the MHO.
- Clients undergoing 14-day isolation should be placed on droplet and contact precautions.
- Notify the transferring facility/residence and the local Medical Health Officer if a client develops COVID-19 symptoms within 14 days of transferring in from that facility/residence.

Laboratory Testing

- Review the latest BCCDC Public Health Laboratory COVID-19 Testing Guidance before testing: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/lab-testing
- Test clients experiencing influenza-like illness (ILI) or respiratory symptoms, clients with fever without known cause, and clients experiencing other symptoms possibly due to COVID-19 (see Section 1: Screening). COVID-19 cases in LTC populations are known to occur in clients with mild presentations.
- Ensure that the correct swabs and collections systems are ordered and being used.
- Obtain a nasopharyngeal (NP) swab (preferred) or an oropharyngeal (throat) swab from any symptomatic client to send for laboratory confirmation.
    - Note: Taking a swab for culture and susceptibility is not a restricted activity according to the Nurse's (Registered) and Nurse Practitioner Regulation. Accordingly, this activity does not require an order for a nurse to carry out this activity.[1]
- Use the Virology Requisition form.
    - Write "COVID-19 testing requested" OR add a special label to the requisition indicating the need for COVID-19 testing.
    - To prioritize testing, label the requisition as coming from a Long-term Care facility (i.e., label as "LTCF").

Please see Appendix D of this document for instructions on how to collect a Nasopharyngeal Swab (preferred specimen).

Notification & Reporting

- Notify the Infection Control Practitioner or designate at the facility/residence regarding all clients, care providers, staff, volunteers or visitors with symptoms related to COVID-19.
- The Infection Control Practitioner or designate at the facility/residence must notify Public Health of all clients, care providers, staff, volunteers or visitors confirmed to have COVID-19.
- The Director of Care or Site Manager should call the Communicable Disease Unit at their local Public Health unit. Please see Section C: Outbreak Protocol of this document.

Contact Tracing

- In conjunction with Public Health, start contact tracing of clients and staff potentially exposed to a person diagnosed with COVID-19 while in the facility.
- All client(s) who share a room with the ill client should be considered as exposed and should be monitored for symptoms at least twice a day for 14 days from last date of exposure.
- Report any new symptoms to the area Medical Health Officer or their designate. http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/public-health-management

- Follow BCCDC guidance regarding health care worker exposures to COVID-19 while at work: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/testing-and-case-management-for-healthcare-workers
- For staff exposed to COVID-19 outside of work, follow BCCDC guidance for the management of cases and contacts associated with novel coronavirus in the community: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%201%20-%20CDC/2019-nCoV-Interim_Guidelines.pdf

Discontinuation of Droplet/Contact Precautions

- HCWs, such as a physician or a nurse, should assess the clinical status of theclient for resolution of symptoms related to COVID-19 and follow the criteria below to determine discontinuation of contact and droplet precautions.
- If the client tested POSITIVE for COVID-19 AND their illness was mild AND they were NOT hospitalized or immunocompromised, the following conditions should be met for discontinuing contact and droplet precautions:
    a. At least 10 days have passed since onset of symptoms; AND
    b. Fever has resolved without use of fever-reducing medication; AND
    c. Symptoms (respiratory, gastrointestinal, and systemic) have improved.
- If the client tested POSITIVE for COVID-19 AND their illness was severe AND they were hospitalized or they have a compromised immune system (e.g., transplant, hematology-oncology), the following conditions should be met for discontinuing contact and droplet precautions:
    a. At least 10 days have passed since onset of symptoms; AND
    b. Fever has resolved without use of fever-reducing medication; AND
    c. Symptoms (respiratory, gastrointestinal, and systemic) have improved; AND
    d. Two negative laboratory test results for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart. Note: Exceptions can be made at the discretion of the MHO.
- Mild symptoms may include some or all of the following: Low-grade fever, cough, malaise, rhinorrhoea, fatigue, sore throat, gastrointestinal symptoms such as nausea, vomiting, and/or diarrhea.
- More severe symptoms may include any of the above, as well as fever, shortness of breath, difficulty breathing and/or chest pain.

Note: The residual dry cough after 10 days of symptom onset may persist for several weeks and is not considered to be infectious, as long as all other symptoms have resolved. This includes temperature being back to normal without the use of fever-reducing medication (e.g., acetaminophen or ibuprofen) and improvement in clinical symptoms, including respiratory, gastrointestinal and systemic symptoms.

Managing Deceased Persons

- Follow BCCDC guidance for the safe handling and care of deceased persons with suspected or confirmed COVID-19: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/deceased-persons

Psychosocial Supports

Support for Clients

The implementation of infection prevention and control measures, such as the use of PPE, restrictions on visitation, and curtailing of group activities during the COVID-19 pandemic, may adversely affect the mental health and

psychological well-being of clients. Prevention measures may lead to behavioural and non-compliance issues. Some clients may become more agitated, stressed and withdrawn during the outbreak or while in isolation, and may require mental health and psychological support.

- Provide clients with up-to-date information about COVID-19.
- Make every effort to connect with clients and understand their needs during this stressful time. Consider using one-on-one support programs for clients.
- Gently educate, inform, explain and encourage clients about the measures being put in place to maintain their health and the health of those around them.
- Where personal electronic devices (e.g., tablets, phones) are used to support virtual communication and social interactions during the pandemic:
- Ensure mobile devices are dedicated to a single client;
- Ensure mobile devices are cleaned after use. To avoid damaging electronics, follow the manufacturer's instructions regarding cleaning products and technique; and
- Ensure clients and staff wash their hands regularly when using mobile devices.
- Support the adoption and implementation of the World Health Organization's Mental Health and Psychosocial Considerations During the COVID-19 Outbreak for older adults: https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf

Support for Staff

It is important to support the psychosocial well-being and resilience of staff during the COVID-19 pandemic. Open communication is key to this objective.

- Provide staff with up-to-date information about COVID-19.
- Provide staff with information on how to protect themselves and others against COVID-19 transmission.
- Where possible, offer staff options for teleworking/working from home.
- Regularly communicate and check-in with staff who are working from home or self-isolating.
- Acknowledge staff feelings of grief, exhaustion, anger and fear.
- Remind staff about the importance of physical activity, healthy eating, sleep and good personal hygiene.
- Support the adoption and implementation of BCCDC guidance for Health Care Provider Support during the COVID-19 pandemic: http://www.bccdc.ca/health-professionals/clinical-resources/covid- 19-care/health-care-provider-support

An ethical analysis of the duty of HCWs to provide care in circumstances where there is a risk of harm to their own person is available online: http://www.bccdc.ca/health-professionals/clinical- resources/covid-19-care/ethics

Staff who have any questions or concerns regarding their possible exposure or symptoms are advised to call their local Public Health unit and/or their Workplace Health and Safety department for assessment and advice. Information regarding risk assessment of HCWs exposed to COVID-19 while at work as well as guidance to support decision-making on return to work for HCWs with symptoms of COVID-19 is available online: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/testing- and-case-management-for-healthcare-workers

Mental health support for health care providers is available online: https://careforcaregivers.ca/

E. Outbreak Protocol for COVID-19

Early detection of influenza-like-illness (ILI) or gastrointestinal symptoms and laboratory testing of symptomatic clients will facilitate the immediate implementation of effective control measures. In addition, the early detection and immediate implementation of control measures are two of the most important factors in limiting the size and length of an outbreak.

- Use COVID-19 outbreak surveillance forms (see Appendix E and Appendix F of this document for examples) to maintain ongoing surveillance for influenza-like illness (ILI) or gastrointestinal symptoms.
    - Monitor all clients for influenza-like illness or gastrointestinal symptoms, such as new or worsening cough, sneezing, runny nose, fever, sore throat, difficulty breathing, or episodes of vomiting and/or diarrhea.
    - Difficulty breathing is another common symptom of COVID-19.
- In the event of a suspected outbreak of influenza-like-illness, immediately report and discuss the suspected outbreak with the Medical Health Officer (or delegate) at your local health authority.
- Take viral specimens (nasopharyngeal or nasal swab) for lab testing as soon as possible. See Appendix D of this document for instructions on how to collect a Nasopharyngeal Swab (preferred specimen).
- Isolate all symptomatic individuals promptly (see Section 10: Placement and Accommodation of this document).

Outbreak Detection and Confirmation

Outbreak definition: One or more clients and/or staff of a Long Term Care facility/Senior's Assisted Living residence with a laboratory-confirmed COVID-19 diagnosis.

- The staff member(s) must have worked at the facility while symptomatic.
- In principle, an outbreak is considered over two full incubation periods after the last date of exposure, without any new cases. For COVID-19, two incubation periods equate to 28 days after the last date of exposure. The length of time to conclude an outbreak may be reduced or extended at the direction of the Medical Health Officer.

- Immediately report and discuss the suspected outbreak with a Medical Health Officer or designate (i.e., Public Health Nurse, Residential Care Licensing Officer) at your local health authority.
- Isolate all symptomatic clients in their rooms (see Section 10: Placement and Accommodation).
- Implement routine, droplet and contact precautions (see Section 8: Respiratory Protection) for the confirmed positive client(s).
- Post signage on the door of the client's room indicating that droplet and contact precautions must be followed.
- During an outbreak, test all clients in the facility/residence for COVID-19 as a screen.
- Review the latest BCCDC Public Health Laboratory's COVID-19 Guidance for specimen collection. The testing guidance specifies the number of samples to be collected from symptomatic clients to confirm an outbreak.
- Obtain viral specimens as soon as possible.
- Forward specimens to the BCCDC laboratory for testing (see Section 13: Laboratory Testing of this document).

- Start contact tracing of clients and staff members potentially exposed to another client or staff member who is diagnosed with COVID-19 (see Section 15: Contact Tracing of this document).
- Re-confirm that staff are not working at multiple Long Term Care facilities or Seniors Assisted Living residences.
- Notify all non-facility staff, professionals and service providers of the outbreak and assess their need to enter the facility.
- Communicate with families of clients about the outbreak and associated risks.
- Implement a daily outbreak management meeting to discuss operations and issues arising at the facility.

Outbreak Management Infection Control, Cleaning and Disinfection Procedures

- All outbreak control measures shall take priority over routine operations until the outbreak is declared over.
- **All restrictions shall remain in place until the outbreak is declared over by the Medical Health Officer.**

Facility/Residence

a. Post notification sign(s) at all facility entrances and on all entrances to floors/units/wards advising clients, staff and visitors about the outbreak: http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_OutbreakInFacility_poster.pdf
b. Maintain an outbreak **Line List** of cases in clients and a Line List of cases in staff (e.g., nursing, food handlers, housekeeping, others).
    i. Record details on the accompanying Influenza-Like-Illness Line List for Clients and/or the Influenza-Like-Illness Line List for Staff (see Appendix E and Appendix F).
    ii. Forward the Line List(s) to the Medical Health Officer or designate.
c. Notify housekeeping, food services and laundry that the facility has an outbreak of COVID-19 so that department-specific outbreak management protocols are initiated, including:
    a. Enhanced housekeeping and cleaning, including increased frequency of cleaning and disinfection, with a focus on high touch surfaces and items,
    b. Safe disposal of contaminated items and laundry within client rooms,
    c. Increased availability of alcohol-based hand-sanitizers (with a minimum of 70% alcohol content) in each client's room, and
    d. Cleaning and disinfection of equipment between use for different clients/areas. Refer to the Cleaning and Disinfection section of this document for more details.
d. Close the affected floor/unit/ward or facility/residence to new admissions, re-admissions, or transfers, unless medically necessary and/or approved by a Medical Health Officer.
    a. Notify the receiving hospital, facility or clinic to ensure that care can be provided safely (see the Client Transfer section of this document for more information).
e. If a client is transferred to an acute care facility for treatment of COVID-19 or its complications, that client may return back to their home facility/residence when they are medically stable.
f. Clients transferred to an acute care facility who do not have COVID-19 should not generally be re-admitted to the facility/residence until the outbreak is declared over. Exceptions can made at the discretion of the Medical Health Officer.
g. Notify other service providers such as volunteers, clergy, Handy DART, oxygen service, BC Ambulance, companions, students, and others of any outbreak control measures that may affect their provision of services.

h. Suspend non-essential services for the duration of the outbreak.
i. Notify any facility that has received/admitted a client from the facility on COVID-19 outbreak status within the past 14 days.
j. For facilities owned and operated by Health Authorities, notify and consult with Infection Prevention and Control.

Clients

d. For symptomatic clients, restrict contact as much as possible while maintaining essential care, until symptoms resolve. This includes:
    i. Placing symptomatic clients in private rooms or, if that is not possible, cohorting symptomatic clients with other symptomatic clients.
    ii. Serving meals in the client's room or floor/unit.
    iii. Restricting participation in any group activities.
    iv. If tolerated, clients wearing a surgical or procedure mask when a health care worker or essential visitor is in the room.
e. For all clients:
    i. Minimize contact between clients on affected floors/units/wards with clients from unaffected floors/units/wards.
    ii. Remind clients to practice hand hygiene and respiratory hygiene, and to report any symptoms.
    iii. In consultation with the Medical Health Officer or their designate, discontinue any remaining group activities, adult day programs, in-facility respite and outings. In general, all group activities within a facility/residence should be discontinued and non-essential outings should be cancelled. The Medical Health Officer can make exceptions on a case- by-case basis.

Staff

f. If symptoms develop, staff should isolate promptly, phone 8-1-1 or their health care provider and report their illness to those responsible for Occupational Health.
g. If staff develop respiratory symptoms while on duty, they should perform hand hygiene, continue wearing their surgical mask, inform their supervisor to arrange for replacement, safely transfer care as soon as possible and then go directly home to self-isolate.
h. Staff will remain off work until a decision to discontinue isolation is made, in consultation with Workplace Health and Safety and Public Health. To maintain adequate staffing levels, exceptions can made at the discretion of the MHO.
i. Follow the current guidance for testing HCWs for COVID-19, available at the BCCDC Lab Testing page.
j. Maintain a COVID-19 outbreak Line List for staff diagnosed with COVID-19 (see Appendix F of this document).
k. Cohort staff as much as possible. Staff working with symptomatic clients should avoid working with clients who are well.
l. If dedicated staff for sick clients are not available, staff should first work with the well and then move on to care for the ill, avoiding movement between floors and units wherever possible.
m. Staff must practice strict hand hygiene between clients at all times.
n. Comply with all Orders from the Provincial Health Officer regarding staff assignment and restricted inter-facility staff movement.

Visitors:

o. In the event of an outbreak, restrict visitors to facilities in accordance with advice and direction from the local Medical Health Officer.
p. If a visit is deemed essential, the visitor should wear a surgical or procedure mask during the visit and visit only their immediate family member or friend.
q. Symptomatic persons should not enter a facility.
r. Essential visitors must keep a two-meter distance from symptomatic clients during their visit.
s. Visitors to a client with COVID-19 symptoms should be offered the same personal protective equipment as that worn by health care providers, in accordance with the PPE Allocation Framework.
t. Restrict all visitation involving multiple clients. If visiting multiple clients is essential, visit asymptomatic clients first.
u. Provide education to essential visitors about the importance of diligent hand hygiene and respiratory hygiene during their visit.

Outbreak Termination

- Control measures will be continued until the outbreak is declared over by the Medical Health Officer.
- In principle, an outbreak is considered over two full incubation periods after the last date of exposure, without any new cases. For COVID-19, two incubation periods equate to 28 days after the last date of exposure. The length of time to conclude an outbreak may be reduced or extended at the direction of the Medical Health Officer.
- Once the outbreak is declared over:
  a. Order replacement viral specimen kits by emailing an updated Sample Container order form to kitorders@hssbc.ca or by faxing a request to BCCDC at 1-604-707-2606.
  b. Debrief with facility managers and staff to evaluate the management of the outbreak. Implement all corrective actions, as required.
  c. Remain alert for possible new cases in staff and clients.
  d. Report any suspect outbreaks to the Medical Health Officer or designate.

Appendix A – Entrance Screening Tool for COVID-19

This tool provides basic information and is not intended to take the place of medical advice, diagnosis or treatment.

Implementation Checklist:

- Are staff posted at entry points during business hours to actively screen every person who enters the building for symptoms related to COVID-19?
- Is a comparable process implemented to screen and log all persons entering the building outside of regular business hours?
- Have you limited entry points into the building?
- Is signage posted at building entry points to support the active screening process?
    - Post signs at all facility entrances indicating visitor restrictions in place: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/clinical-care/long-term-care-facilities-assisted-living
    - Signage reminding people not to enter if they are sick or if they are required to self-isolate in accordance with Public Health directives: http://www.bccdc.ca/Health-Info-Site/Documents/COVID19_DoNotEnterPoster.pdf
    - Signage reminding people with COVID-19 symptoms to wash their hands, put on a surgical or procedure mask and self-identify to reception or a health care provider: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/signage-posters
    - Signage on cough etiquette, hand hygiene, and physical distancing: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/signage-posters
    - Signage on how to put on a mask: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/signage-posters
- Is alcohol-based hand sanitizer (minimum 70% alcohol content) available at all building entry points?
- Are tissues, no-touch waste receptacles and disinfection wipes available at all building entry points?
- Are surgical/procedure masks available and accessible at all entry points?
- Are physical distancing supports in place at screening kiosks?
    - Spacing markers on the floor (2 metres apart).
    - Transparent barriers between screeners and others at kiosks.
- Is information for visitors about COVID-19 and the need for visitor restrictions available to be handed out?

Facility Entry Screening Script

Good morning/good afternoon.

To make sure we all stay safe and healthy, we are asking everyone entering the building some questions about their health.

Some of these questions may seem very personal, but they are all important and I need to ask them.

1. Are you experiencing any of the following symptoms?

Fever	■ Yes	☐ No
New or worsening cough**	■ Yes	☐ No
Stuffy or runny nose	■ Yes	☐ No
Sore throat or painful swallowing	■ Yes	☐ No
Difficulty breathing	■ Yes	☐ No
Diarrhea	■ Yes	☐ No
Nausea and/or vomiting	■ Yes	☐ No
Fatigue	■ Yes	☐ No
Muscle aches	■ Yes	☐ No
Loss of appetite	■ Yes	☐ No
Chills	■ Yes	☐ No
Headache	■ Yes	☐ No
Loss of sense of smell	■ Yes	☐ No

** Cough that is not due to seasonal allergies or known pre-existing conditions.

2. Have you traveled outside of Canada - including the United States within the last 14 days?
   ■ Yes ☐ No
3. Have you been in close contact with someone who has COVID-19 within the last 14 days?
   ■ Yes ☐ No
4. Have you been in close contact with someone who has COVID symptoms within the last 14 days? (Cough, sneezing, runny nose, fever, sore throat, difficulty breathing, or episodes of vomiting and/or diarrhea).
   ■ Yes ☐ No
5. Have you been told to self-isolate in accordance with Public Health directives?
   ■ Yes ☐ No

How to Respond:

If a person answers NO to all questions, they have passed the screening and CAN enter the building.

> *Thank you. You are cleared to enter. Please wash your hands and put on a surgical/procedure mask.*
>
> *Please wear the mask for the entire time you are in the building.*

If a person answers YES to any question or refuses to answer, they have not passed the screening and CANNOT enter the facility.

> *I'm sorry, but I'm not able to let you enter the building today. If you have questions or concerns, please contact your health care provider or HealthLinkBC at 8-1-1 for health advice.*

Appendix B – Visitor Sign-in Sheet

First & Last Name	Phone Number	Email	Date

Appendix C – Point of Care Risk Assessment Tool for COVID-19

Prior to each client interaction, staff must complete a Point of Care Risk Assessment (PCRA) to assess the risks posed by a client, situation or procedure to themselves, other care providers, other clients and visitors[2,3].

Conducting a PCRA involves asking following questions before every client interaction to determine the risk of being exposed to a potential hazard, such as COVID-19:

1. Is the hazard present in the situation?
    - Close contact (within two meters) with a client with symptoms of COVID-19?
    - Close contact with surfaces or items contaminated with body fluids?
    - Likelihood of splashes or sprays of blood or body fluids?
2. What is the health status of the client?

    Examples of situations in which there might be a greater risk of exposure include:

    - Clients requiring assistance with care needs and hand hygiene?
    - Clients having copious respiratory secretions?
    - Clients with frequent cough or sneeze?
    - Clients with poor compliance to respiratory hygiene, hand hygiene and physical distancing?
    - Clients who are immunocompromised (potential prolonged viral shedding)?
    - Clients undergoing aerosol-generating medical procedures?
3. What type of task am I doing? (from a specific interaction)
    - Direct care tasks requiring close contact involve a greater risk of exposure (e.g., wound care, feeding, assisting with bathing, dressing, giving medications, transporting clients)?
    - Indirect care tasks do not require close contact (e.g., housekeeping, delivering or removing trays or equipment from an empty room)?

      Note: Always try to maintain a safe distance of two meters for tasks that do not require close contact.
4. Where am I doing my task?

    Some examples of situations in which there might be a greater risk of exposure include:

    - Prolonged and frequent contact to an infected source?
    - Shared rooms or washrooms?
    - Sub-standard housekeeping?
    - Shared client care equipment without cleaning between episodes of client care?
    - Inadequate spatial separation between client and caregiver (at least two meters)?
    - Inadequate ventilation?

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[2] Vancouver Coastal Health (September 16, 2020). IPAC Best Practices Guideline: Point of Care Risk Assessment. http://ipac.vch.ca/Documents/Routine%20Practices/PCRA%20Best%20Practices%20Guideline.pdf

[3] Occupational Health and Safety Agency for Healthcare in British Columbia (March 2010). http://www.phsa.ca/Documents/Occupational-Health-Safety/GuideAssessingandControllingPersonalRiskSelfStudyG.pdf

- Non-compliance with cleaning and disinfections standards?
- Inadequate client placement or cohorting?

5. What action do I need to take?

Choose appropriate actions, control measures and/or PPE needed to minimize the risk of clients, care providers and other staff being exposed to COVID-19. Appropriate actions include consideration of:

- Hand hygiene (see Section 3)
- Respiratory hygiene (see Section 4)
- Source control and physical distancing (see Section 5)
- Environmental and equipment cleaning (see Section 9)
- Accommodation selection (see Section 10)
- Client ambulation or transfer (see Section 12)
- Use of PPE and additional precautions as required (see Section 8)

Appendix D – How to Collect a Nasopharyngeal Swab (Preferred Specimen)

- Review the latest BCCDC PHL COVID-19 Guidance for Testing (see the BCCDC Lab Testing Page). The testing guidance is subject to change and will be updated accordingly. The guidance also specifies the number of samples to be collected from symptomatic clients to confirm an outbreak.
- Ensure the nasopharyngeal swab (NP) is collected by qualified staff trained in the collection method.
- Limit staff in the room to those necessary for the procedure. Persons in the room during the procedure should, ideally, be limited to the client and the staff performing the procedure.
- Assemble supplies:
    - Recommended collection devices that are routinely used for NP swabs for Influenza or other respiratory virus testing.
    - Requisition and label.
    - Biohazard bag.
    - Tissues for client to clean nasal mucous before the procedure and to contain cough and sneezes after the procedure.
- Perform proper hand washing.
- Put on PPE (gown, gloves, surgical/procedural mask with eye protection - face shield or goggles) to protect yourself if the client coughs or sneezes while you are collecting the specimen.
- Explain the procedure to client.
- Provide client with tissues to contain cough and sneezes after the procedure.
- If the client has a lot of mucous in their nose, this can interfere with the collection of cells. Ask the client to use a tissue to gently clean out all visible nasal mucous before a swab is taken. Respiratory viruses are located in cells that line the surface of the nasal cavity and are shed into respiratory secretions.
- Stand to the side of the client, not directly in front of them.
- Seat the client in a high-fowler's (70^0) position in bed with the back of their head supported. It may be necessary to have a second person available to assist with collection.
- With a slow, steady motion along the floor of the nose (straight back, not up the nose) advance the swab until the posterior nasopharynx has been reached (distance from nostrils to external opening of ear). If nasal mucosa is swollen,

  rotating the swab during insertion may facilitate entry.

    - Place a finger on the tip of the client's nose and depress slightly once resistance is met (the swab should pass into the pharynx relatively easily). Rotate the swab twice and allow it to remain in place for a few seconds to absorb the sample, then withdraw the swab.
- Move away (at least 2 meters) from the client when the procedure is complete.

- Place in the tube of transport medium (check your local policy for sending specimens).
- Break the shaft of the swab at the constriction, and screw on the lid without cross-threading.
- Label the swab with 3 patient identifiers and indicate “NP Swab”.
- Remove PPE according to the steps of doffing (taking off) PPE. Ensure attention to hand hygiene.
- Complete the Virology Requisition form requisition indicating the tests requested and write “COVID-19 testing requested” OR add a special label to the requisition indicating the need for COVID-19 testing.
- To prioritize testing, label the requisition as coming from Long-Term Care facility (label as "LTCF").
- Ensure that the client identifiers and ordering physician or health care worker name are correct.
- Place the specimen container in a biohazard transport bag. Insert the requisition in the side pouch.
- Submit samples as you usually do through your local diagnostic Microbiology Laboratories.

Appendix E – COVID-19 Outbreak Line List – Clients

Patient Demographics					**Clinical Presentation**			**Specimen(s) Sent**	
Name	DOB y/m/d	Unit	Room #	Room type*	Date of symptom onset	Symptoms**	Date symptoms resolved	Collection date/date submitted	Result

***ROOM TYPE**: **P**=Private **S**=Semi-private **M**=Multi-bed

****SYMPTOMS**: **C**=Cough, **D**=diarrhea, **SB** = Shortness of Breath, **F**=Fever, **NA** = Nausea, **NC**= Nasal Congestion (runny nose), **O**=Other**, ST=**Sore Throat, **V**=vomiting

Appendix F – COVID-19 Outbreak Line List – Health Care Staff

Health Care Staff Information					**Clinical Presentation**		**Specimen**	
Name	DOB y/m/d	Occupation	Unit(s) worked	Date of symptom onset	Symptoms*	Date symptoms resolved	Collection date/date submitted	Result

***SYMPTOMS**: **C**=Cough, **D**=diarrhea, **SB** = Shortness of Breath, **F**=Fever, **NA** = Nausea, **NC**= Nasal Congestion (runny nose), **O**=Other**, ST=**Sore Throat, **V**=vomiting

Appendix G - Practice Requirements for Family/Social Visits:

To minimize the risk of Covid-19 transmission in long-term care facilities please ensure the following practice requirements have been met:

- There is **no active COVID-19 outbreak** at the care home/residence.
- Social visits are **scheduled in advance** between the visitor and facility.
- **Maximum of one** designated close family or friend per resident
- Residents will meet their visitors in the designated location(s). The three **key locations** are as follows:
  - Outdoor location(s) dedicated to visiting (seasonally when the weather permits)
  - Indoor designated location(s) (summer and especially fall/winter)
  - Individual single-client room (focused on limited mobility of an individual resident)
- **Clear signage** and suitable locations are marked as required to help families and residents to have a safe and successful visit.
- All visitors are **screened** for signs and symptoms of illness, including COVID- 19, prior to every visit.
- Visitors are **instructed when** to perform hand hygiene, respiratory etiquette and safe physical distancing.
- Visitors must bring and wear a mask.
- Visitors are **instructed on how** to put on and remove any required PPE when visiting or caring for patients/clients who are on Droplet and Contact precautions.
- Visitors **go directly to** the patient/client they are visiting and exit the facility directly after their visit.
- There are **adequate numbers of designated staff** to provide pre-screening, screening on arrival, providing information on IPC for the visit, monitoring the visit, monitoring leaving of the residence.
- All furniture and surfaces in the **visit area are sanitized** as per BC CDC IPC COVID-19 Guidance for LTC and Seniors AL at the end of each visit. Time should be allowed for sanitizing visitor areas and supporting residents to move to and from the visiting area between visits.

COVID-19 Infection Prevention and Control: Guidance for Long-Term Care and Seniors' Assisted Living Settings

May 5, 2021

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Key Terms

Resident: A person in care in a long-term care (LTC) facility or in a registered seniors' assisted living (AL) residence.

Resident cohort: Refers to a group of residents with the same diagnosis or suspected diagnosis. In the case of COVID-19, residents with a confirmed COVID-19 diagnosis, residents suspected to have COVID-19 (diagnosis not yet confirmed) and residents without symptoms suggestive of COVID-19 can each be a respective resident cohort. Decisions regarding cohorting should be made in consultation with facility/residence director/administrator, medical health officer or designate and client care leader.

Incubation period: The time from when a person is first exposed until symptoms appear. A close contact is likely to develop COVID-19 illness during this time. Current evidence suggests that the incubation period for COVID-19 is up to 14 days.

Infectious period: Also known as the 'period of communicability,' it is the duration of illness during which a COVID-19 patient is likely to be infectious: 10 days after onset of symptoms for patients with mild to moderate symptoms that can be managed at home, and 20 days for patients with severe illness (e.g., hospitalized due to COVID-19) or those who are severely immunocompromised, as defined in BCCDC's interim public health management guidance.

Period of isolation: The length of time a person must avoid situations where they could come into contact with others in order to reduce the likelihood of passing on COVID-19 to others. In health-care facilities such as LTC and seniors' AL, the period of isolation refers to the time that a resident is cared for using droplet and contact precautions. In outbreak situations, where some symptomatic residents may not be tested, the period of isolation is at the discretion of the medical health officer (MHO).

Health-care worker (HCW): The term HCW includes, but is not limited to, anyone working in LTC facilities and seniors' AL residences, such as registered nurses, licensed practical nurses, care aides, dietitians, allied health professionals, food service workers, activity workers and environmental support staff.

Introduction

This document is intended to provide guidance and recommendations to the operators of LTC facilities and seniors' AL residences[1] in B.C. for the prevention and control of COVID-19. This is based on current scientific evidence about this disease. This guidance may change in the future as new information becomes available. For COVID-19 variants of concern, recommendations for IPC measures remain the same and should be strictly followed and reinforced. See guidance on SARS-CoV-2 variants of concern for more information.

Note: Recognizing that seniors' AL residences may have a regulatory level of care and service that differs from LTC facilities, operators are advised to apply the measures outlined in this document to their facilities to the greatest extent possible.

A COVID-19 preparedness checklist (appendix A) has been developed to assist in implementing the guidance in this document.

Facility operators must maintain awareness of data about the local and regional spread of COVID-19. Individuals over the age of 70, especially those with underlying chronic medical conditions, are most at risk of a serious or fatal illness after contracting COVID-19. Preventing transmission of COVID-19 is essential to minimizing the risks for vulnerable LTC and seniors' AL residents.

Operators are responsible for ensuring adequate and ongoing engagement and training for HCWs on updated infection prevention and control (IPC) requirements as outlined in this document.

HCWs and other staff (including all contractors and volunteers) are responsible for taking reasonable steps to protect their own health and safety, and the health and safety of all other people in their workplace. In the context of COVID-19, this means HCWs and other staff are responsible for their own personal self-care, which includes frequent hand hygiene and staying home when sick.[2]

An essential practice requirement for HCWs is providing care and services that promote and maintain the safety and well-being of residents and families. In addition to adhering to the guidelines outlined in this document, HCWs are required to draw on their foundational knowledge, skills and abilities, as well as their entry to practice competencies[3] to:

- Adhere to health and safety standards;
- Demonstrate effective IPC practices; and
- Implement preventative measures to mitigate harm.

In any situation where the facility operator or facility staff are uncertain about the required IPC measures that need to be in place, please contact your local MHO or your health authority's designated infection control practitioner for guidance.

[1] This guidance does not apply to mental health and supportive recovery AL facilities and independent living facilities.
[2] https://www.worksafebc.com/en/about-us/covid-19-updates/health-and-safety
[3] https://www.health.gov.bc.ca/library/publications/year/2014/HCA-Core-Competency-Profile_March2014.pdf

COVID-19 Immunization

Overall, approved COVID-19 vaccines in Canada are effective against COVID-19. We are continuing to learn about the impact that vaccination has on SARS-CoV-2 transmission, and their effectiveness against certain variants of concern. As the evidence evolves, public health and IPC guidance for individuals who have received their COVID-19 vaccinations will be updated as needed.

Some of the side effects from COVID-19 vaccines are similar to symptoms of COVID-19. Individuals experiencing any symptoms of COVID-19 after receiving their vaccinations are to continue to use the BC COVID-19 Self-Assessment tool to determine if testing for COVID-19 is required.

Currently in health-care facilities, regardless of whether an individual (e.g., patient, HCW, visitor) has received a COVID-19 vaccine(s), they must continue to follow local processes for COVID-19 screening and managing COVID-19 like symptoms. When providing care to symptomatic patients, HCWs must continue to conduct point-of-care risk assessments (PCRAs) and implement additional precautions as needed to prevent the transmission of SARS-CoV-2.

For further information, please see the following resources:

- NACI recommendations on the use of COVID-19 vaccines
- BCCDC monitoring vaccine update, safety and effectiveness (March 30, 2021)
- BCCDC getting a vaccine

Infection Prevention and Exposure Control Measures

To prevent and control transmission of COVID-19 in LTC and seniors' AL settings, the following IPC measures are required:

1. Screening

Passive Screening (Signage)

Post signs at all facility entrances outlining the current visitor restrictions in place. Post signs in multiple languages at all entrances reminding people not to enter if they are sick or if they are required to self-isolate in accordance with public health directives.

Active Screening (Managing Facility Entry Points)

Prevent all individuals who are sick from entering the building. Establish a single entrance point for all people entering the facility to ensure all HCWs, staff, contractors, visitors and others are screened for symptoms of COVID-19. During business hours, post a staff member at the designated entry point to actively screen every person who enters the facility. Outside regular business hours, the administrator should develop and implement a comparable process to ensure that everyone entering the facility is actively screened.

Develop and implement an appropriate script and process for active COVID-19 screening at the entry point for symptoms and risk factors of COVID-19 (see *BCCDC COVID-19 entrance screening tool for health-care facilities*). Increase protections for screener(s) by installing physical distancing supports, including spacing markers on the floor (two metres apart) and transparent barriers that prevent droplet transmission without interfering with communication between the screener(s) and others.

Maintain a daily list of all staff and facility/residence visitors, including their contact information.

Screening of Staff

All staff must be actively screened by a screener with clinical expertise. Supervisors must ensure all staff have been screened for symptoms of COVID-19 prior to every shift. Screening must take place at/near the designated facility entrance so that staff do not have any interaction or close contact with residents and other workers until they have been screened.

The current list of COVID-19 symptoms is posted on the BCCDC website. See *BCCDC COVID-19 entrance screening tool for health-care facilities* for more information.

Staff must actively self-monitor for symptoms associated with COVID-19 and have their temperature taken before the start of their shift. Staff must have their temperature taken twice daily if there is an active COVID-19 outbreak at the facility.

To reduce the possibility of transmitting infection, oral thermometers must not be used for staff screening. When doing temperature checks, refer to the thermometer manufacturer's instructions for use and institutional policies. An additional resource for assessing body temperature can be found here. Staff must follow the safety measures described in the *COVID-19 health-care worker self-check and safety checklist*.

Staff must not come to work if they are experiencing symptoms consistent with COVID-19. If a staff member develops symptoms related to COVID-19 while on duty, they must perform hand hygiene, continue to wear their medical mask, inform their supervisor to arrange for a replacement, safely transfer care and/or assigned duties as soon as possible and go directly home to self-isolate.

Staff who have any questions or concerns regarding possible exposures or symptoms are advised to call their local public health unit and/or their workplace health and safety department for assessment and advice. Information regarding risk assessment of HCWs exposed to COVID-19 while at work as well as guidance to support decision-making on return to work for HCWs with symptoms of COVID-19 is available here.

Screening of Visitors

LTC and seniors' AL facilities:

All visitors must be screened for signs and symptoms of COVID- 19, prior to every visit.
To reduce the possibility of transmitting infection, oral thermometers must not be used for visitor screening.

Visitors with signs or symptoms of COVID-19, as well as those in self-isolation or quarantine in accordance with public health directives, shall not be permitted to visit. All visitors must sign-in when entering the facility (see appendix B of this document).

Screening of Residents

LTC facilities:

All residents must be actively screened for new respiratory and gastrointestinal symptoms. See *BCCDC COVID-19 entrance screening tool for health-care facilities* for more information.

All residents should be monitored for new or worsening cough, sneezing, runny nose, fever, sore throat, difficulty breathing or episodes of vomiting and/or diarrhea, at least once per day. Temperature checks for clinical use and resident care should be carried out per institutional policy.

Seniors' AL residences:

Encourage residents to self-monitor for COVID-19 symptoms and get tested in accordance with provincial testing guidelines

Implement a process to ensure all residents are asked at least daily about COVID-19 symptoms, including fever. The current list of COVID-19 symptoms is posted on the BCCDC website. Identify a point-of-contact for residents to notify (e.g., someone to phone) if they develop symptoms.

Lab Testing of Residents

Residents who meet the BCCDC's viral test presentation definitions are considered possible cases and should be tested for COVID-19 in accordance with the BCCDC COVID-19 testing guidance.

If a resident is suspected of having COVID-19:

LTC Facilities:

If COVID-19 is identified or suspected in a resident (e.g., resident reports fever or symptoms compatible with COVID-19), immediately isolate the resident in their suite and notify public health to make arrangements for testing. All residents suspected of having COVID-19 should be reassessed at a minimum of twice daily to detect additional signs or worsening symptoms.

Implement droplet and contact precautions (see personal protective equipment (PPE)) and continue doing a PCRA prior to any interaction with a resident (see PCRA section on the BCCDC website). Place the resident in a single bed room, if possible (see the placement and accommodation section in this document), and post droplet and contact precautions signs on the door of the resident's room. Notify the facility resident's care leaders (e.g., director of care, medical director, site manager) and test the resident for COVID-19 in accordance with provincial testing guidelines. Inform environmental services of the need for enhanced cleaning in the resident's room and provide meals within the resident's room while awaiting test results, if possible.

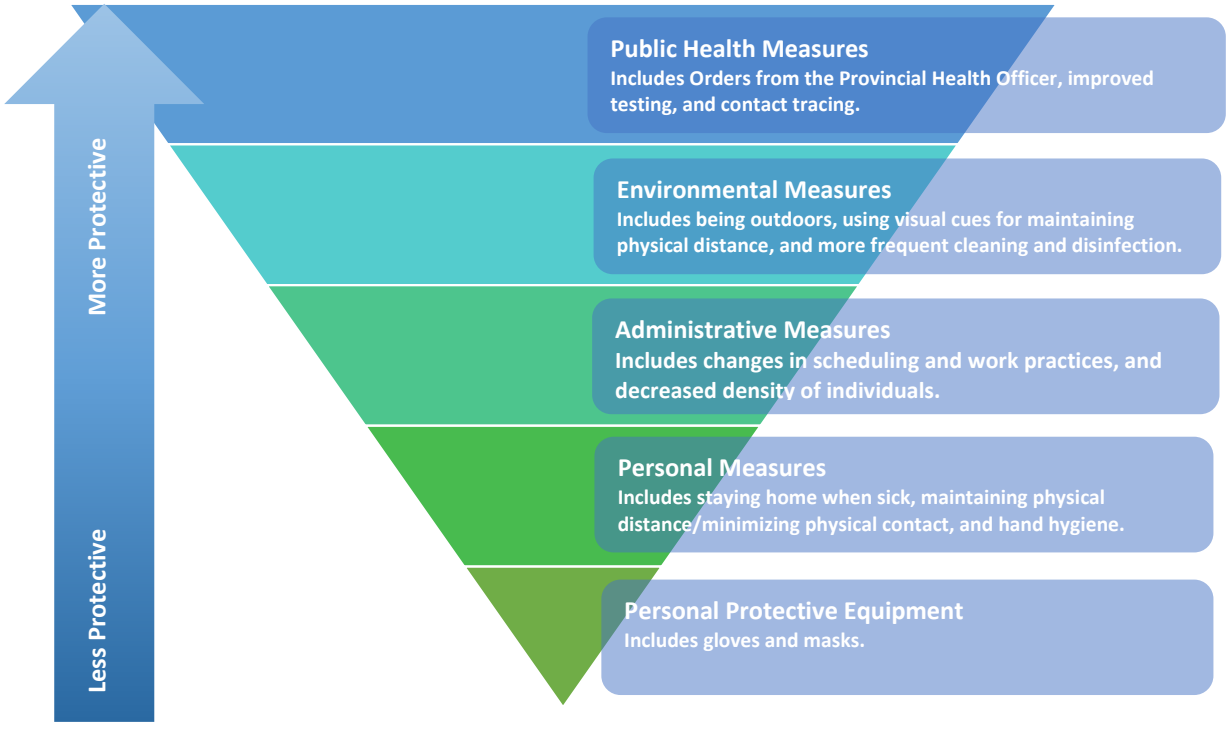
Notify the resident's primary care provider to determine if further assessment or treatment is required and the resident's family, substitute decision maker or next-of-kin about the potential need to set or modify orders from the primary care provider. Ensure the facility's medical director or site manager is aware of the pending test result and the resident's goals of care.

Set up a PPE station/cart outside the resident's room. Ensure all staff entering the resident's room follow routine practices and droplet and contact precautions, including using appropriate PPE and practicing rigorous hand hygiene. Maintain an increased level of surveillance of other residents and for any staff with symptoms consistent with COVID-19.

Seniors' AL Residence:
If a resident develops COVID-19 symptoms, they should remain isolated in their suite. Staff can follow up with residents via phone or through the facility intercom system. Where applicable, follow the above section's guidance for LTC facilities/residents suspected of having COVID-19.

2. Source Control and Physical Distancing

Hierarchy for Infection Prevention and Exposure Control Measures for Communicable Disease



Administrative and engineering controls help protect residents and staff from exposures to infectious agents, including COVID-19.

Assess all areas of the building, including the physical plan and the types of resident care activities undertaken in each of the areas, to determine what administrative and engineering controls are required for your facility to control the transmission of COVID-19. Wherever possible, re-organize work processes within the facility to designate teams of staff to specific units or cohorts of residents. If dedicated teams or staff for ill resident areas are not an option, staff must first work with non-ill residents, before moving on to work with ill residents. Train staff and residents on appropriate IPC measures. Monitor for compliance and take immediate corrective action when needed.

Properly maintain building ventilation systems.

Physical Distancing

Residents living in a single unit or on the same floor may participate in small group recreational activities. The number of residents participating in these group recreational activities should be limited to the smallest feasible group.

Physical touch between residents and their visitors is allowed with IPC measures in place. Maintain a minimum of two metres of safe physical distance between visitors, staff and all residents who are not visiting.

Post signs to promote and encourage safe physical distancing, where possible, and install physical barriers, such as clear partitions at reception desks and sneeze guards in food service areas. Ensure that these physical barriers are regularly cleaned and disinfected.

For LTC facilities, ensure the availability of single rooms with private toilets. If single rooms are not available, use physical partitions to establish at least two metres of physical distance between residents.

3. Point-of-Care Risk Assessment

Prior to every resident interaction, staff must complete a PCRA to assess any infectious risks posed by a resident, situation or procedure to themselves and others. The PCRA helps HCWs select the appropriate actions and PPE required to minimize their risk of exposure to known and unknown infections for a specific interaction, a specific task, with a specific resident and in a specific environment.

The PCRA is based on professional judgment (e.g., knowledge, skills, reasoning and education), as well as up-to-date information on how the specific health-care facility has designed and implemented appropriate physical (engineering) and administrative controls, and the use and availability of PPE. See BCCDC *COVID-19 patient screening tool for direct care interactions* and *routine PCRA tool* for guidance on conducting a PCRA.

4. Hand Hygiene

Hand hygiene sinks, liquid soap dispensers, paper towel holders, hand sanitizer dispensers and waste bins, plus related supplies, should be readily available throughout the facility. Hand sanitizer dispensers should be available in hallways at the entry to each resident room or suite, in communal areas and at the point-of-care for each resident.

Post signs around the facility/residence to promote and guide proper hand washing by residents, staff, and visitors. Alcohol-based hand rub (ABHR) with at least 70% alcohol content should be readily available to residents, staff and visitors at all facility entry and exit points, common areas, resident units and at the point-of-care in each resident's room. Ensure sinks are well-stocked with plain soap and paper towels for hand washing. Antibacterial soap is not required for COVID-19.

Ensure other supplies, including disinfecting wipes, tissues and waste bins are available as required at point-of-use. Teach all residents to perform hand hygiene where physically and cognitively feasible. If residents are unable to perform hand hygiene, help them clean their hands. Promote and reinforce the importance of diligent hand hygiene and proper hand hygiene technique with staff on an ongoing basis.

Staff, residents and visitors must perform diligent hand hygiene at the following moments:

- When hands are soiled
- Before and after touching others
- After using the toilet
- Before and after handling food and eating
- After personal body functions, such as oral care
- Before and after handling medications
- After sneezing or coughing
- When entering or leaving resident rooms

In addition, all staff must clean their hands:

- At the beginning of the workday
- Before preparing or serving food
- After removing each individual piece of PPE, and before putting on new PPE
- Before and after contact with a resident or their environment, even while wearing gloves,
- Before performing an aseptic procedure
- Before moving from a contaminated to a clean part of a resident's body during care
- Before assisting residents with feeding or medications
- After contact with body fluids
- Immediately after removing gloves

5. Respiratory Etiquette

Respiratory etiquette is also known as 'respiratory hygiene' and 'coughing etiquette.' Post signs around the facility/residence to encourage and guide residents, staff and visitors to follow proper respiratory etiquette. Ensure an adequate supply of tissues and waste baskets are available for use by residents, staff and visitors.

Teach residents how to perform respiratory etiquette (e.g., coughing into their elbow, using tissues, disposing tissues into a proper waste bin and performing hand hygiene immediately after), where physically and cognitively feasible. Promote and reinforce the importance of diligent respiratory etiquette with staff on an ongoing basis.

6. Cleaning and Disinfection

Equipment:
Identify which staff are responsible for cleaning resident care equipment and inform them about all required duties.

Dedicate reusable equipment and supplies specifically to individual residents with suspected or confirmed COVID-19 infections.

If dedicating equipment and supplies to an individual resident is not possible, all reusable equipment that is shared between multiple residents must be cleaned and disinfected with a hospital grade disinfectant after each use. Always follow the manufacturer's instructions for

dilution, contact times, safe use and materials compatibility of all cleaning products. Items that cannot be easily cleaned and disinfected should not be shared among residents.

Discard all single-use items into waste bins after use.

Environmental cleaning/laundry/waste management:
Please see the BCCDC's environmental cleaning and disinfectants for clinic settings and the information sheet for environmental service providers in health-are settings for guidance on environmental cleaning, laundry and waste management.

7. Food Service Delivery and Pick Up

Delivery and pick up:
If there are suspected or confirmed cases of COVID-19 in the facility, serve residents individual meals in their rooms while ensuring adequate monitoring and supervision of those residents. If in-room meal service is not possible, serve asymptomatic residents first, clean the dining area, then serve symptomatic residents.

Food services staff should not enter dedicated COVID-19 cohort units or rooms with residents with suspected or confirmed COVID-19. Leave food trays outside the unit/room and notify resident care staff. Use regular, reusable food trays, dishes and utensils for all residents. Disposable dishes are not required to stop COVID-19.

Staff must clean their hands prior to delivering food trays and after leaving resident areas, units or floors when delivering and picking up food trays. Gloves are not required when delivering or picking up food trays. If gloves are worn, staff must change gloves prior to leaving COVID-19 units. Proper hand hygiene must be performed after removing gloves.

Food carts:
DO NOT bring food carts into resident rooms. In addition, DO NOT transport food on carts that have used dishes on them (e.g., carts used to deliver meals cannot be used to pick up used dishes at the same time).

Regularly clean and disinfect carts used for transporting food between meal service and after picking up used dishes. Clean and disinfect cart handles before entering and after leaving each resident area, unit or floor.

Communal dining:
Residents living in a single unit or on the same floor may participate in communal dining. Pre-place utensils and cutlery for residents prior to seating and remove self-service food items and shared food containers (e.g., water/coffee/cream/milk dispensers, salt and pepper shakers) from communal areas. Provide single-use condiment packages (e.g., salt, pepper, sugar, ketchup and mustard) directly to residents. Dispense shared food items for residents, while maintaining a two metre distance as much as possible.

Ensure ABHR with at least 70% alcohol content is available in shared dining rooms. Remind residents to perform hand hygiene before handling or eating food.

Food sharing:
Staff and HCWs should not have buffet-style potluck gatherings, where multiple people are handling and serving food in close proximity or handling and serving food from common, unsupervised serving dishes/containers. Staff and HCWs may use food items that are individually packaged (e.g., creamer cups, sugar packets, crackers, pre-packaged granola bars).

Staff and HCWs should maintain a two metre distance or more from each other at all times when eating food and when in break rooms. Staff and HCWs in active outbreak units/facilities must not share food.

Visitors may bring in food for a resident. Provide visitors with appropriate information on safe food practices, such as protecting foods from contamination, minimizing direct handling of food, preventing cross-contamination of foods and discarding food that may have been contaminated with coughs or sneezes. Please see the BCCDC's food safety webpage for more information related to food safety.

Visitors must confirm with facility staff regarding any dietary considerations before bringing in food for the resident (e.g., allergies, diabetes, choking hazard or swallowing difficulties). Food should be individually packaged for consumption by the resident. Remind visitors and residents to perform hand hygiene before and after handling food or eating.

Please see *BCCDC COVID-19 information sheet for food service providers in health-care settings* for guidance about PPE for food services in health-care facilities, as well as information on food handling, dishwashing, food delivery and tray pick up.

8. Placement and Accommodation of Residents with Suspect or Confirmed COVID-19

Immediately place any resident identified as being exposed to COVID-19 or any resident with new-onset respiratory or gastrointestinal symptoms (e.g., new or worsening cough, sneezing, runny nose, fever, sore throat, difficulty breathing or episodes of vomiting and/or diarrhea) in a single room with a private toilet and sink.

If a single room is not available, maintain a physical separation of two metres between the bed space of the ill resident and all roommates. Provide a designated commode chair for the resident's use. Where available, close the privacy curtains.

Implement droplet and contact precautions and use appropriate PPE when in direct contact with the resident. Please see *BCCDC COVID-19 patient screening tool for direct care interactions* and *routine PCRA tool* for more information.

Post signage outside the resident's room/space indicating the required additional precautions and set up a PPE station outside of the resident's room. Post signs with instructions on how to put on and remove PPE (e.g., donning and doffing) inside and outside of the resident's room.

Restrict the resident to their room or bed space, including during meals and any other clinical or social activities, unless absolutely necessary. Designate reusable equipment to the resident with suspected or confirmed COVID-19, if possible.

For LTC facilities with residents sharing rooms, move roommates of residents with symptoms related to COVID-19 to a new private room for isolation, then monitor the roommates for symptoms. If a new private room is not available, maintain a physical separation of two metres between all beds in the current room and close any privacy curtains.

In the rare circumstances where a resident with COVID-19 symptoms must leave their room, they should wear a medical mask (if tolerated) or use tissues to cover their mouth and nose. Assist residents in performing hand hygiene. Encourage residents to use respiratory hygiene. Residents should minimize touching surfaces or items outside of their room. Immediately clean and disinfect any surfaces touched by the resident while outside of their room.

Identify and assign specific floors or units within the facility just for residents with confirmed COVID-19. LTC residents with suspected COVID-19 should only be cohorted with other residents with suspected COVID-19. Designated COVID-19 units should not be located close to vulnerable residents (e.g., residents with compromised immune systems or underlying health conditions). Cohorting of residents who are confirmed to have COVID-19 should only be considered once other infectious causes have been ruled out and upon consultation with IPC and/or MHO.

Dedicate teams of staff to care for residents with suspected or confirmed COVID-19, wherever possible. To minimize the risk of the transmission of infection in the building, consider re-organizing the workflow to limit the movement of staff between units/floors. Provide training for staff in how to care for COVID-19 residents.

9. Resident Transfer/Outings

Residents transferring from a LTC or seniors' AL residence:
Residents with confirmed or suspected COVID-19 infection should stay in their room unless there is essential need for movement and/or transport. Transfers within and between buildings should be avoided unless medically indicated.

Moving residents who are using a CPAP (continuous positive airway pressure) or BiPAP (bilevel positive airway pressure) machine within a facility should be avoided.

Residents with suspected or confirmed COVID-19 who require urgent medical attention and transfer to an acute care facility should wear a medical mask, if tolerated. Call the receiving unit, physician and/or MHO (or designate) to review and discuss the transfer. Notify the ambulance dispatch and the receiving institution about the resident's known or suspected COVID-19 status ahead of transport.

Provide the resident with clean clothing or hospital gown for the transfer. Instruct and assist the resident in performing hand hygiene. Remind the resident to practice respiratory hygiene and to avoid touching surfaces outside of their room/space.

Clean wheelchairs and transport stretchers before exiting the resident's room/space. Ensure residents and staff are at least two metres away from the transferring resident. Staff who are within two metres of the transferring resident must follow routine practices, and droplet and contact precautions.

Clean and disinfect all high touch surfaces, such as doorknobs, push buttons or handrails touched by the resident after leaving their room/space.

Personal Protective Equipment

10. Access to and Distribution of PPE

During the COVID-19 pandemic, LTC and seniors' AL health-care providers requiring PPE have direct access through established health authority supply contacts. Supply requests are assessed based on need, urgency and availability of supply and are filled accordingly. Distribution mechanisms may vary across health authorities. For more information, please visit BCCDC's PPE webpage.

11. PPE Use

Always use PPE in combination with frequent hand washing using plain soap and water or ABHR with a minimum of 70% alcohol content. Where PPE is used, the employer must train, test and monitor staff compliance to ensure vigilant donning (putting on), wearing and doffing (removing) of PPE.

Monitor and safely secure PPE stock to prevent theft and loss, while still ensuring staff can access PPE when needed. Whenever possible, PPE should be accessible and available at the point-of-care for each resident.

12. Mask and Eye Protection Use

All individuals in LTC and seniors' AL facilities must wear medical masks in accordance with Ministry of Health policy communique 2020-05 - mask use in health-care facilities during the COVID-19 pandemic. Medical masks should be changed if the mask becomes wet, damaged or visibly soiled.

HCWs who enter the patient/exam room or bed space or when within two metres of a patient must wear appropriate eye protection. Eye protection must be a well-fitting device that covers the front and sides of the face. Regular eyeglasses are **not** sufficient to protect from all splashes or droplet spray and are not considered adequate protection.

Eye protection, such as goggles, safety glasses or combination medical mask with attached visor need to cover from the eyebrow to the cheekbone, and across from the nose to the boney area on the outside of the face and eyes. Eye protection should be fitted so that gaps between the edges of the eye protection and the face are kept to a minimum. Full face shields should extend

below the chin to cover the face, to the ears at either side of the face and there should be no exposed gap between the forehead and the shield's headpiece.

For tasks with significant risk of splash, like aerosol generating medical procedures (AGMPs), a full-face shield or goggles must be used. When reusable eye protection is used for multiple patient encounters, it should be cleaned and disinfected as per the guidance found on BCCDC's PPE webpage. Properly doff, clean and disinfect your eye protection when visibly soiled and when leaving the patient care area (e.g., at end of shift or during a break).

Extending the use of PPE during the COVID-19 pandemic:
Extending the use of PPE conserves the overall PPE supply and supports the continued safe delivery of care in the context of critical global supply shortages during the COVID-19 pandemic.

Extended PPE use can include:

- Wearing the same medical mask and eye protection for repeated, close contact encounters.
- Wearing the same eye protection, gown and mask for repeated close encounters where there is a known diagnosis of COVID-19 for all the residents being cared for.
- Cleaning and disinfecting eye/facial protection when visibly soiled and at the end of each shift.
- Maximizing the number of services delivered during a single resident interaction.
- Minimizing the number of times staff enter/leave the resident area during their shift.
- Minimizing the number of staff who care for residents with confirmed or suspected COVID-19.
- Designating staff to specific units or cohorts of residents, whenever feasible.
- Performing AGMPs only when necessary to preserve N95 respirators.

When using PPE always:

- Change gloves in between residents, accompanied by hand hygiene between each glove change.
- Doff old PPE and don a new set when moving from residents with COVID-19 to those not diagnosed with COVID-19.
- Change medical mask if the mask becomes wet, damaged or soiled or when leaving the facility.
- Practice hand hygiene after removing each individual piece of PPE and before putting on new PPE.

Signage to guide PPE use:

- Post signage for droplet and contact precautions outside the room/space of residents who are suspected of having or have been diagnosed with COVID-19.
- Post signage on how to extend the use of PPE during the COVID-19 pandemic throughout the facility.
- Post signs at appropriate locations with instructions on how to put on (don) and take off (doff) PPE.
- Post signs at appropriate locations on how to wear a medical mask.
- Post instructions at appropriate locations on how to clean and disinfect eye and facial protection.

13. Droplet and Contact Precautions

Staff should always follow droplet and contact precautions when entering COVID-19 units or rooms on droplet and contact precautions (e.g., rooms where residents diagnosed with

confirmed or suspected COVID-19 have been admitted). PPE for droplet and contact precautions includes gloves, gown, eye protection and a medical mask.

In the context of COVID-19, use of a fit-tested N95 respirator is **only** required when performing AGMPs on a person with suspected or confirmed COVID-19. Use an N95 respirator or equivalent and eye protection (e.g., goggles or face shield), gloves and a gown for AGMPs performed on residents with suspected or confirmed COVID-19.

In LTC and seniors' AL settings, AGMPs on residents suspected or confirmed to have COVID-19 should only be performed when medically necessary. If an AGMP is performed, ensure the fewest number of staff necessary to perform the procedure are present.

Nasopharyngeal and throat swabs can be performed using droplet and contact precautions with medical masks and eye protection and do not require the use of an N95 respirator. Follow and implement all additional measures ordered by the MHO or outlined in health authority guidelines to minimize risk.

Access to additional PPE, such as respirators, will be provided in circumstances where a HCW determines there is elevated risk of COVID-19 transmission through patient interaction.

14. Discontinuation of Droplet and Contact Precautions

HCWs, such as a physician or a nurse, should assess the clinical status of the resident for resolution and improvement of symptoms related to COVID-19 and follow the criteria below to determine if discontinuation of droplet and contact precautions is indicated.

These decisions should be made in consultation with the resident's most responsible care provider, IPC professional and/or MHO.

Resources:

- Interim guidance: public health management of cases and contacts associated with novel coronavirus (COVID-19)
- Discontinuing additional precautions related to COVID-19 for admitted patients in acute care and associated decision tree.
- Information about self-isolation.

Public Health Measures

15. Facility Staff Assignment Order

By law, regional health boards, MHOs, operators, contractors, staff, educational institutions, students and volunteers must comply with all orders from the provincial health officer.

16. Laboratory Testing

Review the latest BCCDC's COVID-19 testing guidelines prior to any testing. Note: COVID-19 cases in LTC populations are known to occur in residents with mild presentations.

Ensure that the correct swabs and collections systems are ordered and being used. Please see appendix C of this document for instructions on how to collect a nasopharyngeal swab.

17. Notification & Reporting

Notify the IPC or designate at the facility/residence regarding all residents, care providers, staff, volunteers or visitors with symptoms related to COVID-19.

The IPC or designate at the facility/residence must notify public health of all residents, care providers, staff, volunteers or visitors confirmed to have COVID-19. The director of care or site manager should call the communicable disease unit at their local public health unit.

18. Contact Tracing

In conjunction with public health, start contact tracing of residents and staff potentially exposed to a person diagnosed with COVID-19 while in the facility. All residents who share a room with the ill resident should be considered exposed and should be monitored for symptoms at least twice a day for 14 days from the last date of exposure.

Report any new symptoms to the area MHO or their designate and follow BCCDC guidance regarding health-care worker exposures to COVID-19 while at work. For staff exposed to COVID-19 outside of work, follow BCCDC guidance for the management of cases and contacts associated with novel coronavirus in the community.

19. Managing Deceased Persons

Follow BCCDC guidance for the safe handling and care of deceased persons with suspected or confirmed COVID-19.

20. Psychosocial Supports

Support for residents:
The implementation of IPC measures, such as the use of PPE and restrictions on visitation during the COVID-19 pandemic, may adversely affect the mental health and psychological well-being of residents. Prevention measures may lead to behavioural and non-compliance issues. Some residents may become more agitated, stressed and withdrawn during an outbreak or while in isolation, and may require mental health and psychological support.

Support and facilitate virtual social connections wherever possible. Where personal electronic devices (e.g., tablets, phones) are used to support virtual communication and social interactions during the pandemic:

- Ensure mobile devices are dedicated to a single resident;
- Ensure mobile devices are cleaned after use. To avoid damaging electronics, follow the manufacturer's instructions regarding cleaning products and technique; and
- Ensure residents and staff wash their hands regularly when using mobile devices.

Support the adoption and implementation of the World Health Organization's mental health and psychosocial considerations during the COVID-19 outbreak for older adults.

Support for staff:
It is important to support the psychosocial well-being and resilience of staff during the COVID-19 pandemic. Support the adoption and implementation of BCCDC guidance for health-care provider support during the COVID-19 pandemic. Mental health support for health-care providers is available through Care for Caregivers.

An ethical analysis of the duty of HCWs to provide care in circumstances where there is a risk of harm to their own person is available online. Staff who have any questions or concerns regarding their possible exposure or symptoms are advised to call their local public health unit and/or their workplace health and safety department for assessment and advice.

Information regarding risk assessment of HCWs exposed to COVID-19 while at work as well as guidance to support decision-making on return to work for HCWs with symptoms of COVID-19 is available online.

Please see BCCDC's *COVID-19 health-care worker self-check and safety checklist* for more information.

Visitors

Visitor guidance supports safe, meaningful visits in LTC and seniors' AL settings while adhering to IPC requirements. The restrictions on visitation are grounded in regional/provincial health officer orders under section 32(2)(b)(ii) of the Public Health Act.

Please see the Ministry of Health – Overview of Visitors in Long-Term Care and Seniors' Assisted Living guidance, available on the BCCDC website, for the latest information pertaining to essential and social visits.

21. Hairdressing and Other Services

All service providers must follow the WorkSafeBC protocols for hairdressing and other services, including mask use for both service providers and clients, hand hygiene and the cancellation of services if the service provider or client has symptoms. Additionally, all operators or facilities are asked to retain a list of every resident who has received services and when these services are provided.

Hairdressers and other service providers working onsite will develop and submit safety plans to the director of the facility, who will confirm the feasibility of the plan and work to determine the starting date. These plans will need to follow the guidelines within this document and should be posted in the service area prior to services being resumed.

Key Sources of Provincial COVID-19 Guidance

Provincial guidance and information specific to COVID-19 can be found at:

- British Columbia Centre for Disease Control (BCCDC) – COVID-19 Information for Health Professionals
- BCCDC – COVID-19 Information for the Public
- BCCDC – Guidance for Long-Term Care & Assisted Living Facilities
- Office of the Provincial Health Officer – COVID-19 Orders, Notices and Guidance
- Government of British Columbia – COVID-19 Provincial Support and Information

Appendix A: COVID-19 Long-Term Care and Seniors' Assisted Living Preparedness Checklist

COVID-19 IPC Preparedness Checklist for Long-Term Care and Seniors' Assisted Living Facilities

General IPC Measures

- ☐ Educate all staff about COVID-19.
- ☐ Develop a contingency plan for staff illness and shortages.
- ☐ Assign a staff member to coordinate pandemic planning and monitor public health advisories.
- ☐ COVID-19 posters and signage (e.g., hand hygiene, cough etiquette) placed at all entrances and in all common areas.
- ☐ Ensure alcohol-based hand sanitizer with at least 70% alcohol is available at multiple locations: entrances, reception counter, common areas and exits.
- ☐ When available, provide staff with small bottles of alcohol-based hand sanitizer with at least 70% alcohol.
- ☐ Consider installing physical barriers (e.g., plexiglass partitions) to separate visitors from reception staff.
- ☐ Replace cloth-covered furnishings with easy-to-clean furniture, where possible.
- ☐ Provide disposable tissues and no-touch waste receptacles in appropriate areas.
- ☐ Provide plain soap and paper towels in resident washrooms and at staff sinks.
- ☐ Where permitted by fire regulations, keep frequently used interior doors open to avoid recurrent door handle contamination.

PPE and Mask Use

- ☐ HCWs should conduct a PCRA prior to any interactions with a patient or a visitor. See *COVID-19 patient screening tool for direct care interactions* & *routine PCRA tool* for more information.
- ☐ Ensure all staff and visitors are wearing medical masks at all times within the facility.
- ☐ Display PPE usage and donning (putting on) and doffing (taking off) instructions in locations available to all health-care workers.
- ☐ If an airborne precautions sign is posted or an AGMP is being performed, ensure staff wear an N95 respirator, in addition to gown, gloves and eye protection.
- ☐ Always use PPE in combination with frequent hand washing using plain soap and water or an alcohol-based hand sanitizer with a minimum of 70% of alcohol content.
- ☐ Where PPE is used, operators must train, test and monitor staff compliance to ensure vigilant donning, wearing and doffing of PPE.
- ☐ Monitor and safely secure PPE stock to prevent theft and loss, while still ensuring staff and residents can access PPE when needed.

Screening

- ☐ Put processes in place to identify and prevent individuals with suspected or confirmed COVID-19 from entering the facility:
  - ☐ Establish a single entrance point for all persons entering the facility to ensure all HCWs, staff, contractors, visitors and others are screened for symptoms of COVID-19.

- ☐ Develop and implement an appropriate script and process for active COVID-19 screening at the entry point for symptoms and risk factors of COVID-19. See *BCCDC COVID-19 entrance screening tool for visitors, patients & staff* for more information.
- ☐ During business hours, post a staff member at all entry points to actively screen every person who enters the building.
- ☐ Outside of business hours, implement a comparable process to screen and log all people entering the building.

☐ Increase protections for screeners by installing physical distancing supports, including spacing markers on the floor (two metres apart) and transparent barriers that prevent droplet transmission without interfering with communication between the screeners and others.

☐ Maintain a list of all staff and facility visitors.

☐ Ensure supplies for implementing these measures are available at all building entry points including medical masks, alcohol-based hand sanitizer (minimum 70% alcohol content), tissues, no-touch waste receptacles and disinfectant wipes

☐ Staff must actively self-monitor for symptoms related to COVID-19 and follow measures in the *COVID-19 staff self-checklist and safety checklist*.

☐ Staff must not come to work if they are experiencing acute respiratory or gastrointestinal symptoms.

☐ Post signage at all building entry points to support the active screening process.

- ☐ Visitor restrictions in place.
- ☐ Do not to enter if they are sick or required to self-isolate in accordance with public health directives.
- ☐ Guide symptomatic individuals to perform hand hygiene, put on a medical mask and self-identify to reception or a health-care provider.
- ☐ Cough etiquette, hand hygiene and physical distancing.
- ☐ How to put on a face mask.

Cleaning and Disinfection

☐ Identify which staff are responsible for cleaning resident care equipment and inform them about all required duties.

☐ Dedicate reusable equipment and supplies specifically to individual residents with suspected or confirmed COVID-19 infections.

☐ If dedicating equipment and supplies to an individual resident is not possible, all reusable equipment that is shared between multiple residents must be cleaned and disinfected with a hospital grade disinfectant after each use.

☐ Items that cannot be easily cleaned and disinfected should not be shared among residents.

☐ Discard all single-use items into waste bins after use.

Appendix B: Visitor Sign-in Sheet

First & Last Name	Phone Number	Email	Date

Appendix C: How to Collect a Nasopharyngeal Swab

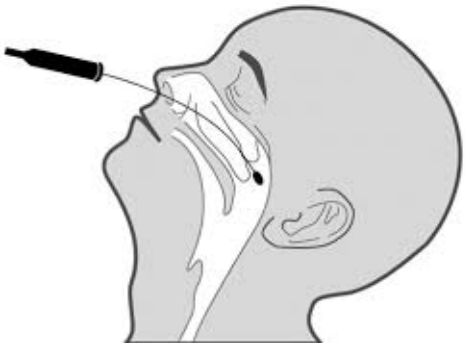
Review the latest BCCDC COVID-19 guidance for testing (see the BCCDC lab testing page). The testing guidance is subject to change and will be updated accordingly. The guidance also specifies the number of samples to be collected from symptomatic residents to confirm an outbreak.

Watch the How to take a Nasopharyngeal Swab video.

Ensure the nasopharyngeal swab (NP) is collected by qualified staff trained in the collection method. Limit staff in the room to those necessary for the procedure. Persons in the room during the procedure should, ideally, be limited to the resident and the staff performing the procedure.

Assemble supplies:

- Recommended collection devices that are routinely used for NP swabs for influenza or other respiratory virus testing.
- Requisition and label.
- Biohazard bag.
- Tissues for resident to clean nasal mucous before the procedure and to contain cough and sneezes after the procedure.



Perform proper hand hygiene. Put on PPE (gown, gloves, medical mask with eye protection, face shield or goggles) to protect yourself if the resident coughs or sneezes while you are collecting the specimen.

Explain the procedure to resident. Provide resident with tissues to contain cough and sneezes after the procedure.

If the resident has a lot of mucous in their nose, this can interfere with the collection of cells. Ask the resident to use a tissue to gently clean out all visible nasal mucous before a swab is taken. Respiratory viruses are located in cells that line the surface of the nasal cavity and are shed into respiratory secretions.

Stand to the side of the resident, not directly in front of them. Seat the resident in a high-fowler's (700) position in bed with the back of their head supported. It may be necessary to have a second person available to assist with collection.

With a slow, steady motion along the floor of the nose (straight back, not up the nose) advance the swab until the posterior nasopharynx has been reached (distance from nostrils to external opening of ear). If nasal mucosa is swollen, rotating the swab during insertion may facilitate entry.

Place a finger on the tip of the resident's nose and depress slightly once resistance is met (the swab should pass into the pharynx relatively easily). Rotate the swab twice and allow it to remain in place for a few seconds to absorb the sample, then withdraw the swab.

Move away (at least two metres) from the resident when the procedure is complete. Place in the tube of transport medium (check your local policy for sending specimens). Break the shaft of the swab at the

constriction, and screw on the lid without cross-threading. Label the swab with three patient identifiers and indicate “NP Swab.”

Remove PPE according to the steps of doffing (taking off) PPE. Ensure attention to hand hygiene. Complete the virology requisition form requisition indicating the tests requested and write “COVID-19 testing requested” or add a special label to the requisition indicating the need for COVID-19 testing. To prioritize testing, label the requisition as coming from LTC facility (label as "LTCF"). Ensure that the resident identifiers and ordering physician or health-care worker name are correct.

Place the specimen container in a biohazard transport bag. Insert the requisition in the side pouch. Submit samples as you usually do through your local diagnostic microbiology laboratories.

Long-term Care, Assisted Living, and Hospice COVID-19 Resource Toolkit

Updated: July 30, 2021

The following compilation of tools and resources in this toolkit are intended for use in conjunction with the general guidelines and directions from the British Columbia Communicable Disease Centre (BCCDC), Infection Prevention and Control Requirements for COVID-19 in Long-Term Care and Seniors' Assisted Living.

- *Areas where the IH Planning and Response Coordination Committee (PRCC) have recommended a more conservative standard have been flagged.*
- *All contents have been approved by the IH PRCC and will be updated regularly as the response to and evidence regarding COVID-19 evolves.*
- *A number of restrictions are already in place to prevent a potential outbreak. This toolkit focuses primarily on outbreak management.*
- *We encourage all sites to be proactive with prevention.*

The IH PRCC wishes to acknowledge the Fraser Health Authority (2020) for granting permission for the use of this document template and 'cross authority information' contained within.

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The following compilation of tools and resources in this toolkit are intended for use in conjunction with the general guidelines and directions from the British Columbia Communicable Disease Centre (BCCDC), Infection Prevention and Control Requirements for COVID-19 in Long-Term Care and Seniors' Assisted Living *1*

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1.0 Introduction

The purpose of the toolkit is to provide sites and Interior Health personnel working in Long-Term Care (LTC), Hospice and Assisted Living (AL) with a common reference for current information to guide response to outbreaks of COVID-19. Guidance in this toolkit is based on the expectation that sites have implemented all foundational elements of COVID-19 prevention measures *applicable to their facility* as described in their Pandemic Response Plan for Long-term Care, Assisted Living and Hospice.

The guidance is meant to provide a set of interventions for COVID-19 outbreaks that builds upon existing approaches to IH respiratory outbreak protocols, available evidence on COVID-19, and current regional experience with COVID-19 control in these settings. The guidance is not prescriptive, and should be applied in the context of a specific outbreak scenario as directed by CD Unit and/or the Medical Health Officer and/or Interior Health designated Pandemic Response Coordination Centre (PRCC).

1.1 BCCDC's Infection Prevention and Control Requirements for COVID-19 in Long-Term Care and Assisted Living

This toolkit builds upon the general guidance provided in the BCCDC's Infection Prevention and Control Requirements for COVID-19 in Long Term Care and Seniors' Assisted Living – UPDATED May 5, 2021. Key contents of this document are below:

Contents of BCCDC Infection Prevention and Control Guideline

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1.2 Medical Health Officer (MHO) Orders

MHO orders, updates and guidance can be found here: MHO Updates.

1.3 Key Contacts

This document is updated with the most current direction, guidance and resources regarding COVID-19 received from the Ministry of Health, the BCCDC and Interior Health.

If you are unable to find the answer to your questions or concerns within these resources, questions and comments related to the COVID-19 pandemic response can be submitted to the following key contact areas:

- Questions related to Contracted Services: Paul.Champness@interiorhealth.ca
- Single Site: SingleSiteFeedback@interiorhealth.ca
- **Currently Not Available**: IH Emergency Response Team – General questions: Shannon.paul-jost@interiorhealth.ca
- General Questions can be sent to Licensing Direct: LicensingDirect@interiorhealth.ca
- IH Infection Prevention and Control: IHInfectionControl@interiorhealth.ca
- IH Communicable Disease Unit: CDunit@interiorhealth.ca
- IH COVID-19 Hub: **Accessing the Hub** The new COVID-19 Hub is **best viewed, and saved as a bookmark, in Chrome** at: COVID-19 Hub for IH Employee & Medical Staff. (Not accessible to Contracted Partners)
- IH LTC/AL/Hospice ExtraNet Sharepoint Site **for Partner Site Designates only**
- Complaint Escalation when unable to resolve within 24 hours – PCQO@interiorhealth.ca
- For additional questions: COVIDRecovery@interiorhealth.ca - Questions will be monitored from Monday to Friday from 0800 – 1600 PST.

*Note if your site is actively managing a COVID-19 outbreak, please contact your IH Communicable Disease Unit: CDunit@interiorhealth.ca.

KEY CONTACT TO NOTIFY OF 1+ SUSPECTED (SWABBED) AND/OR CONFIRMED CASES:

Communicable Disease Unit (CDU) 1-866-778-7736 (M-F 8:30 to 16:30) or
On-call Medical Health Officer (MHO) 1-866-457-5648 (after hours and weekends)

1.4 Who should be tested for COVID-19?

Complete resources on testing can be found through the BCCDC here: BCCDC COVID-19 Testing Viral Testing.

1.5 Definitions for Terms with in the Toolkit

The term **"Client"** will be used throughout this document in reference to clients, residents and/or tenants.

Community Hospice Beds (CHBs) dedicated hospices or short-stay palliative beds.

Most Responsible Provider (MRP) throughout refers to Medical Practitioner, Physician or Nurse Practitioner.

The term **"Site(s)"** will be used throughout this document in reference to all types of LTC/AL/Hospice facilities.

2.0 Outbreak Management

COVID – 19 Outbreak Management Protocol for Acute Care, Long-term Care and Seniors' Assisted Living Settings – March 4, 2021

Reminder: If a resident (LTC) or a client (AL) is exhibiting potential COVID-19 symptoms, the site team will:

1. Place the individual on isolation and initiate Droplet Contact Precautions immediately;
2. Notify site leadership or manager on-call of a possible outbreak situation; and
3. Perform nasopharyngeal swab collection and submit to the lab.
4. Assess all site residents or clients for symptoms of COVID – 19; follow steps 1-3 for all individuals identified with possible COVID-19 symptoms.
5. Initiate RI Outbreak protocols for unit and/or facility.

Isolation of persons exhibiting possible COVID-19 symptoms will remain in effect until Infection Prevention and Control Practitioner or Medical Health Officer directs otherwise.

Leadership to assess if any staff exhibiting COVID-19 like symptoms. **Any symptomatic staff are to be relieved from duties, directed to contact Public Health to obtain COVID-19 testing and to remain at home on self-isolation until result of COVID-19 testing has been received.**

2.1 Client and Staff Daily COVID-19 Illness Reporting

Interior Health's COVID-19 response resources have been mobilized to increase support for Long-term care, Assisted Living, and Independent - Supportive Living Sites. As part of this work an active monitoring process has been implemented for these sites. This process allows for timely reporting of COVID-19 symptoms for clients and staff within sites. This information will allow IH to work with you to identify any COVID-19 cases and quickly respond.

IH is using the TELUS Home Health Monitoring (HHM) system to support the collection of this valuable monitoring information. This HHM system is a platform that is also being used in Home Health for client monitoring for COVID-19 contact tracing symptom check-in.

Each facility is provided with access to the HHM web based system to complete a very short daily questionnaire that includes questions about if there is any known illness in clients, staff, and if any testing has occurred.

Should there be known illness or testing that has occurred the Communicable Disease (CD) Unit and Adult Care Facility (ACF) COVID Response Team follows up with the facility/site to obtain further information for assessment and possible action. This may include recommendations and organizing of testing.

ALL sites are required to report seven days per week unless in a declared outbreak.

2.2 Presentation (Symptoms) – Average Adult

Clients who meet the following presentation definitions are considered possible cases and should be tested for COVID-19 via a nasopharyngeal swab.

BCCDC Resource: COVID-19 Patient Screening Tool for Direct Care Interactions Poster

Summary of COVID symptoms:

Does client have any new or worsening symptoms?

- Fever or Chills Cough (equal to or greater than 38^0 or a temperature that is greater than usual for that individual)
- Difficulty Breathing
- Loss of Smell or Taste

If yes - isolate, place on Droplet Contact Precautions and obtain COVID-19 testing.

Does the client have two or more of the following symptoms that are above baseline for more than 24 hours?

- Sore Throat
- Extreme Fatigue or Tiredness
- Body Aches
- Diarrhea
- Loss of Appetite
- Headache
- Nausea or Vomiting

If yes - Isolate, place on Droplet and Contact precautions and obtain COVID-19 testing.

Testing Information

COVID-19: Adult and Pediatric Viral Testing Guidelines for British Columbia (Dec 17, 2020)

2.3 Monitoring the Older Adult – Always think Atypical – Introducing Early Symptom Presentation – INTERACT - STOP and WATCH

The above COVID-19 symptom presentation is for the average adult. It is imperative that Long-term Care and Assisted Living teams understand and be observant for early signs and symptoms in the older adult; and to understand that these symptoms may be exhibited long before the above average adult symptom presentation.

- BCCDC – Clinical Management of COVID-19 Resource Section 9.2 states: *"Older age and comorbid conditions such as diabetes and cardiovascular disease have been reported as risk factors for death in persons with COVID-19. Because older persons are at highest risk for severe disease and fatality and are one of the most vulnerable populations, they should be screened for COVID-19 at the first point of access to the health system, be diagnosed promptly if they are suspected to have COVID-19 and treated appropriately. As older patients may present with atypical symptoms, health workers should*

take this into account during the screening process."

Teams must first understand the individual's baseline presentation and then observe for early potential COVID – 19 signs and symptoms. To support teams to be vigilant in monitoring clients for these early symptoms, the INTERACT, 'STOP and WATCH' tools Version 4, has been adopted with permission from the Alberta Health Services, 2020 and INTERACT © 2014 Florida Atlantic University (Updated June, 2018).

Resources:

IH: INTERACT – STOP and WATCH Early Warning Tool (Care Aide Observation tool)

Partners: INTERACT – STOP and WATCH Early Warning Tool (Care Aide Observation tool)

IH: SBAR Communication Preparation Tool for Physicians and Nurse Practitioners – Multi Concern

Partners: SBAR Communication Preparation Tool for Physicians and Nurse Practitioners – Multi Concern

(Reminder: the preparation tool above is not a fax. It is only a preparation tool to support gathering of information and is not part of the permanent health care record)

IH and Partners: Symptom Management for Adult Patients with COVID-19 Receiving End-of-Life Supportive Care Outside of the ICU – BC Centre of Palliative Care Guidelines

IH and Partners: COVID-19 Conversation Guide for Long-term Care

Key Points:

- Increase client monitoring to twice daily for signs and symptoms of COVID-19 during suspect or confirmed outbreak.
- Be a vigilant observer for the early warning signs (atypical presentation) in the Older Adult. Place any suspect or confirmed clients on droplet contact isolation.
- Notify Leadership of situation.
- Individuals who show suspect signs and symptoms of COVID-19 should be immediately placed on isolation with droplet and contact precautions and tested by a nasopharyngeal swab (BCCDC COVID-19 Viral Testing.)
- If they are asymptomatic of the typical symptoms but concerns are identified contact the Most Responsible Practitioner for guidance.
- **Remember: DO NOT test for COVID-19 in asymptomatic individuals,** *unless directed by MHO*

Many of our older adults may exhibit post infectious delirium regardless of whether or not they experienced respiratory symptoms of COVID-19. This may lead to an elongated recovery period with no medical treatment currently known as effective. Supportive care is critical during this time, monitoring for basic needs such as hydration, mobilization, skin integrity, pain management, and psychosocial support. An interdisciplinary team approach is the best defense.

2.4 COVID-19 Screening Log for Residents and Tenants

For all Long-term Care and Assisted Living teams who do not have a process already in place for recording the once daily (when not in outbreak) and twice daily (when in outbreak) screening of the Residents and Tenants for symptoms of COVID-19, the 'COVID – 19 Symptom Screening Log for Residents and Tenants' has been developed.

To ensure teams are being vigilant observers the screening log also supports clinicians to be monitoring for the early warning signs (atypical presentation) in the older adult.

As this is an observation-monitoring log it may be completed by the nurse or designate (Health Care Assistant or Tenant Helper etc.). **If any signs are present, the observer is required to notify the nurse for further assessment and to document your observations, your actions and the Resident/Client's**

response to your actions in the health care record.

IH: COVID-19 Symptom Screening Log for Residents and Tenants
Partners: COVID-19 Symptom Screening Log for Residents and Tenants

2.5 Monitoring Requirements for Residents and Tenants and Initial Response for Possible COVID-19 Cases

- All clients are monitored once daily when site is not in outbreak for signs and symptoms of COVID-19.
- Monitoring of clients is increased to twice daily during outbreak for signs and symptoms of COVID-19.
- Individuals who show suspect signs and symptoms of COVID-19 should be isolated, placed on Droplet and Contact Precautions and tested by a nasopharyngeal swab (BCCDC COVID-19 Viral Testing).
- **DO NOT test for COVID-19 in asymptomatic individuals,** *unless directed by MHO.*

2.6 Determination of COVID-19 Exposure Event

CD Unit is notified of and investigates all new lab-positive COVID-19 cases. If an exposure in a LTC or AL facility is identified in the interview, the CD Unit will contact the affected facility and the Infection Control Practitioner for the IH facility, to conduct a risk assessment and provide outbreak measures. If a facility hears about a case through a source that is not the CD Unit, the facility should ensure COVID-19 routine precautions are in place and identify if any breaches may have occurred and await further instructions from CD Unit.

Exposure event:
When there is only a single LTCF Health Care Worker COVID-19 case, whom is assessed by the MHO to most likely to have acquired infection from the community setting, and had only worked for part of their initial period of infectivity for the 2 days pre-symptomatic and/or initial symptomatic days, with good PPE and IPC procedures in place.

Action: Monitor for any subsequent cases for a 14 day period from last worksite exposure.

2.7 Determination of COVID-19 Site Outbreak

Outbreak criteria for acute care, LTC or AL facilities:

At least one staff or client/resident diagnosed with COVID-19, **and**

An investigation indicates transmission most likely occurred in the facility, from another patient/resident, visitor or staff, rather than prior to admission (for patients/residents) or from the community (for staff).

- Client/Resident example: Transmission in the facility is suspected when there are two or more epidemiologically linked cases of COVID-19, each occurring more than 48 hours after admission and within two to 14 days of each other, in a geographic area (e.g., unit or floor; this may vary depending on facility layout and movement of staff/patients). One of these cases must be a patient.
- Staff example: A staff member has tested positive for COVID-19 after caring for a patient/resident with COVID-19 without appropriate use of personal protective equipment (PPE).

2.8 Outbreak Stages

1. Declared Outbreak: Medical Health Officer (MHO) declares the outbreak at a facility in communication with the Infection Control Practitioners (ICP).

2. Concluded Outbreak: Medical Health Officer declares when an outbreak is concluded; again in communication with the ICP. Generally, it will be 28 days with no new cases after the date of symptom onset of the last lab-confirmed COVID-19 diagnosis at the facility or from the date the outbreak was declared, whichever is later. This uses the conservative two incubation periods of 14 days each.

2.9 At Least ONE (Resident) or Staff Member or More Positive Cases (Staff, Visitor, or Residents) COVID-19 Test Result = Outbreak

CD Unit is notified of and investigates all new lab-positive COVID-19 cases. If an exposure in a LTC or AL facility is identified in the interview, the CD Unit will contact the affected facility and the Infection Control Practitioner for the IH facility, to conduct a risk assessment and provide outbreak measures. If a facility hears about a case through a source that is not the CD Unit, the facility should ensure COVID routine precautions are in place and identify if any breaches may have occurred and await further instructions from CD Unit.

At least ONE Resident or Staff Member or more positive COVID-19 case (staff, visitors, Residents) **IS** considered an outbreak in the facility unless otherwise directed by the Medical Health Officer (MHO). An outbreak may also be declared by MHO based on multiple suspect cases.

- Communicable Disease Unit (CD Unit) 1-866-778-7736 (M-F 8:30 to 16:30)
- OR the Adult Care Facility COVID Response Team (ACFCOVID@interiorhealth.ca)
- On-call Medical Health Officer (MHO) 1-866-457-5648 (after hours and weekends) if communication has not occurred

BCCDC: ATTENTION: COVID-19 OUTBREAK Poster

2.10 Site Outbreak Management Team

Site Outbreak Management Team (OMT) is established with the declaration of an outbreak or exposure event. The Adult Care Facility COVID-19 Response team (ACF)will activate the OMT which includes *at a minimum* the Manager, Long-term Care Coordinator / Director of Care, the Facility Medical Director (if applicable)/ Infection Control Practitioner (if applicable) , and any affiliated third party contractors (housekeeping, staffing etc.).The ACF Team initiates contact with the IH Pandemic Response Coordination Centre (PRCC) and two-way communications occur to support management of the outbreak.

This process applies to all IH owned and operated and contracted partner long-term care and assisted living sites; and may include independent living sites if the MHO deems the site in outbreak. The IH ACF team will establish and lead the COVID-19 OMT at the outbreak facility in partnership with facility leadership. IH ACF team connects with the facility leadership daily (by telephone) and identifies/escalates concerns requiring follow up. The OMT will communicate with the (PRCC).

The ACF team works with the facility on a daily basis to re-evaluate the outbreak and supports the OMT to identify and implement measures to manage the outbreak.

2.11 Post-Outbreak Debrief

- Once the MHO has declared the outbreak over, consider a debriefing meeting, to evaluate the management of the COVID-19 outbreak and make recommendations to further COVID-19 outbreak management guidance.
- Remain alert for possible new cases in Clients and Staff.

3.0 Operations

3.1 Transfers between Long-term Care Sites and Assisted Living

Effective July 12, 2021, the Ministry of Health has directed health authorities to resume admissions from Assisted Living to LTC, and transfers between LTC for the purpose of meeting client choice.

Access Coordinators have resumed matching clients to preferred sites for admission using previously established processes.

Most Responsible Practitioner (MRP) notification of the MHO approval is required in the following situations only:

- Transfers of client/patient with known or suspected COVID-19 infection; OR
- Client is a known contact of a COVID-19 case; OR
- The transferring or receiving facility has a declared a COVID-19 outbreak.

3.2 UPDATED - Admissions from Community to Long-term Care and Assisted Living Sites

Community clients being admitted to LTC and Assisted Living sites are no longer required to isolate for 14 days upon admission if they are fully vaccinated. Staff are to use the BCCDC Point of Care Risk Assessment **(Updated June 4, 2021)** before all interactions and follow PPE Risk Assessment Guidelines during COVID-19 Pandemic **(Updated July 6, 2021)** for selection of appropriate PPE.

> *'A point of care risk assessment (PCRA) assesses the task, the patient and the environment, based on the patient's history and presentation. A PCRA is a dynamic risk assessment completed by the Healthcare worker (HCW) before every patient interaction in order to determine whether there is a risk of being exposed to an infection. The PCRA will help determine the correct PPE required to protect the HCW in their interaction with the patient.*
> ***Note:** During COVID-19 routine practices have been amended to include mask, gloves and eye protection for all direct patient interactions.'*

Partners: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(Updated July 6, 2021)**

3.3 Transfers/Admissions from LTC Sites to Acute or Acute to LTC Sites

To support safe and appropriate transfers to Acute Care refer to the Provincial COVID 9-1-1 LTC Transfer Algorithm.

3.4 Updated, May 17, 2021 - Changes to Transfers / Admissions from Acute Care Hospital in Outbreak to Long-term Care & Assisted Living

Effective immediately, there are changes to all new or returning Long-term Care / Assisted Living admissions **from** Acute Care site when the Acute Care site is in COVID-19 outbreak (this includes all permanent and Short Stay beds).

Required COVID-19 Testing Prior to a Planned Transfer to LTC/AL Site:

Please ensure **all new or returning** Residents/Clients have been tested for COVID-19 before their transfer from Acute Care site in Outbreak to the LTC/AL site, which includes:

- Resident/Client is tested for COVID-19 at Acute Care facility point of discharge, testing result is negative, and Resident/Client is transferred to the site within 24 hours of receiving the result; **or**
- Resident/Client had a confirmed COVID-19 infection and is now cleared of the COVID-19 infection and approved by the CD Unit for transfer to the site.
- If Resident/Client has not been vaccinated for COVID-19 and there are no contraindications for vaccination, the Resident/Client must be offered the COVID-19 vaccine prior to transfer. LTC/AL site to confirm Resident/Client vaccine status, if not already communicated.

Pre-Approval Required for an Urgent Transfer from Acute Care Site in COVID-19 Outbreak

When transfers to LTC/AL must occur from an Acute Care site in COVID-19 outbreak and the Resident/Client has not received COVID-19 testing and/or immunization prior to transfer, the transfer must be pre-approved by the CD Unit (during business hours) or the MHO on-call after hours. LTC/AL site to:

- Confirm with discharge unit that they have contacted the CD Unit or MHO on-call after hours for transfer approval, and
- Notify Infection Control Practitioner of pending transfer.

Isolation Requirements for all LTC/AL Residents/Clients admitted from an Acute Care Site in Outbreak

LTC/AL site must continue to follow established control measures, including:

- Transfer incoming Residents/Clients directly to their room or designated space;
- Initiate 14-day isolation period and Routine Practices, which includes masks, gloves, and eye protection during the COVID-19 pandemic;
- If Resident/Client becomes symptomatic of COVID-19 symptoms:
    - Initiate Droplet and Contact Precautions
    - Notify CD Unit (during business hours) or MHO on-call after hours
    - Inform CD Unit or MHO on-call of discharge details from Acute

Additionally, Residents/Clients transferring from Acute Care site (whether in Outbreak or not) or other Long-term Care/Assisted Living sites specific to Short Stay Convalescent, End of Life, and Respite are required to be offered the COVID-19 vaccination prior to any admission to long-term care.

IH: Patient-Resident Transfer from Acute Facility to LTC-AL-Congregate Setting
Partners: Patient-Resident Transfer from Acute Facility to LTC-AL-Congregate Setting

3.5 Updated, July 12, 2021 - Respite – Resumption of In-facility Respite Services

As of July 12, 2021, the Ministry of Health (MoH) directed health authorities to resume In-facility respite services. This means that Interior Health (IH) case managers may resume previous processes for booking, documenting, and supporting facility respite while collaborating with LTC providers to arrange for service provision.

Community clients who are fully vaccinated, being admitted to LTC for Respite Care are no longer required to isolate for 14 days upon admission. Community clients who are not fully vaccinated are still required to isolate for 14 days upon admission. Staff are reminded to use the BCCDC COVID-19 Point of Care Risk Assessment before all interactions and follow PPE Risk Assessment Guidelines during COVID-19 Pandemic **(July 6, 2021)** for selection of appropriate PPE.

> *'A point of care risk assessment (PCRA) assesses the task, the patient and the environment, based on the patient's history and presentation. A PCRA is a dynamic risk assessment completed by the Healthcare worker (HCW) before every patient interaction in order to determine whether there is a risk of being exposed to an infection. The PCRA will help determine the correct PPE required to protect the HCW in their interaction with the patient.*
> ***Note:** During COVID-19 routine practices have been amended to include mask, gloves and eye protection for all direct patient interactions.'*

Partners: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(July 6, 2021)**

3.6 UPDATED - Appointments/Visits in the Community

Clients are no longer restricted from going to appointments, outings and visits in the community as long as the following conditions are met:

- Client has no symptoms of possible early COVID-19 infection.
- Client does not require 14 days isolation and symptom monitoring.
- Remind client to perform hand hygiene on entry to the facility and after removal of their mask (still required to wear a mask in an acute care setting).
- If being transported to hospital - client, transportation personnel, and acute care staff wear appropriate personal protective equipment as required.
- Any potential breaches or potential COVID-19 exposures during transfer are reported immediately to the facility.

Individuals requiring transfer to medical appointments, a higher level of care or to an acute setting during the COVID-19 pandemic will be transferred according to the:

Process to Decrease Risk of Contamination for Transport of Patients with Suspected or Confirmed COVID-19 Clinical Practice Standard and Procedure.

Individuals for transfer to an acute care facility should wear a surgical/procedural mask if tolerated. All Health Care Workers (HCWs) involved in transporting the client must wear a surgical/procedural mask, eye protection, gown and gloves as per droplet contact precautions.

If a LTC individual attends an essential medical appointment off site at a controlled health care setting, the expectation is that the settings are applying the necessary infection control measures; therefore, there is no need for the client to isolate upon return. Upon return ensure the individual performs hand hygiene on facility entry and post removal of mask.

3.7 Same Day LTC Transfers to and back from Acute Care for Appointments

Same day medically essential or recurring treatments or appointments are no longer restricted (e.g. renal dialysis) and do not require MHO approval as long as the following conditions are met:

- Client is asymptomatic.
- All transport and acute care staff must maintain contact and droplet precautions at all times.
- Client is transferred directly to appropriate department for procedure and back to LTC facility.
- If no exposure to the client was identified during visit to acute care facility, then client may return to the LTC facility without requiring 14 days isolation and symptom monitoring. Unless the acute care site is in outbreak, (refer to Section 3.4).
- Clients will perform hand hygiene on entry to the facility and after the removal of their mask.
- Any potential breaches are to be reported immediately to the MHO.

The clients' MRP is responsible for determining whether a specific appointment is essential.

Please make sure to inform the IH Patient Transport Office and Acute Care in advance if the:

- LTC facility initiating the transfer has an active outbreak of RI, or
- Client is under investigation for COVID-19, or
- Client is a known contact of a COVID-19 case.

Please ensure that physical distancing, hand hygiene and PPE protocols are followed as outlined in the Optimal Use of PPE Guidelines and physical distancing (two metres from all others including visitors and other patients) is maintained throughout the treatment/appointment.

3.8 HandyDART: Transportation of Patients, Clients and Clients during COVID-19 Pandemic

Please use clinical judgment when considering transporting clients. The information below is intended to guide team decision-making:

Non-Urgent: Consider local transit, HandyDART, family/friends or other options within the community that maximize space between client and driver to follow physical distancing precautions and hygiene principles are followed. Provide client with PPE (minimal requirement is a surgical/procedural mask) and hand hygiene is performed.

Emergent: Call 911 for BC Ambulance and inform dispatcher that the client is symptomatic, awaiting test results, or presumed/confirmed COVID-19 positive. To support safe and appropriate transfers to Acute Care refer to the Provincial COVID 9-1-1 LTC Transfer Algorithm.

3.9 Provincial COVID 9-1-1 Long-term Care Transfer Algorithm

The Provincial COVID 9-1-1 Long-Term Care (LTC) Transfer Algorithm defines the protocols regarding client transfers to Emergency Departments (ED) during COVID-19 and beyond. The algorithm aims to ensure timely, medically appropriate transfers that align with the clients' goals of care. LTC sites are directed to follow the transfer algorithm **anytime they are considering ANY client's transfer to the ED via a 911 call, regardless of COVID-19 status.**

- BCCDC Clinical Decision Pathway COVID-19 in LTC Residents
- Provincial COVID 9-1-1 Long-term Care Transfer Algorithm
- IH: Provincial COVID 9-1-1 Long-term Care Transfer – Cue Card
- Partner: Provincial COVID 9-1-1 Long-term Care Transfer – Cue Card
- Clinical Decision Pathway COVID-19 Clients in LTC

3.10 UPDATED - Admissions to Assisted Living Guidelines

The following recommendations and suggestions are provided for operational guidance to mitigate the risks against the transmission of COVID-19 with the resumption of AL admissions.

Standard precautions during COVID pandemic (for all clients/visitors):

- Complete Client/Visitor facility entry screening upon arrival to site.
- Plan visit at non-peak hours if possible.
- During a site tour, potential clients and visitors are required to wear a mask.
- All clients/visitors to hand sanitize/hand wash upon arrival and prior to leaving site
- Site to support clients/visitors to practice regular hand-washing/hand sanitizing during the visit.
- Clients/visitors are to maintain a two meter physical distance from others during the visit.
- Log visitor/client details on the Visitor log for future tracing needs and keep for 28 days.

Before Onsite Pre-admission Visit & Tour

Initial phone conversation:

After client is screened for the suite vacancy, contact the client/family by phone and inform the client/family of the following:

- At any step of the assessment, it is at AL provider's discretion to decline the client if the provider does not believe they can meet the needs of the client.

Admission Package Delivery to Client:

- Explore the opportunity to send the documentation package to the client/family to review by e-mail, fax, and ground mail and/or connect with AL clinician and referring clinician for in-person delivery. The package may include tenancy agreement and consent forms, menu, provided services and COVID-19 safety and PPE information.

Site/Unit Tours

- Site tours for prospective clients and their families can resume.

Onsite Pre-admission Visit & Tour Day

- Brief tour of the suite and main communal areas (dining and activity room) before moving to the meeting room or explore the possibility of virtual tour/photos of communal areas.

- The room arranged for onsite meeting needs to accommodate for required physical distancing masking and hand hygiene between client, family member/friend and the AL provider staff.
- If the suite offer is made, minimize the duration of onsite visit by reviewing essential pieces of documentation only and giving the rest of the package to the client/family to review at home.
- Ensure client and family is aware of COVID signs and symptoms and to report to site leadership if feeling unwell. All clients are required to provide proof of vaccine status to the site, to receive vaccine information, and direction on hand hygiene, masking and physical distancing requirements when in common areas.
- Notify client and family member that as of **July 19, 2021** – All unvaccinated clients are required to isolate for 14 days upon admission.

On Move-in/Out Day

- Refer to and follow the standard precautions during COVID-19 pandemic and BCCDC screening guideline.
- Family member/friend and mover(s) must sign-in when entering the site.
- Family member/friend and mover(s) must bring and wear a mask and perform hand hygiene on entry and exit to facility. *AL providers should be prepared to provide a medical mask if required.*
- Allow at least two movers for heavy objects.
- To facilitate physical distancing requirements, arrange visit time with the AL site and plan the move in/out when clients are in their suite or ask clients to stay in their suite while movers are on site. Family/movers are to proceed from the entrance to the suite and back, minimize the number of trips as much as possible, and keep physical distance from the staff and other clients at all times.
- Allow family member/friend to stay in client's room to help with packing/unpacking and to provide support for client. *They are required to remain in the client's suite during this time.*
- Items must be cleaned and disinfected prior to and after the move in as per BCCDC cleaning and disinfecting guidelines.

3.11 UPDATED - June 15, 2021- Social Activities for Assisted Living Tenants

BCCDC:

- Assisted Living clients can engage in social and external activities that are aligned with general public health guidance. BC Province Wide Social Gatherings and Events **(June 15, 2021).**
- Current information suggests that older people with chronic health conditions are at higher risk of developing more severe illness or complications and should take the measures to protect themselves including avoiding large gatherings and stay away from other people who are ill and accessing COVID-19 vaccine (in consultation with their MRP). They should maintain safe physical distance at all times and wear a medical mask when in enclosed spaces such as transit or stores where safe physical distances cannot be maintained.

3.12 UPDATED - July 19, 2021- Standard Precautions during COVID Pandemic (For Social Visits between Tenants/Visitors) in Assisted Living

- Assisted Living Tenants are no longer required to wear a mask.
- **Visitors who are fully vaccinated** are only required to wear a mask in common areas and when moving through the building and can remove their mask when visiting with their loved one.
- **Visitors who are not fully vaccinated** are required to wear a **medical** mask **at all times during an indoor or outdoor visit.** Sites to provide mask to those who do not have a medical grade mask.

- Provide education to all visitors on how to properly wear a mask.

BCCDC Resource: How to Wear A Mask

Updated - Social Visiting Guidelines

As part of their ongoing efforts to keep residents safe, operators will complete an initial and then monthly review of their current practices to ensure for themselves, residents and families that there is full compliance against the current practice requirements set out below. Any gaps identified should be addressed.

Operators will engage with residents, their families and care providers on both the current status of IPC practices in the facility and processes for visitors, including the request for proof of vaccination. There will be ongoing engagement to ensure residents and families understand the risks of visiting and their collective accountability and necessary commitment to adhere to guidelines to minimize risk for both residents and visitors. This engagement will strive to ensure an ongoing-shared approach to maintaining the challenging balance of safety and quality of life; requiring continued collaboration and mutual accountability of residents, families and caregivers through the coming months.

Residents/Tenants should be supported to participate in social outings, including leaving the facility for family visits and appropriate activities. Residents will not be required to isolate when they return from an outing.

- Visitors will still be screened for signs and symptoms of illness, including COVID-19, before their visits.
- Visitation will be suspended if there is an active COVID-19 outbreak at the facility.

3.13 UPDATED - Congregate Dining, Recreation Programming and Scenic Bus Outings

The Ministry of Health requirement for the assignment of 'Social bubbles/cohorts' in LTC and AL for congregate dining, recreation programming and scenic bus outings has been rescinded. This step forward, in alignment with the implementation of the phase 3 BC Restart Plan, will support and improve the quality of life of the clients residing in all LTC and AL sites.

Facility Restart Plans must be updated to include changes in the safety plans for accommodating the new guidelines for congregate dining, recreation programming, and scenic bus outings prior to the introduction of the 'social bubbles/cohorts' and must adhere to public health, infection prevention and control and regulatory guidelines, Interior Health Authority, Medical Health Officer and Ministry of Health directives.

A current copy of the Facility Restart Plan and Social Visit Safety Plan must be available for review if requested by Licensing Officers and/or the Assisted Living Registrar.

Forward any questions to Licensing Direct.

Update: Pet Visitors to LTC, Assisted Living or Hospice facilities:

Recognizing the value that dogs bring to the mental and emotional wellness of residents in LTC/AL sites, volunteers can bring dogs for visits if the following criteria are met:

- Owner is fully vaccinated,
- Owner has passed the Facility Entry Screening Requirements, and
- Resident being visited is asymptomatic.

If any staff wish to bring their dogs in to work, they will need approval from their site manager.

As per IH MHO consultation with the COVID Recovery Team - Pet Therapy programs may resume as long as the Pet Handler for the Pet Therapy program is fully vaccinated, provides proof of vaccination status to the site, the pet handler passes the Facility Entry Screening requirements and follows all infection prevention and control required practices.

3.14 UPDATED - July 12, 2021 Re-opening of ALL Adult Day Service Programs

Effective July 12, 2021, The Ministry of Health has directed that **all adult day programs may resume;** including those that share space, staff and/or equipment with a long-term care home or assisted living residence.

To support the ongoing safety of clients, residents, and staff the following will be required:

- The opening of each Adult Day Program (ADP) site will continue to be dependent on a Regional Medical Health Officer (MHO) (or delegate) approved operating plan.
- Require all ADP clients to be fully vaccinated and provide proof of vaccination, with exception by MHO approval only and with appropriate infection prevention and control precautions in place (i.e., for clients who have a medical reason to not receive vaccination and who can wear a mask)
- In the event of a COVID-19 outbreak in an adjoining home or residence, adult day programs will be suspended.
- Recognizing a period of transition may be needed to achieve opening of all ADP sites, health authorities are asked to **target opening of all sites by September 2021.**

These COVID-19 response actions are intended to recognize the increased level of protection provided by COVID-19 vaccination and to mitigate the ongoing client, family and system impacts of restrictions. Enhanced cleaning, screening, and reporting requirements continue as per the Infection Prevention and Control Requirements for COVID-19 in Long-Term Care and Seniors' Assisted Living.

For support or questions, please contact:

Darlene Russell: Practice Lead, Home Health

3.15 UPDATED - July 19, 2021- COVID-19 Screening Process for Clients Accessing Adult Day Service Programs

Effective July 19, 2021 – All Adult Day Service clients must be fully vaccinated or have received an exemption from the MHO to be able to attend if unable to be vaccinated.

All Adult Day Service (ADS) clients will be screened by ADS unregulated health-care staff **prior to entering** a program.

Staff members will screen for risk and exposure to COVID-19, using the new guideline – COVID-19 Client Screening Process for Adult Day Service Programs. **(Updated June 30, 2021)**

If an ADS client screening is positive for COVID-19 concerns, the staff member will communicate with the program ADS licensed practical nurse, Home Health professional, or manager for further assessment and management.

Additional Resources:
BCCDC COVID-19 Self Assessment as of Jan 11, 2021
BCCDC Health Information – Diseases – Conditions – COVID-19 as of Jan 11, 2021
BCCDC and BC Ministry of Health COVID-19 Infection Prevention and Control: Guidance for Home and Community Health-Care **(Updated: June 2, 2021)**
Interior Health PPE Risk Assessment Guideline during COVID-19 Pandemic **(Updated: July 6, 2021)**
Interior Health Algorithm - AGMP and PPE in the Community (UCP's)
BCCDC Self-Isolation guidelines:
BCCDC – How to Self-Isolate after a Test
BCCDC – How to Self-Isolate if You are a Close Contact
BCCDC – Caring for Someone with COVID-19 in your home

3.16 UPDATED - Community Bathing Programs

All Community bathing programs both stand-alone programs and those connected to LTC/AL sites can now resume with MHO approved **safety plan to re-open.** At the beginning of June, all the Home Support managers were given the go ahead to begin recovery planning. The expectation is that they will work with their LTC and AL managers to develop the safety plan.

3.17 UPDATED - Volunteers

As per the Ministry of Health directives July 19, 2021, all volunteers may return to the facilities **BUT** only if they are fully vaccinated and must provide proof of vaccination status to the facility.

Essential volunteers do not require approval from the Medical Health Officers, as their services are considered essential to support the individual. When on-site, a Hospice Volunteer may only provide direct support to one individual.

General non-essential volunteer programs in LTC/AL facilities must adhere to the following guidelines:

- Volunteers are required to be familiar with the responsibilities and expectations regarding outbreak prevention, detection, and management in the facility.
- Volunteers adhere to the same PPE guidelines as those for staff.

In the event of a COVID-19 outbreak at a facility, volunteers will be restricted to essential volunteers only.

IH: PPE Risk Assessment Guideline during COVID-19 Pandemic **(Updated July 6, 2021)**
Partners: PPE Risk Assessment Guideline during COVID-19 Pandemic **(Updated July 6, 2021)**

The determination of which volunteer activities can resume will be at the site's discretion. We are encouraging each site to begin by focusing on reinstating volunteer activities that are low risk which include:

- No close physical contact between volunteers and clients
- Not entering patient rooms

Examples of Low Risk Activities:

- Volunteers who support programs that require minimal contact with clients such as pet therapy, large group activities with social distancing requirements in place, recycling, gardening, and friendly shoppers programs

3.18 Technologies During COVID-19 – Order Extended by Ministry of Citizen's Services

The Province is extending a temporary ministerial order until Dec. 31, 2020, to continue to allow health-care workers and other public sector staff to use communication tools not normally permitted for use during the COVID-19 state of emergency.

On March 26, 2020, Minister of Citizens' services, approved a ministerial order under the Freedom of Information and Protection of Privacy Act (FOIPPA) to temporarily permit the use of vital software and technologies in the public sector that have proven useful in B.C.'s successful efforts to flatten the curve. The order allows patient-care teams to use multiple communication tools, including things like smartphones, text messaging, chat programs and other applications during their response to the public- health emergency. This has made it easier to communicate between teams and follow up with patients using virtual platforms.

3.19 Virtual Care Delivery

Although physicians, client physicians, nurse practitioners, and paramedics are all exempt from the single site order, they are required to be mindful about the need to attend multiple sites during this pandemic. Where possible, reduce multiple site visits to reduce the risk of spread of COVID-19 and utilize virtual technology. The health and safety of all IH staff and MRPs and clients are the focus of these considerations. For more information, resources and education see on:

IH: Virtual Care Toolkit - BC Telehealth Clinical Guidelines

Partners: BC Telehealth Clinical Guidelines

For questions about virtual care or for individual Zoom training, contact us at Virtual Care or 1-855-870-4755.

3.20 Using Zoom on Deployed iPads for Virtual Care Delivery

Interior Health has deployed 200 iPads with the Zoom video communication tool to iPad site contacts in Long-term Care (including contracted partners), Acute Care, Community Emergency Departments and Tertiary Mental Health.

How should the iPads be used?

- The primary purpose for these iPads is for medical staff remote assessments/consults for patients/clients, to reduce physical contact for those vulnerable medical staff/patients/clients.
- When not being utilized for virtual care delivery, these iPads can be used to support remote patient/client family visits.
- Stringent cleaning must be completed between each use.

IH: Guideline for Cleaning IMIT (IT Equipment)

Partners: Guideline for Cleaning IMIT (IT Equipment)

Technical Support:

More information on using Zoom is available as follows:

- IH staff: Telehealth & Virtual Care.
- Partners and medical staff: Virtual Care Services.
- Patients/clients/clients and their families at Virtual Care Services for Patients and Clients.

4.0 UPDATED – July 19, 2021 Visitors

4.1 UPDATED - Visitor Guidelines from BCCDC (MoH Clarification)

On July 19, 2021, The BCCDC released to Interior Health the **new** MoH – Overview of Visitors in Long-term Care and Senior's Assisted Living Guidelines. All LTC, AL, Hospice (O&O, Contracted Provider and Private) sites are strongly encouraged to become familiar with the new guidelines.

4.2 NEW - Proof of Vaccination Status for Visitors

On July 19, 2021, in recognition of the added layer of protection provided by the COVID-19 vaccine and given the vulnerability of residents in LTC and seniors' AL even when fully immunized themselves, there is a strong recommendation that individuals visiting long-term care homes or seniors' assisted living residences (both essential and social visitors) are fully immunized (e.g., two weeks post second dose) against COVID-19.

Proof of vaccination will be requested at the time of screening for entry into the facility. Fully immunized visitors will be required to wear a medical mask while moving through the facility and in common areas but are not required to wear a mask while in direct contact with the person they are visiting or when outdoors. Visitors who do not demonstrate that they are fully immunized are required to wear a medical mask for the duration of their visit, including when in direct contact with the person they are visiting.

NEW: Visitor Resource:

IH: Long-term Care and Assisted Living Visitor Guidelines Brochure

Partners: Long-term Care and Assisted Living Visitor Guidelines Brochure

Scope of Visitation Criteria and Precaution Measures

- Visitation precautions apply to **all** licensed long-term care and registered seniors' assisted living settings in B.C., including health authority-owned and operated facilities and contracted affiliates or fully private operators.

4.3 Definitions and Foundational Information

Visitation restrictions aim to protect vulnerable seniors and elders who are residing in long-term care and seniors' assisted living settings from COVID-19 while lessening the negative impacts associated with being apart from family and friends.
Health authorities and facility operators shall continue to support visitors for essential visits and allow social visits within established criteria, supported by a detailed plan and process as outlined below. The Ministry of Health acknowledges the need to support operators to ensure safe visitation with adequate staffing.

A written plan must be developed in accordance with the practice requirements outlined below. The plan must be available for licensing or the Assisted Living Registry if requested. A visitor list, with contact information, will be maintained as per the provincial COVID-19 infection prevention and control (IPC) guidance for long-term care and seniors' assisted living.

A visitor list, with contact information, will be maintained as per BCCDC IPC COVID-19 Guidance for long-term care and seniors' assisted living. **(Updated - May 5, 2021)**

4.4 UPDATED - Criteria for Essential and Social Visits

NEW Guidelines Effective July 19, 2021 - MOH – Overview of Visitors in Long-term Care and Seniors' Assisted Living
NEW Supporting Resource, sent out to operators July 14, 2021:
IH: Questions and Answers LTC and Seniors' Assisted Living Facilities – Easing Visitor Restrictions
IH: **New** Long-term Care and Assisted Living Visitor Guidelines Brochure
Partner: Questions and Answers LTC and Seniors' Assisted Living Facilities - Easing Visitor Restrictions
Partner: **New** Long-term Care and Assisted Living Visitor Guidelines Brochure
Provincial Health Officer Class Order (Visitation) (COVID-19) – February 5, 2021

Ministry of Health - July 19, 2021 - No changes have been made to the essential visitor policy for LTC and seniors' AL facilities and it remains in effect.

Essential Visits:

- Essential visits are necessarily linked with an essential need that could not be met in the absence of the essential visit.
- The facility leadership will determine if a visit is essential, as per previous communication, a licensing exemption is not required for essential visits but site must make the written plan available for Licensing or the Assisted Living Registry if requested.
- A written plan must be developed in accordance with the practice requirements outlined below.

An essential visit includes:

- Visits for compassionate care, including critical illness, palliative care, hospice care, end of life and medical assistance in dying;
- Visits paramount to the resident's physical care and mental well-being (e.g., assistance with feeding, mobility, personal care or communication, assistance by designated representatives for persons with disabilities);
- Visits for supported decision-making;
- Existing registered volunteers providing the services described above;
- Visits required to move belongings in/out of a resident's room; and

- Police, correctional officers and peace officers accompanying a resident for security reasons;

Essential visits shall be limited to one visitor per resident within the facility at a time (except in the case of palliative/end-of-life care). An essential visit is not a social visit and essential visits are permitted in a care home/residence that has an active COVID-19 outbreak, under guidance and direction from the local medical health officer.

Practice Requirements for Essential Visits

As part of their ongoing efforts to keep residents safe, operators will complete an initial and then monthly review of their current practices to ensure for themselves, residents, and families that there is full compliance against the current practice requirements set out below. Any gaps identified should be addressed.

The LTCF must ensure the following criteria is met and a process for documenting each aspect in writing for each requested/approved essential visitor(s) is in place prior to visitations taking place:

1. In order for the visitor request to be considered by the LTCF, they must meet the definition of an Essential Visitor (definition described above – Section C. Criteria for Essential Visitors and Social Visits).

2. The LTCF has considered how to provide this support virtually or with the staffing model in place; and has assessed that the need for the essential visitor(s) is still required and congruent with the care plan of the person in care.

3. The LTCF supports the request for the specific named Essential Visitor(s) and proposed plan for visitation. In addition, the person in care, their family or representative, the Most Responsible Physician (MRP), the health care team or any persons who contributed to the person in care's care plan are also supportive of the proposed essential visits.

4. The Essential Visitor/Visitation plan describes how:
    - The LTCF will screen the essential visitor(s) each time of entry using the greeter's script. If the essential visitor(s) does not pass the screening questions in the greeter's script, the LTCF will not allow admission to the LTCF.
    - The LTCF will provide education and training on infection control processes, and applicable policies and procedures.
    - Visitors shall be instructed when to perform hand hygiene, respiratory etiquette and safe physical distancing. How to wear a Mask
    - The essential visitor(s) will meet the expectations for the provision of required PPE.
    - The LTCF will assess the essential visitor's comprehension and implementation of infection control measures, PPE use, and all facility policies.
    - The LTCF will monitor the essential visitor's adherence with the infection control measures and all expectations as set out in policy.
    - The plan includes a plan should the essential visitor(s) fail/refuse to abide by the expectations set out in the request for visitation.
    - The operator will escort the essential visitor(s) to and from the specified room and ensure that the essential visitor(s) is confined to that area that ensures social distancing or avoids contact with other persons in care, and does not engage in activities outside of the specified room.
    - The essential visitor(s) has access only to a prescribed person in care in the specified room at the

time of the visit.
- The plan includes specific days and times for the essential visitor(s) attending the LTCF.

4.4 UPDATED July 19, 2021 Social Visits

A social visit includes:

- Someone not routinely involved in the resident's health-care or support needs;
- Someone whose time with the resident is discretionary and usually temporary; or
- Visiting for purposes that are more social in nature.

Not every situation can be anticipated or addressed in detail. Where there is uncertainty, individuals are encouraged to employ cultural safety and humility and take a person and family- centred approach that appropriately balances risk of transmission. Virtual options for visiting will continue to be supported when appropriate.
Visitor restrictions do not apply to key administrative staff entering for purposes related to facility operations.
Family and visitors can request an immediate review of the decision and shall be provided the ability to speak with an administrator or administrator-on-call or request further review of a decision through, or facilitated by, the health authority Patient Care Quality Office (see appendix for details on the review process).

NEW July 19, 2021 - BCCDC Resource: Facility Entrance Visitor Guidance - Social Visiting Poster
IH: LTC_AL - Screening - Social Visiting Poster
Partners: LTC_AL – Screening – Social Visiting Poster

4.5 UPDATED July 19, 2021- Practice Requirements for Social Visits

As part of their ongoing efforts to keep residents safe, operators will complete an initial and then monthly review of their current practices to ensure for themselves, residents and families that there is full compliance against the current practice requirements set out below. Any gaps identified should be addressed.

Operators will engage with residents, their families and care providers on both the current status of IPC practices in the facility and processes for visitors, including the request for proof of vaccination. There will be ongoing engagement to ensure residents and families understand the risks of visiting and their collective accountability and necessary commitment to adhere to guidelines to minimize risk for both residents and visitors. This engagement will strive to ensure an ongoing-shared approach to maintaining the challenging balance of safety and quality of life; requiring continued collaboration and mutual accountability of residents, families and caregivers through the coming months.

Residents should be supported to participate in social outings, including leaving the facility for family visits and appropriate activities. Residents will not be required to isolate when they return from an outing.

These practice requirements are intended to support residents, families, staff, administrators and managers, boards or owners of long-term care homes and seniors' assisted living

residences to provide the opportunity for social visits and to provide guidance about how they can collectively work together to minimize the risk of COVID-19 transmission in these facilities. These practice requirements may be updated as required with renewed direction from the Ministry of Health and Provincial Health Officer. This visitor guidance replaces the earlier visitor guidance and supplements the IPC guidance as posted:

- COVID-19 Infection Prevention and Control: Guidance Long Term Care and Seniors' Assisted Living Settings (May 5, 2021)

The primary purpose of social visits is to provide opportunities to spend time with loved ones and support the emotional wellbeing of residents. Social visits may occur without advance booking during the daily-designated social visiting hours at a facility.

Care homes/residences will make every effort, while maintaining the safety of all residents, visitors and staff, to ensure adequate time and space for meaningful social visits between residents and their visitors. Residents' differing needs for what is required for meaningful visits should be accounted for in determining appropriate frequency and maximum duration of visits, as well as the number of visitors at one time. Any limits on the frequency, duration and number of visitors or visits should only be to meet resident needs or WorkSafe BC safety plans.

Facility wide indoor social events/gatherings may occur involving residents and staff from multiple units/floors of a facility. Outdoor social events may include staff, residents and visitors (e.g., summer BBQ) in alignment with the current PHO guidance while adhering to applicable IPC practices to ensure the safety of all staff, residents and visitors.

Social visits are separate from essential visitation and resident outings. Operators will continue to support resident outings in alignment with public health guidance regarding indoor and outdoor gatherings for the public.

The shared approach to establishing and maintaining the balance of benefits and risks will be informed by the following core practices:

1. Social visits will only be allowed if there is no active COVID-19 outbreak at the care home/residence and will cease immediately if an outbreak is declared and the facility goes into active outbreak management. Social visits will resume immediately when the outbreak is declared over with lessons learned applied to ongoing practice.

2. Visitors should receive advance guidance on the process and guidelines for social visits. Operators will identify details about the processes for visiting on their websites; inform residents and visitors in writing/by email. This will include the requirement for visitors to show proof of vaccination status and the associated requirements for masks while visiting.

3. The maximum number of visitors at one time for both indoor and outdoor social visits must align with site capacity to ensure the safety of all residents, visitors and staff, as well as resident needs and wellbeing in support of meaningful visits. Whenever possible, residents residing in multi-bed rooms should receive visitors in a separate, designated location.

4. Social visits may occur without the requirement to schedule or book in advance. Daily social visiting hours may be designated by the facility to ensure adequate staffing to support safe visiting practices, provided significant opportunities are made available daily with visiting options in the morning, afternoon and evening on weekdays and weekends.

5. All visitors shall be actively screened for signs and symptoms of illness, including COVID- 19, prior to entry at every visit: http://www.bccdc.ca/health-info/diseases-conditions/covid-19/about-covid-19/symptoms. Visitors with signs or symptoms of illness, as well as those in self-isolation or quarantine in accordance with public health directives, shall not be permitted to visit.

6. Larger, facility-wide social events or gatherings may occur. Indoor events/gatherings may include residents and staff across units/floors of a facility. Outdoor events/gatherings may include family/friends. The number of visitors at outdoor social events/gatherings must align with current PHO guidance, meet WorkSafe BC safety plans and follow appropriate IPC practices to ensure the safety of all staff, residents and visitors.

7. When visiting with a resident requiring additional precautions (e.g., droplet and contact precautions), all visitors shall be instructed on how to put on and remove any required personal protective equipment (PPE). Visitors are required to limit circulation/movement throughout the facility while visiting. If the visitor is unable to adhere to appropriate precautions, the visitor shall be excluded from visiting.

8. Any furniture and surfaces in communal visit areas will be cleaned and disinfected as per the provincial IPC COVID-19 guidance for long-term care and seniors' assisted living, at the end of each visit. Visits in resident rooms do not require additional enhanced cleaning following visits.

9. Health authority and facility operators are expected to provide consistent and easy access to information regarding the complaints process and mechanism for appealing decisions related to essential and social visitor status.
   • Facility operators will post on the facility's public-facing website and at all main entrances to the facility the visitor policy and appeal process including the contact information for the site administrator and will provide a copy to a resident or another person, on request.
   • Health authorities will ensure visitation information is available on their main public-facing website, including the provincial health order, policy and process for appeal.

BCCDC Resource: COVID-19 Entrance Screening Tool for Health-Care Facilities

NEW July 19, 2021 - BCCDC Resource: Facility Entrance Visitor Guidance - Social Visiting Poster

IH Link: LTC_AL - Screening - Social Visiting Poster

Partners: LTC_AL – Screening – Social Visiting Poster

All: MoH - Overview of Visitors in Long-TermCare and Seniors' Assisted Living
IH: Questions and Answers LTC and Seniors' Assisted Living Facilities – Easing Visitor Restrictions
Partner: Questions and Answers LTC and Seniors' Assisted Living Facilities - Easing Visitor Restrictions
BCCDC Visitor Policy - Poster

4.6 UPDATED July 19, 2021- Paid Companions

Paid Companions can be a social visitor, designated essential visitor or an end-of-life visitor for a resident in Long-term Care.

As a service provider, the Paid Companion must be fully vaccinated and must provide proof of vaccination before entry will be allowed into the LTC/AL facilities. The Paid Companion must follow best

practices, complete Point of Care Risk Assessment to determine appropriate Personal Protective Equipment (PPE) need, perform hand hygiene and social distancing while on site.

In addition to the standard requirements, the following are conditions required for the Paid Companion as an exempted individual:

- Paid Companions must follow the Single-Site order and sign the Declaration Statement for Paid Companions:

IH: Declaration Statement for Paid Companions
Partners: Declaration Statement for Paid Companions

- They may see more than one resident in a single facility ensuring they follow all ICP and PPE requirements between visits with residents.
- Must complete Point of Care Risk Assessment and don appropriate PPE when in direct patient care areas.
- The site will provide education and training on infection control processes and applicable policies and procedures to the Paid Companion, and will assess the comprehension and implementation of infection control measures, PPE use and all facility policies.
- Instruction will include when to perform hand hygiene, PPE use as determined by Point of Care Risk Assessment, respiratory etiquette and safe physical distancing. How to Wear a Mask
- The site will monitor the adherence with the infection control measures and all expectations as set out in policy.
- The site will provide appropriate PPE to the Paid Companion
- Complete screening and sign in process
- Gowns are not required unless resident is suspect or confirmed COVID in which case the paid companion will not be visiting.

Paid Companion as an 'Essential Visitor':

As of July 19, 2021, all Paid Companions must be fully vaccinated to work in LTC/AL/Hospice facilities and must provide proof of vaccination status to the site manager.

Sites must ensure the following criteria are met as identified in the Ministry of Health - Overview for Visitors in Long-term Care and Assisted Living Residences **(July 19, 2021)**:

- The service they are providing must meet the definition of an Essential Visitor: "Visitor is considered paramount to the health and well-being of the resident to ensure care is provided as set out in the resident's care plan".
- The resident's care plan addresses how the paid companion meets the resident's needs.
- The site supports the request for the Paid Companion to be named as the Essential Visitor and the proposed plan for visitation. In addition, the resident, their family or representative, the Most Responsible Practitioner (MRP), the health care team or any persons who contributed to the resident's care plan are also supportive of the proposed essential visits.

UPDATED: Visitor Policy Required Signage and Key Messages

- Long-term Care and Assisted Living Providers are required to have Visitor Policy Signage posted inside the main entrances to clearly communicate essential and social visit policies, with the phone number of the LTC facility so visitors can call if they have questions or need immediate assistance.
- Sites are required to follow facility entrance screening process, **ask for and document visitor vaccination status after visitor has passed initial facility entrance screening process** and provide

information/guidance regarding PPE and other processes and then direct visitors on the checking out process at the end of visit. Supervision of visit is not expected and may be considered intrusive.

NEW Resources: July 19, 2021 –

BCCDC Resource: Facility Entrance Visitor Guidance - Social Visiting Poster

IH: LTC_AL - Screening - Social Visiting Poster
IH Manager Resources:

- Master Visitor Vaccine Status Log
- Master Personal Service Provider Vaccine Status Log

Partners: LTC_AL – Screening – Social Visiting Poster
Partners – Manager Resources:

- Master Visitor Vaccine Status Log
- Master Personal Service Provider Vaccine Status Log

4.7 Family Member Communication

Sites are instructed to insert a link on site-specific newsletters to website IH news:
news@IH Long-term Care and Assisted Living
news@IH Visitor Information (for all other departments)

4.8 UPDATED- July 19, 2021 Supporting Information Resources for Screeners

ALL visitors and staff require screening prior to each visit/shift to ensure the ongoing safety of the residents/tenants and staff of the facility.

Effective July 19, 2021 - Scheduling of social visitors is no longer required.

Visitor Screening:

UPDATED July 19, 2021 - Screener will complete:

1. Facility Entry Screening Visitor Sign In/Out log for all Visitors – **(Revised July 19, 2021)**.
   - If the Screener observes that, the visitor is unwilling or unable to comply with the infection control practices as identified in Step C of the Facility Entry Screening Script **(UPDATED July 19, 2021)**, please inform the Administrator/Delegate for the facility.
   - Screeners are to escalate visitor complaints as per the LTC/AL Complaint Escalation Visitor Process Algorithm (Section 4.5 of the toolkit) to the manager/manager on call.
   - Family and visitors who are **not** permitted entry and wish to have an immediate review of the decision shall be provided guidance according to the LTC/AL Complaint Escalation Visitor Process Algorithm (Section 4.5 of the toolkit).

IH: New Forms for Screeners, Greeters and Patient Ambassadors (July 19th, 2021)
Revised - Facility Entry Screening Script
Revised - Facility Entry Screening Visitor Sign In – Out log
Revised – COVID-19 Staff Screening Sheet – LTC AL Hospice
NEW Master Visitor COVID-19 Vaccination Status Log
NEW Master Personal Service Providers COVID-19 Vaccination Status Log (for Paid Companions, Foot Care Nurses, Massage Therapists, Acupuncturists, and Hairdressers etc.)

IH: NEW form – CONFIDENTIAL – Completed by Managers Only

NEW Master Staff Vaccination Status Log

Partners: New Documents for Screeners, Greeters and Patient Ambassadors (New – July 19, 2021)
Revised - Facility Entry Screening Script
Revised - Facility Entry Screening Visitor Sign In – Out log
Revised – COVID-19 Staff Screening Sheet – LTC AL Hospice
NEW Master Visitor COVID-19 Vaccination Status Log
NEW Master Personal Service Providers COVID-19 Vaccination Status Log (for Paid Companions, Foot Care Nurses, Hairdressers)

Partners: NEW form – CONFIDENTIAL – Completed by Managers Only
NEW Master Staff Vaccination Status Log

Algorithms: Please note these Algorithms have not been updated at the time of the release of this toolkit – As of August 1st, 2021 all facilities are no longer required to submit monthly complaint escalation logs to the PCQO!
IH Link: Funded LTC and AL Complaint Escalation Visitor Process Algorithm
Partners Link: Funded LTC and AL Complaint Escalation Visitor Process Algorithm

Algorithm: Please note this Algorithms has not been updated at the time of the release of this toolkit – As of August 1st, 2021 all facilities are no longer required to submit monthly complaint escalation logs to the PCQO!
Private Operators: LTC and AL Complaint Escalation Visitor Process Algorithm

4.9 NEW - June 21, 2021- COVID-19 Rapid Antigen Testing – LTC Voluntary Visitor Screening

LTC is supporting voluntary COVID-19 Rapid Antigen Testing by visitors as an additional measure visitors can participate in to support the health and safety of our vulnerable residents and themselves. The COVID-19 Rapid Antigen test screens for COVID-19 antigens (or proteins) which can be present in a person up to 1 – 3 days before they experience actual symptoms of COVID-19; during this time, they could be spreading the COVID-19 virus without even knowing it. Even individuals who have been vaccinated against COVID-19 could still potentially contract different strains of COVID-19; therefore, all LTC sites are encouraged to implement this additional voluntary visitor screening process as the site has capacity.

Please contact the COVIDRecovery inbox for further information and access to train the trainer education and support resources.

PROCESS RESOURCES

IH:

- LTC Sites – Rapid Antigen Testing Site Readiness Checklist
- 828681 – Visitor Information and Instructions (Handout)
- 821490 – Visitor Handout – My LTC COVID-19 Rapid Antigen Test is Positive
- COVID-19 Rapid Antigen Testing - Supply List
- Donning and Doffing Competency Checklist (Pt Ambassadors, Greeters, Screeners and Site – Designates)
- PANBIO Point of Care Rapid Antigen Testing – Training Checklist (Pt Ambassadors, Greeters, Screeners and Site Designates)

- PANBIO – Rapid Antigen Testing – LTC Competency Assessment (All persons providing oversight and instruction for COVID-19 Rapid Antigen Testing at sites)
- LTC Rapid Antigen Self-Testing Guide Poster (4 pages, print separately, laminate and post)
- LTC Visitor COVID-19 Rapid Antigen Test Recording Log
- PANBIO – Rapid Antigen Testing – Weekly Usage Log - Visitors
- Pt Ambassador Role in Supporting the PANBIO Rapid Antigen Testing Process
- Pt Ambassador, Screener, Greeter Script for the LTC Visitor Voluntary COVID-19 Rapid Antigen Testing
- Sample of Site Clinical Process

Partners:

- LTC Sites – Rapid Antigen Testing Readiness Checklist
- 828681 – Visitor Information and Instructions (Handout)
- 821490 – Visitor Handout – My LTC COVID-19 Rapid Antigen Test is Positive
- COVID-19 Rapid Antigen Testing - Supply List
- Donning and Doffing Competency Checklist for Pt Ambassadors, Greeters, Screeners and Site – Designates
- PANBIO Point of Care Rapid Antigen Testing – Training Checklist (Pt Ambassadors, Greeters, Screeners and Site Designates)
- PANBIO – Rapid Antigen Testing – LTC Competency Assessment (All persons providing oversight and instruction for COVID-19 Rapid Antigen Testing at sites)
- LTC Rapid Antigen Self-Testing Guide Poster (4 pages, print separately, laminate and post)
- LTC Visitor COVID-19 Rapid Antigen Test Recording Log
- PANBIO – Rapid Antigen Testing – Weekly Usage Log – Visitors Voluntary
- Pt Ambassador Role in Supporting the PANBIO Rapid Antigen Testing Process
- Pt Ambassador, Screener, Greeter Script for the LTC Visitor Voluntary COVID-19 Rapid Antigen Testing
- Sample of Site Clinical Process

4.10 UPDATED - COVID-19 Staff Screening Requirements

All staff regardless of COVID-19 vaccine status must complete daily health screen prior to begin work shift to ensure the ongoing safety of the residents/tenants and staff of the facility.

Updated July 19, 2021 - Staff Screening:
As part of our pandemic response across IH, it is essential that all employees and medical staff perform self-screening health checks before going to work each day, and follow the guidance for screening procedures upon arrival at our work sites.

This aligns with the provincial public health orders and directions – with the concerted focus on everyone doing their part to decrease the risk of COVID-19 exposure and spread.

To support this, the COVID-19 Employee and Medical Staff Self-Screening Guideline has been developed and outlines in detail:

- Roles & responsibilities
- Screening requirements
- Approved screening process for:
  - Prior to coming to work (prior to leaving your residence), and
  - Prior to starting shift (at the facility)

Partners: COVID-19 Employee and Medical Staff Self-Screening Guideline

At the facility:

- All staff entering the building will be screened before the start of their shift.
- Staff screening will consist of asking the COVID-19 questions and recording the answers.
- Screeners do NOT take the staff's temperature (*temperatures must still be taken as per site process)*.
- **NEW –** All staff who are not fully vaccinated against the COVID-19 virus are also required to complete COVID-19 Rapid Antigen testing at your site – Frequency of testing will be determined by work schedule (Fulltime – 3 times per week; Part-time and Casual TBD) – **Ministry of Health requirement – July 19, 2021**
- All screened staff will have their information recorded on:
  IH: LTC AL Hospice Staff Screening Sheet **(Updated July 19, 2021)**
  NEW July 19, 202: LTC AL Hospice Master Staff Vaccine Status Log
  Partners: LTC AL Hospice Staff Screening Sheet **(Updated July 19, 2021)**
  NEW July 19, 2021: LTC AL Hospice Master Staff Vaccine Status Log
- Pt. Screeners, Greeters and Ambassadors will submit staff and visitor screening documents to the manager/designate at the end of each day.

Personal Care Packages:
Clients may receive care packages of food, clothing, **and live flowers**, **plants (April 1, 2021),** and treasured personal or cultural items. Personal care packages may be delivered by the Residents essential, social or end-of-life visitors.

ALL Care packages will require sanitization; follow your site-specific process for this.

Additional Resources to Support Greeters/Managers:

All: Supporting Information for Facility

All:Screeners Facility Authorized Visitor List

IH: Facility Screening - Visitor Sign In/Out Log **Updated – July 19, 2021**

Partners: Facility Screening - Visitor Sign In/Out Log **Updated – July 19, 2021**

IH: COVID-19 Manager's Resources for Staff Screening Assessment

Partners: COVID-19 Manager's Resources for Staff Screening Assessment

4.11 NEW – July 19, 2021 COVID-19 Non- Vaccinated Staff Screening Requirements

As per the Ministry of Health new precautionary measures to protect the vulnerable population residing in the Long-term Care and Seniors' Assisted Living environments **all non-vaccinated employees** must complete required **COVID-19 Rapid Antigen Testing on-site** (frequency to be determined) prior to beginning work shift to ensure the ongoing safety of the residents/tenants and other staff of the facility.

COVID-19 Rapid Antigen Testing is not a Nasopharyngeal Swab Test!

- It is a point of care screening process that picks up the proteins of the COVID-19 virus up to 1-3 days before a person may experience symptoms of the COVID-19 virus. For the testing:
  - The staff member swabs their own nose,

- The swabbing for this process is only completed inside the front of each nostril to a depth of approximately ¾ of an inch (2 cm):
  - It is more comfortable, significantly less invasive, convenient and only takes approximately 2 minutes of the individual staff members' time,
  - It will be completed on-site by the staff member prior to beginning their scheduled shift under the observation of the site designate,
  - It is required by the Ministry of Health as an additional precautionary action up to 3 times a week based on the individual staff members' FTE,
  - Results of the screening are available within 15 minutes, and
  - A positive result does not mean the staff member has the COVID-19 virus; further assessment with a COVID-19 test at a public health clinic will be required to determine if the staff member has the virus.

See Section 4.9 Above for Process Resources as well as additional specific Staff Process Resources below:

IH:

- **NEW** LTC AL Hospice Staff COVID-19 Rapid Antigen Test Recording Log
- **NEW** PANBIO Rapid Antigen Testing – Weekly Usage Log for Staff Testing

Partners:

- **NEW** LTC AL Hospice Staff COVID-19 Rapid Antigen Test Recording Log
- **NEW** PANBIO Rapid Antigen Testing – Weekly Usage Log for Staff Testing

4.12 Patient Ambassador/Screener/Greeter Job Descriptions (For IH O&O)

A new job description has been created for the position of Patient Ambassador (also known as greeter or screener). Their primary role is to greet and engage with all individuals entering the building; such as, visitors, employees and contractors to ensure their attendance at the site is essential and to ensure non-essential visitors understand entrance restrictions. This position supports the safety of residents and clients, their families and staff, by communicating information to visitors about limits in a thoughtful and informative manner.

Please Note - Long-term Care/Assisted Living:

- Patient Ambassador positions are approved for 18 months
- Funding questions regarding this position are covered in the following document:

IH: Questions & Answers Long-Term Care and Seniors' Assisted Living Facilities – Easing Visitor Restrictions

Partners: Questions & Answers Long-Term Care and Seniors' Assisted Living Facilities – Easing Visitor Restrictions

4.13 Interior Health i-Learn Job-Ready Orientation Curriculum to Support the New IH Patient Ambassador/Screener/Greeter positions

A new IH i-Learn curriculum has been developed to support onboarding of employees being hired to fill the newly created positions of the Patient Ambassador (also referred to as: Screener or Greeter).
As of Oct 27, 2020, IH Managers can assign the new curriculum to the employee (Curriculums # 231, 232, and 233) and the program will be uploaded to the employee learning opportunities.

Please note: Managers need to direct the employee to open i-Learn #2800 first to access the program outline, instructions and validation process for the Orientation Curriculum.

IH Only: Manager's Checklist - Screener/Greeter/Patient Ambassador Orientation - October 27, 2020

5.0 UPDATED - Single Site Transition Framework

5.1 Single Site Order

Please be advised that **effective July 21, 2021**, there have been changes to the list of the classes of occupations that are exempted from the Single Site Staffing Order and the infection control requirements for these individuals when they are working in your facility.

In the event that a COVID-19 Outbreak is declared at your facility all exemptions will be suspended and additional control measures will be put into place. Please refer to the chart below for the most up to date list of exemptions:

biomedical engineers	medical laboratory technologists	podiatrists
certified foot care nurses	medical students	psychiatrists
critical delivery persons	music therapists	psychologists
critical facility managers/leaders	nurse practitioners	psychometric technicians
dental hygienists	nursing students	recreation therapists
dentists	occupational therapists	Red Seal chefs and cooks
dieticians	occupational health and safety specialists	regular and biochemical waste removal people
first responders	paramedics	rehabilitation attendants
***home health, including home support workers **in assisted living only** (contingent on information below)	pharmacists	resident physicians
immunizers	pharmacy technicians	respiratory therapists
infection control practitioners	physicians	social workers
inter-facility transport staff	physiotherapists	speech language pathologists
medical laboratory assistants	plant operators and trades people	wound care nurses

*Home Support Workers that are providing services in Assisted Living facilities **ONLY,** are exempted as a class of employee. This is conditional on the fact that every effort is made by the scheduling departments to schedule the same Home Support Worker for each Assisted Living facility, and minimize the occurrence whereas Home Support Workers are working at more than one Assisted Living facility for the duration of the COVID-19 pandemic.

NEW - Provincial Health Officer Order - July 28, 2021 permits fully vaccinated staff to work in health authority assigned site clusters to promote and support sites through the summer months to reduce staffing shortages; review the new Provincial Health Officer Order and the Ministry of Health guidance for the supporting creation of the facility clusters below:

NEW - Provincial Health Officer Order – **July 28, 2021**
NEW – MoH and Provincial Health Officer Guidance on the Creation of Facility Clusters – **July 28, 2021**

All service providers and other individuals that enter your site need to follow best practices with Personal Protective Equipment (PPE), hand hygiene and social distancing while in your Care Facility.

Due to the wildfire concerns throughout the Interior Health Authority regions the following update has been applied to the single site orders:

IH: July 21, 2021 - Single Site Order – COVID-19 – Emergency Exemptions for Evacuations
Partner: July 21, 2021 - Single Site Order – COVID-19 – Emergency Exemptions for Evacuations

Please review the Infection Prevention and Control Requirements for COVID-19 in Long-term Care and Seniors' Assisted Living **(Updated May 5, 2021)** and ensure that you are aware of the most up-to-date requirements.

In addition to the standard requirements, the following are conditions required for all exempted individuals:

- The Care Facility will ensure that the exempted individuals/employees follow all required infection control precautions, including donning and doffing of PPE, hand hygiene, appropriate use of PPE, social distancing, environmental cleaning and respiratory etiquette.
- The Care Facility will provide education and training on infection control processes and applicable policies and procedures to the exempted individuals/employees, and will assess the exempted individuals/employees comprehension and implementation of infection control measures, PPE use and all facility policies.
- The Care Facility will monitor the adherence with the infection control measures and all expectations as set out in policy.

The best practices and conditions for exempted individuals are designed to protect the vulnerable persons in care at your facility.

IPAC Resources:

BCCDC: COVID-19 Additional PPE Poster

IH: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(Updated July 6, 2021)**

Partner: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(Updated July 6, 2021)**

IH: Donning and Doffing PPE for COVID-19 Instruction and Video

IH Only: 4 Moments of Hand Hygiene

BCCDC: How to Wear a Mask

BCCDC: COVID-19 Environmental Cleaning Guidelines

Questions regarding exemptions: singlesitefeedback@interiorhealth.ca

Questions regarding other operational issues: licensingdirect@interiorhealth.ca

Links to Single Site and Staff Assignment MoH directives:

April 10, 2020 Single Site Transition Framework

April 15, 2020 Facility Staff Assignment Order

NEW May 16, 2021 HCAP Practicums – Variance of the Facility Staff Assignment Order

5.2 Enforcement Action

In the event that compliance cannot be achieved through other progressive enforcement means, Environmental Health Officers, Licensing Officers, Tobacco Enforcement Officers and/or Medical Health Officers may issue tickets, orders, and/or proceed to court action, in order to achieve compliance and protect public health.

Full update: Enforcement Action-Minimizing environmental health risks: orders

5.3 UPDATED - Hair Salon Services

Long-term Care Sites (LTC)

- **As of July 19, 2021, All hair stylists must be fully vaccinated to provide services in LTC/AL and Hospice facilities**
- Hair stylists are screened and follow the precautions outlined by Work Safe BC for personal services (i.e. both persons in care and Hair stylists wear a mask).
- The Work Safe BC Covid-19 Safety plan must be completed, reviewed and approved by the Manager of the LTC Facility and posted outside the hair salon for the persons in care to view.

- Hair stylists must comply with the Single Site order:
  - Same hair stylists for a facility, versus multiple different hair stylists, AND
  - The hair stylist is designated to a single site facility (hair stylists can work in a salon, just not in multiple LTC sites).
  - One hair stylist is permitted for a campus of care, i.e. the same hair stylist provides services to LTC and AL clients.

Assisted Living (AL):

AL clients can either make appointments at hair salons or attend in-facility to the single hair stylists arranged by and designated by the AL.

- Clients making appointments at community based hair salons should be instructed to wear a mask while at the salon and request that their hair stylists wear a mask too.
- For Clients opting to attend in-facility hair stylists, a hair stylist can come in the AL facility provided they:
  - Are **Fully Vaccinated (New Requirement: July 19, 2021)**
  - Are screened and follow the precautions outlined by Work Safe BC for personal services (i.e. both client and hair stylists wear a mask).
  - One hair stylist is permitted for a campus of care, i.e. the same hair stylist provides services to LTC and AL clients.

5.4 Dental Hygienists/Dentists

Dental hygienists and Dentist are exempted from the Single Site Order and the Infection Control Order Exemption.

5.5 UPDATED - Foot Care Services

Effective July 19, 2021 - All Certified Foot Care Nurses must be fully vaccinated to provide services in any LTC/AL or Hospice facility.

5.6 UPDATED - Personal Service Providers

Effective July 19, 2021 – All Massage, reflexology, and private paid companions must be fully vaccinated to provide services in any LTC/AL or Hospice facility.

5.7 Public Trustees

Public Trustees are not permitted at this time. We recommend that the PG&T work with the on-site social worker (or on-call) to document client belongings if a client is deemed incapable.

5.8 Student Placement Strategy

Student placements and practicums are allowed to continue in LTC/AL and Hospice facilities during the COVID – 19 pandemic as long as all students are following all PPE and IPAC precautions in place in the facility to ensure the safety of students, staff and clients.

The Planning Board for Health and Medical Education (PBHME), representing the Ministry of Advanced Education, Skills and Training (AEST) and Ministry of Health (MoH) recognizes the impact of the COVID-19 pandemic on the education and health-care sectors. While the rationale for disruption to routine processes and practices is clear, both ministries would like to emphasize the continued importance of practice education/ clinical placements in supporting the health system and student learning (BCCDC Student Practice Education Guideline for Health-Care Settings during the COVID-19 Pandemic).

To further clarify, the Facility Staff Assignment Order (April 15, 2020) as it pertains to students and faculty – please see below information from the PHO as of April 29, 2020:

- The Order only pertains to sites named within the document and does not apply to acute care or community settings (and no plans to expand upon the Order at this time).
- Students and faculty can participate in clinical placements in Non-Order sites (e.g. community and acute sites) while at the same time being in an employment/ volunteer/ other role in a facility named in the Order (e.g. LTC/ Assisted Living/ Provincial Mental Health Facility) and vice versa.
- Students and faculty are NOT able to hold dual roles within sites covered under the Order (e.g. two separate LTC sites).
- There is NO requirement for students and faculty to complete a 14-day self-isolation period before moving to/ from a site within/ outside of the Order (and vice versa), UNLESS they have illness symptoms and/ or have come from a facility that has experienced an outbreak.
- Students and faculty should complete a self-assessment using the provincial self-assessment tool prior to each shift to ensure they are asymptomatic.

As per IHA Memo May 7, 2020 Posting and Recruiting Information - Single-Site Order Sites:

Q. Are student placements still allowed at affected sites?

A. Yes. Students can participate in clinical placements in non-Order sites (e.g. community and acute sites) while at the same time being in an employment/ volunteer/ other role in an affected site named in the Order (e.g. LTC/ Assisted Living/ Provincial Mental Health Facility) and vice versa.

5.9 Guidance for External Contractors

Non-essential repairs are not permitted. Essential repairs are permitted. Phone, internet and cable installers are permitted, as these are considered essential for communication.

5.10 Movers

Movers are permitted to move clients in/out of LTC and AL, ensuring infection prevention and control measures are in place.

5.11 Regional Knowledge Coordinators for Complex Behaviours are now providing On-site Consultations for High Risk Residents

Since April, the Single-Site Order has restricted Regional Knowledge Coordinators for Complex Behaviours (RKC-CBs) from entering multiple sites. IH Medical Health Officers recently approved a proposal to allow RKC-CBs to perform on-site consults for high-risk residents, without the need to go through the Single-Site Exemption Process. The site requesting the consultation will work directly with the appropriate RKC-CB to coordinate the on-site visit, including ensuring the resident meets the criteria of high risk and that all necessary precautions are in place.

For the steps to request a consultation:

IH: Consultation Process

Partners: Consultation Process

6.0 Logistics

6.1 Nasopharyngeal Swabs

Labelling of Nasopharyngeal Swabs for COVID-19 testing for HCWs in LTC/AL/Hospice:

- All specimens (cylindrical tube) must have an attached label with:
  - Patient name
  - PHN or Date of Birth (DOB)
  - Specimen type (e.g., NP swab)
  - Date & time of collection
- Please add one of the following codes to the specimen label:
  - HCW1 – Health Care Worker – Direct Care
  - HCW2 – Health Care Worker – Non Direct Care
  - LTC – Long-term Care Facility
  - OBK – Outbreaks, clusters or case contacts
  - HOS – Hospitalized
  - CMM – Community or Outpatient, including Urgent and Primary Care Centres
  - CGT – People living in congregate settings such as work camps, correctional facilities, shelters, group homes, assisted living and seniors' residences.
  - TREEPL – Tree planters
  - SCHOOL – People attending school in-person including students, teachers and support staff

To order swabs, please contact: SwabsCOVID@interiorhealth.ca

6.2 Virology Requisition Form

A sample BCCDC virology requisition form may be found here: Virology Requisition

6.3 Interior Health COVID-19 Testing & Assessment Centres

Location	Facility	Address	Phone Number	Testing Times
100 Mile House	South Cariboo Health Centre	555D Cedar Ave.	250-395-7637	M - F: 1 – 3 p.m. Weekends: 1 - 2 p.m.
Ashcroft	Ashcroft Hospital and Community Health Care Centre	700 Ash-Cache Creek Hwy	250-453-1905	M, W, F: 1 - 2 p.m.
Cranbrook	Health Unit Centre (Rocky Mountain Lodge)	20 23rd Ave. S	250-417-9252 or 250-919-8406	M - Sat: 10 a.m. - 4 p.m.
Creston	Creston Valley Hospital	312 15 Ave N	250-254-2055	M, W, F: 3 - 4 p.m.

Enderby	Enderby Health Centre	707-3rd Avenue	250-838-2450	M – F: 9 a.m. - 11 a.m.
Golden	COVID-19 Testing Location @ Golden and District Hospital	835 9th Ave. S	250-344-5271	M – F: 2 p.m. – 4 p.m. Weekends: 8 - 10 a.m.
Grand Forks	COVID-19 Testing Location @ Boundary District Hospital	7649 22nd St.	250-443-2120	8 a.m. - 8 p.m.
Kamloops	Urgent Primary Care and Learning Centre	102-311 Columbia St.	250-314-2256	F - Sat: 4:30 p.m. – 8:30 p.m.
Kamloops	Kamloops CD Unit (Drive Thru)	519 Columbia St.	250-851-7467	M: 1 - 4 p.m. T-F: 9 a.m. to 12 p.m.
Kelowna	Urgent and Primary Care Centre	1141 Harvey Ave.	250-469-6985	9:30 a.m. – 8:30 p.m.
Lillooet	Lillooet Hospital & Health Centre	951 Murray St.	250-256-1381	M, W, F: 9 a.m. - noon T, T: 11 a.m. - 2 p.m.
Merritt	Nicola Valley Hospital and Health Centre	3451 Voght St.	250-378-3407	M, W, F: 12:45 - 2:15 p.m.
Nelson	Kootenay Lake Hospital	3 View St.	250-551-7500	8:30 a.m. - 4:30 p.m.
Penticton	Penticton Regional Hospital	550 Carmi Ave. (access off Industrial Avenue)	250-770-3434	M - Sat: noon - 4 p.m. including stat holidays

Location	**Facility**	**Address**	**Phone Number**	**Testing Times**
	Health Centre			noon T, T: 11 a.m. - 2 p.m.
Revelstoke	Revelstoke Health Center	1200 Newlands Rd.	250-814-2230	9:30 - 11:30 a.m.
Salmo	Salmo Wellness Centre	413 Baker Avenue	250-608-6174	W: 8:30 a.m. - 2:30 p.m.

Salmon Arm	Salmon Arm CD Unit Centre	851 - 16th St. N	250-833-4100	M – F: 1:30 p.m. - 4:30 p.m. Weekends 9:30 a.m. – 12:30 p.m.
Sparwood	Sparwood Health Centre	570 Pine Ave.	250-425-3777 (Health Centre)	1 - 3 p.m. (except Wed and Sat)
Trail	Kiro Wellness Centre	1500 Columbia Ave.	250-304-5210	M - Sat 8:30 a.m. - 12:30 p.m.
Vernon	Urgent and Primary Care Centre	101-3105 28th Ave.	250-541-1097	9 a.m. – 1 p.m.
William s Lake	Collection Centre near Cariboo Memorial Hospital	525 Proctor St. (access via 7th Ave. to parking spots 59, 60, or 61)	250-302-5006	Mon: 1:30 p.m. - 4:30 p.m. Tues.-Fri: 10 a.m. - 12 p.m.

6.4 First Nation Health Service Organizations COVID-19 Testing & Assessment Centres

Interior Health is collaborating with First Nation Health Service Organizations who would like to implement COVID-19 testing within their community. The principle of this work is to ensure that access to testing is available for those presenting with symptoms and who live in remote and rural First Nation communities. Testing at First Nation Health Service Organizations is by appointment. Please call to determine testing times and to determine eligibility to access testing.

Location	Facility	Address	Phone Number
Coldwater	Scw'exmx Health Services	103-2090 Coutlee Ave Merritt	250-378-9745
Lytton First Nation	Lytton First Nation		250-256-8182
Nooaitch	Scw'exmx Health Services	103-2090 Coutlee Ave Merritt	250-378-9745
Okanagan Indian Band Community Services and Development		76 Head of Lake Road, Vernon	250-542-5094 or 236-600-0242
Penticton Indian Band	Snxastwilxtn Centre “A Place to Heal”	198 Outma Sqilx’w Place	250-493-7799
Shackan	Scw'exmx Health Services	103-2090 Coutlee Ave Merritt	250-378-9745
Splatsin	Splatsin Health Centre	5775 Old Vernon Road	250-838-9538

Tlesqox/Toosey	Toosey Clinic	36 Raven Rd Toosey, Riske Cr	250-659-5655
Ulkatcho/Anahim Lake	Anahim Lake Nursing Station	6674 Clinic Lane	250-742-3305
Yunesit'in/Stone	Yunesit'in Health Clinic and Government Office-	6678 Taseko Rd Hanceville	250-394-4041

6.5 Ordering and Placement for Floor Decals, Wall Signs, and Protective Barriers *(Applicable to Interior Health Owned, Operated Sites)*

The following information is provided for direction on the procurement and implementation of decals, signage, and a reminder regarding protective barriers to support COVID-19 ongoing response planning.

Ordering Decals and Signage:

New Interior Health decals, using improved materials and signage, have been designed and sourced through Supply Chain.

These can be ordered by emailing the below information to Kevin.McKinnon@phsa.ca:

- Delivery Site
- Contact Name
- Total number of each (floor decals and wall signs) requested
- Cost Centre

For Leased sites, please submit your request to Sarah.Dewolfe@interiorhealth.ca

6.6 Signage

BCCDC Link to All: COVID-19 Signage and Poster Resources

BCCDC COVID-19 Physical Distancing Poster

BCCDC COVID-19 Additional PPE Poster

Facility Entry Poster - COVID-19 Symptoms

Droplet & Contact Precautions

Poster - Be Kind

IH Only: 4 Moments for Hand Hygiene

7.0 Infection Control Practices

7.1 Hand Hygiene

Hand hygiene (hand cleaning) is the single most important procedure for preventing the spread of healthcare associated infections.

Hand Hygiene Resources:

- Infection Prevention and Control Hand Hygiene Guidelines
- Hand Hygiene Policy
- BCCDC Hand Hygiene Poster
- IH only: 4 Moments of Hand Hygiene

7.2 Enhanced Cleaning Measures for COVID-19

When to Use Gloves with Cleaning Agents

Interior Health's Glove Selection Guide has been updated to reflect the recent direction with respect to glove use; specifically, glove use with Accel Intervention/Prevention and Oxivir TB/Plus **ready-to-use** wipes or solutions.

Please pay particular attention to the following:

- Accel Intervention/Prevention and Oxivir TB/Plus **ready-to-use wipes or solutions do not require glove protection for short duration of use (**e.g., less than 5 minutes) in non-clinical setting with no blood or bodily fluid exposure. Hand hygiene is recommended after use.
- Many gloves listed in the 'Selection Guide for Non-sterile Exam Glove' have been substituted with ones from other manufacturers/brands.
- IH: Selection Guide for Non-Sterile Exam Glove
- Partner: Selection Guide for Non-Sterile Exam Glove

For any questions regarding the safe use of substituted gloves, refer to the Product Change Notice that is sent to managers.

In addition to the routine "all-hazard" based regular cleaning schedules, housekeeping staff across Interior Health cleans high-touch surfaces twice daily, as per the BCCDC Environmental Cleaning and Disinfectants for Clinical Settings guideline (*High touch, or frequently touched surfaces – such as door knobs, bathrooms, charts, medical equipment – are those that have frequent contact with hands and require frequent cleaning*).

Please be aware, overall demand on Housekeeping will exceed our resources; therefore, all staff will need to do their part. It is the expectation that all staff in contact with patients, clients and clients will assist with enhanced cleaning of high-touch surfaces and equipment in the patient environment and between patients.

For guidelines on enhanced cleaning and disinfection of equipment to help prevent transmission of COVID- 19:

IH: Standard Operation Procedures (SOP) Novel Coronavirus (COVID-19) Cleaning Specifications.

Partners: BCCDC COVID-19 Environmental Cleaning Guidelines

Cleaning Process

As a reminder, staff should follow this three-step process when cleaning:

Step 1: Clean

- Perform hand hygiene, put on gloves, and use one side of a disinfectant wipe to remove any foreign matter from surface(s) using friction (rub/scrub motion). Note: A large piece of equipment will require a cloth and liquid disinfectant (Oxivir Plus concentrate) versus the use of multiple disinfectant wipes.

Step 2: Disinfect

- Turn the disinfectant wipe over for a second pass to apply disinfectant. Allow surfaces to remain wet for the necessary 'contact time,' as written on product label. Avoid electronic connectors to prevent malfunction
- Remove and dispose of gloves, clean hands with Alcohol Based Hand Rub (ABHR) or soap and water.

Step 3: Dry

- Let surface air dry.

IH Approved Cleaners & Disinfectants Effective Against COVID-19

- Accel Intervention wipes - 1 min contact time
- Accel Prevention wipes - 3 min contact time
- Oxivir plus concentrate (used primarily by Housekeeping) - 5 min contact time
- Complete 6000 wipes - used only for C. difficile disinfection and to clean CADD®-Solis lockboxes - 5 min contact time

Follow instructions on the product label for appropriate personal protective equipment and contact time or refer to the Safety Data Sheets.

7.3 Care Packages for LTC Clients / Deliveries Patients, Clients and Staff - Guidelines

Clients may receive care packages of food, clothing, and treasured personal or cultural items.

These items can be delivered by essential, social or end of life visitors. To ensure the safety of individuals in care, visitors, and staff, Interior Health does not encourage delivery of packages. However, we understand that some items (for example, food, clothing, fresh flowers and plants - updated - April 1, 2021, and treasured personal or cultural items) may be essential or necessary for the individual's wellbeing.

Care packages will require sanitization; follow your site-specific process for this.

If staff has concerns about the type, frequency, or number of items being delivered, they can consult with the individual's Most Responsible Provider (MRP) to ensure the items meet the criterion of essential or necessary for wellbeing.

To the extent possible, non-food items should be wiped with disinfectant wipe, and/or cleaned appropriately for that item before being provided and used by the individual or patient. See the BCCDC Cleaning and Disinfecting Guidelines.

Reminder for Staff receiving deliveries for themselves

Deliveries for staff should follow the same guidelines as above for patients and clients. Food deliveries can be accepted by staff but should be minimized to the extent possible. This update rescinds the IH memos of April 2, 2020, All Food Delivery Services Suspended until Further Notice, and May 8, 2020.

Reminder – Non-Essential Delivery Services Remain Suspended.

It is the responsibility of the staff member or physician who ordered food from a delivery service to meet the delivery person outside of any IH sites. Delivery people will not be permitted to enter any IH facility. It is not the role of the greeters to handle food deliveries.

7.4 Food Service, Delivery and Pick-Up for COVID-19 Suspect/Positive Cases

As per BCCDC: Infection Prevention and Control Requirements for COVID-19 in Long-term Care and Seniors' Assisted Living - June 30, 2020:

- If there are suspected or confirmed cases of COVID-19 in the facility, serve clients individual meals in their rooms while ensuring adequate monitoring and supervision of those clients.
- If in-room meal service is not possible, serve asymptomatic clients first, clean the dining area, and then serve symptomatic clients.
- Food services staff should not enter dedicated COVID-19 cohort units or rooms with clients with suspected or confirmed COVID-19. Leave food trays outside the unit/room and notify client care staff.
- Use regular, reusable food trays, dishes and utensils for all clients. Disposable dishes are not required to stop COVID-19.
- Staff must clean their hands prior to delivering food trays.
- Food trays are delivered individually.
- Staff must clean their hands after leaving client areas, units or floors when delivering and picking up food trays.
- Gloves are not required when delivering or picking up food trays. If gloves are worn, staff must change gloves prior to leaving COVID-19 units. Proper hand hygiene must be performed after removing gloves.
- Do NOT bring food carts into client rooms or within 2 meters of clients in dining rooms.
- Do NOT transport food on carts that have used dishes on them (i.e. carts used to deliver meals cannot be used to pick up used dishes at the same time).
- Regularly clean and disinfect carts used for transporting food between meal service and after picking up used dishes.
- Clean and disinfect cart handles before entering and after leaving each client area, unit or floor.

7.5 Staff Change Rooms/ Changing of Clothes

All employees and medical staff who are providing direct care to patients, clients, and residents are **strongly encouraged** to:

- Come to work in clean scrubs and shoes you have identified as work use only.
- If you work in an area with site-issued uniforms/scrubs, please continue that practice, ensuring you change into them at work and are also using shoes that you have identified for work use only.
- Change into clean regular/civilian clothing and shoes before you leave your work site.
- Transport your used uniforms/work designated clothes home in a plastic bag and launder immediately.
    - Site-issued uniforms/scrubs are not to be removed from the site and should be placed in the provided laundry hampers for cleaning.

- Shower at work or immediately at home.

Community Health Workers

- To support social distancing and infection prevention practices, consider not returning to the office between visits.
- Consider use of IH fleet vehicle when available versus personal vehicles and disinfect hard surfaces of vehicle interior before/after use. **IH Only**: See the Fleet Vehicles and COVID-19 for further guidance.
- If you are starting work from home, ensure you start in uniform/scrubs or clothing and shoes you have identified for work use only and launder immediately when you return home.
- Wait in vehicle if there is less than an hour between visits. Do not congregate in office spaces where social distancing cannot be practiced.
- Wipe down shoes with disinfectant wipes after a visit with a client who has had a positive screen (case or contact) to COVID-19 prior to your next visit.
- Tie back hair that is below shoulder length.
- Adhere to the Hand Hygiene Policy and review section 4.4: Nails, Jewelry and Clothing. Nail polish and artificial nails are not to be worn.

At Home Laundering For Personal Scrubs and Work Clothing

- Handle carefully and avoid shaking.
- Wash with regular laundry detergent and hot water (60-90°C). All linen and clothing should be mechanically dried. Ensure that all items are completely dry.
- Be sure to wash hands with soap and water thoroughly after handling dirty linen, even if gloves were used.
- Dispose of plastic bag that scrubs were transported home in.
- For linen from persons suspected of having COVID-19, clean and disinfect clothes hampers and baskets. If possible, consider placing a bag liner that is either disposable or can be laundered.
- Clothing and linen belonging to someone suspected of having COVID-19 can be washed with other laundry.

Employees and medical staff should review the guidelines found in the Staff Safety for Health-care Workers infographic.

Partner: Staff Safety for Health-care Workers Infographic

7.6 Common Areas, Break Rooms and Physical Distancing – Guidelines

The health and safety of our employees and medical staff remain paramount in all areas of the facility. To support ongoing physical distancing requirements and PPE requirements, all employees and medical staff must review Guidelines on Common Areas, Break Rooms and Physical Distancing for COVID-19 and ensure all actions are in place.

Partners: Break Rooms and Physical Distancing Poster

7.7 Safer Celebrations – Tips for Holiday Decorations and Gatherings

The change of seasons is a time to recognize holidays and spread joy among colleagues, family, and friends. Workplace holiday decorating and celebrations may look a little different this year, but with a little creativity, we hope everyone can find ways to enjoy the coming season.

Please abide by your site safety plans in adopting a reasonable and safe approach to decorating and celebrating at your workplace. Below are some suggestions for ways to celebrate, as well as guidance on how we can keep each other safe during this time of year.

Tips for Safer Celebrations in the Workplace

- Consider virtual options for celebratory activities.
- Ensure holiday celebrations are inclusive amongst work sites and types of celebration.
- Avoid any events that may involve sharing food (e.g., cookie exchanges, potlucks, cookie or gingerbread decorations).
- Be creative! Engage your team in ideas for safe celebrations (e.g. virtual team photo using Elf Yourself or JibJab, virtual holiday bingo, virtual holiday trivia, virtual baking contest).
- Follow capacity limits in meeting rooms and maintain physical distancing.

Considerations for Holiday Decorating

- Wash hands or use hand sanitizer often.
- Disinfect all surfaces before and after decorating (decorating surfaces makes it difficult to clean properly).
- Maintain physical distancing and keep groups small.
- Where possible, reduce the number of decorations.
- Do not use decorations that invite interaction or touching (e.g., props that move).
- Use decorations that can be put up and then left alone.
- Avoid multiple people touching the same decoration. One person – one decoration.
- Each person should have their own individual supplies to use while decorating (e.g., tape, scissors).
- For specific details on safe holiday decorating:

IH: IPAC Recommendations for Holiday Decorations and Activities; October 30, 2020

Partner: IPAC Recommendations for Holiday Decorations and Activities; October 30, 2020

7.8 IPAC Recommendations for Holiday Decorations and Activities; October 30, 2020

To provide guidance for the selection, display and storage/handling of holiday decorations to all health care setting (acute, long-term care or community) in Interior Health.

Please note:

- As of April 1, 2021 Residents and tenants are permitted to have live flowers and plants in their rooms/suites.

Decoration Selection:

- Choose decorations that can be easily cleaned and disinfected
- Old, dirty, worn, or damaged decorations should be discarded

Decoration Display:

- Ceiling tiles are not to be lifted or compromised in order to hang decorations or signs
- Keep nursing stations and other work surfaces clear to allow for Housekeeping to clean and disinfect
- Live trees (with or without soil) and artificial trees should not be used in patient care areas. Artificial trees may be placed in public spaces (e.g. main lobbies)

- Decorations in health care setting such as waiting rooms and public areas should be reduced as much as possible to allow for proper environmental cleaning and placed in an area or cordoned off to avoid touching and contamination via droplets.

Do not place decorations in the following areas:

- Clean and dirty utility rooms
- Medication rooms
- Treatment/procedure rooms
- Medical device reprocessing areas or any area used for sterile supply storage
- Operating theaters
- Do not place decorations on the floor
- Do not place decorations on high touch areas (e.g. Door knobs, light switches)
- Outdoor decorations are permitted. Maintain physical distancing when displaying

Storage and Handling

- Store in a sealed lidded plastic container to minimize accumulation of dust
- Clean decorations with hospital grade disinfection wipes prior to storage and prior to being displayed
- Avoid multiple people touching the same decoration. One person – one decoration (maintain physical distancing when displaying)
- Hand hygiene should be performed before and after handling decorations

Costumes, Special Character Visits & Activities

- Costumes worn by staff in patient care areas must still allow for hand hygiene compliance,
- Effective donning and doffing of PPE and not compromise aseptic technique in any way.
- Please refrain from sharing food
- Toys must be in compliance with the IPAC Toy Management Guideline
- Santa, clowns etc. must have visits approved and coordinated prior to day of visit and they must Adhere to the following measures while on site:
    - Strict adherence to hand hygiene guidelines before and after patient contact
    - Wear a mask
    - No patient contact with costumes or costume gloves
- No entry into isolation rooms
- Compliance with annual Influenza vaccination is required. The event coordinator must confirm that the provider has received the annual influenza vaccination
- No visiting if ill. Must meet the COVID-19 screening process

IH: IPAC Recommendations for Holiday Decorations and Activities; October 30, 2020

Partner: IPAC Recommendations for Holiday Decorations and Activities; October 30, 2020

7.9 IPAC Recommendations for Flower Delivery in LTC/AL

- Effective April 1, 2021 all LTC/AL facilities can accept flower deliveries. Continue to use established processes for receiving deliveries. Clean and disinfect vase/pots with disinfectant wipes as appropriate for that item.
- Designated social/essential visitors can give flowers directly to residents/clients after vase/pot has been appropriately sanitized.

- Delivery services are to leave flowers with greeters and the facility will be responsible for further dissemination to the resident/client.
- Consider placing floral arrangements in locations that are not high touch locations to support cleaning done by environmental services. Once vase/pots are no longer needed store or dispose of them as appropriate to support minimal clutter and enhanced cleaning measures.
- During outbreaks, flowers deliveries will be suspended for the duration of the outbreak.

8.0 Personal Protective Equipment

8.1 UPDATED - PPE Risk Assessment Guideline during COVID-19 Pandemic

To prevent potential exposures to COVID-19, and all communicable diseases, it is important you do your part to ensure the correct personal protective equipment (PPE) is used. An overview of the most up-to-date information that is in alignment with Provincial Guidelines of the use of PPE across Interior Health **(July 6, 2021)** can be accessed here:

IH: PPE Risk Assessment Guideline during COVID-19 Pandemic **(July 6, 2021)**
Partners: PPE Risk Assessment Guideline during COVID-19 Pandemic **(July 6, 2021)**
Questions about this guideline: Infection Prevention and Control Contact List (July 2020)

Interior Health

PPE Risk Assessment Guideline during COVID-19 Pandemic

Last Update: July 6, 2021
Revision History

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For questions about this guideline, please contact: Infection Prevention and Control Practitioners

Point of Care Risk Assessment (PCRA) should guide the choice of PPE

A point of care risk assessment (PCRA) assesses the task, the patient and the environment, based on the patient's history and presentation. A PCRA is a dynamic risk assessment completed by the Healthcare worker (HCW) before every patient/resident interaction in order to determine whether there is a risk of being exposed to an infection.

The PCRA will help determine the correct PPE required to protect the HCW, and to prevent the spread of pathogens. Access to additional PPE, such as respirators, will be provided in circumstances where a HCW determines there is elevated risk of COVID-19 transmission through patient/resident interaction.

Appropriate use of PPE supply continues to be the single most important element to ensuring both staff and medical staff safety and conserving our PPE supply in BC. We ask that you continue to use PPE responsibly, according to the below guidelines. Managers/supervisors/staff should ensure those utilizing PPE are properly trained on the appropriate procedures prior to use (e.g. donning, doffing, fit testing).

IMPORTANT:

- During COVID-19, routine practices include medical mask and eye protection for all direct patient interactions.

1) ASSESS SYMPTOMS:

Does the patient have any ONE of the following key symptoms of COVID-19?	Does the patient have any TWO of the following symptoms for more than 24 hours?	
☐ Fever or chills?	☐ Sore throat?	☐ Loss of appetite?
☐ Cough?	☐ Extreme fatigue or tiredness?	☐ Headache?
☐ Difficulty breathing?	☐ Body aches?	☐ Nausea or vomiting?
☐ Loss of sense of smell or taste?	☐ Diarrhea?	

NOTE: **Symptoms should be new or worsening**, i.e., unrelated to or exacerbation of a known pre-existing medical condition (e.g., allergies) or other circumstance (e.g., muscle ache from overexertion or injuries). If it is unclear or unknown whether the patient has a symptom, proceed with the "Yes" options. **In case of clinical suspicion for COVID-19 healthcare provider can order test regardless of the number of symptoms.**

Interior Health

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PPE Risk Assessment Guideline during COVID-19 Pandemic General Care - Table 1

NO DIRECT PATIENT / CLIENT CARE*	Hand Hygiene (pre/post)	Gown[1]	Gloves[2]	Respiratory Protection		Eye Protection	Head Cover	Signage
				Procedure Mask[3]	N95 Respirator			
Long Term Care & Assisted Living Entering resident room or within 2m of resident	✓	×	New! If based on PCRA	✓	×	✓	×	None
Health Care Facilities or Areas Where Health Care is Provided Including common areas and breakrooms	✓	×		✓	×	×	×	None
Patient Care Unit No work in patient rooms (e.g. unit clerks)	✓	×		✓	×	×	×	None
Patient Areas (Support Staff) Work involves patient rooms	✓	×		✓	×	✓	×	None
COVID-19 Unit / Outbreak Unit All persons within unit, regardless of distancing	✓	×		✓	×	✓	×	None
DIRECT PATIENT / CLIENT CARE* (within 2 metres)	**Hand Hygiene (pre/post)**	**Gown[1]**	**Gloves[2]**	**Respiratory Protection**		**Eye Protection**	**Head Cover**	**Signage**
				Procedure Mask[3]	**N95 Respirator**			
COVID-19 Immunization Clinics	✓	×	New! If based on PCRA or on additional precautions	✓	×	✓	×	None
NO COVID Diagnosis is suspected	✓	×		✓	×	✓	×	None
Respiratory Symptoms (Non-Infectious) as per physician assessment	✓	×		✓	×	✓	×	None
Respiratory Symptoms (Non-COVID) until other infectious etiology excluded	✓	✓		✓	×	✓	×	Droplet & Contact
Known or highly suspected COVID (i.e., awaiting testing) patient ∞	✓	✓		✓	×	✓	×	Droplet & Contact Enhanced PPE
AEROSOL GENERATING MEDICAL PROCEDURES (AGMP) NON-INTUBATION See APPENDIX 1 - AGMP Categories								
Asymptomatic (Non-COVID) with (AGMP)	✓	×	New! If based on PCRA or on additional precautions	✓	×	✓	×	None
Respiratory Symptoms (Non-Infectious) as per physician assessment	✓	×		✓	×	✓	×	None
Respiratory Symptoms (Non-COVID) with (AGMP) until other infectious etiology excluded	✓	✓		✓	×	✓	×	Droplet & Contact
Known or highly suspected COVID - AGMP ∞	✓	✓		×	✓	✓	✓ (optional)	Droplet & Contact Enhanced PPE

*Additional precautions may be required based on a point of care risk assessment / room signage. (eg: C. difficile or TB)
[1] Gown selection guide [2] Glove selection guide [3] Mask selection guide For purpose of this document shoe covers are NOT PPE
∞ For air changes after AGMP, see Appendix 4 Air Changes Recommendations
Droplet/ Contact PPE: Donning PPE – Droplet & Contact Precautions / Doffing PPE – Droplet & Contact Precautions
Enhanced PPE (AGMP) : Donning Enhanced PPE – Aerosol Generating Medical Procedures (AGMP) / Doffing Enhanced PPE - Aerosol Generating Medical Procedures (AGMP)
APPENDICES: 1 - AGMP Categories, 2- Oxygen Devices, 3 - Air Changes Recommendations, 4 - Definitions

PPE Risk Assessment Guideline during COVID-19 Pandemic July 6, 2021 Revision Workplace Health & Safety, Infection Prevention and Control Return to first page

8.2 UPDATED - Patient Care PPE Guidelines

All staff must engage in 'Point of Care Risk Assessment' prior to providing care for a Resident to determine which personal protective equipment (PPE) is required.

BCCDC - Health-Professionals-COVID19_Point of Care Risk Assessment Tool.pdf

Routine Practice:

Required PPE:

- Surgical/Procedure mask with eye protection
- Gloves

Droplet and Contact Precautions

Required PPE:

- Surgical/ procedure mask with eye protection
- Gown
- Gloves

AGMP with known or suspect COVID

Required PPE:

- N95 respirator
- Head Cover
- Gown
- Gloves

*** More pieces and layers of PPE does not mean more protection**.

BCCDC: COVID-19 Additional PPE Poster

IH: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(July 6, 2021)**

Partner: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(July 6, 2021)**

IH: Donning-&-Doffing-PPE-for-COVID-19-Instruction-and-Video

Partners: 5 Steps for Putting on Personal Protective Equipment - Poster

Partners: 9 Steps for Taking off Personal Protective Equipment - Poster

BCCDC – 9 Steps for Taking off Personal Protective Equipment for Airborne Precautions (AGMP) - Poster

PHSA - Masking Requirements

BCCDC - How to Wear a Mask

8.3 PPE and ICP Guidelines for Social Visiting

BCCDC: Social visiting guidelines for Long Term-care and Assisted Living facilities - Poster

8.4 How to Access PPE Supplies

Sites are responsible for ordering their own PPE supplies. If a facility has difficulty obtaining supplies and has a supply of less than 3 days on-hand, sites are instructed to reach out to:

pandemicresponseppe@interiorhealth.ca

COVID-19 - Pandemic Response - PPE Central Supply Hub Master Contact List (Sept 25, 2020)

Regular PPE from Known Supplier

The Provincial Health Services Authority (PHSA) Supply Chain has long-standing relationships with suppliers that provide PPE from trusted manufacturers. Item models that are already part of the Supply Chain inventory system (e.g. 3M N95 respirators) received from a known supplier can go directly to the PHSA distribution warehouses without further assessment or testing.

Product Documentation: Standard/Certification Validation

Certified PPE typically arrives with appropriate documentation, packing and markings. In the current supply chain environment, documentation from an unknown manufacturer cannot be trusted blindly. Product must be assessed to ensure documentation is valid and the product bears the appropriate labelling.

At the product documentation stage of assessment, alternative PPE (see step B), fabricated PPE (see step C) and donated PPE (see step D) will be assessed to determine if it:

• **Meets and passes all criteria**. In this case, it will move to the next stage of visual and manual inspection (see step H).

• **Is uncertain, unknown or incomplete**. In this case, it will move to the next stage of visual and manual inspection (see step H). If these products pass: visual and manual inspection, fitting characteristic assessment (see step I), as well as quantitative fit-testing (for respiratory protection only, see step J), it will still be required to undergo laboratory testing (see steps K and L).

• **Fails**. These would be cases where the product is determined to be counterfeit or misrepresenting standard/certification approvals. These products will be categorized (see step M) as Category 4 PPE (unacceptable) and will not be used in the health-care environment.

Each type of PPE has specific criteria and requirements for standard/certification or equivalency.

Distribution: Deliver to PHSA Distribution Warehouses

PHSA has distribution warehouses in Langley, Victoria, Kelowna, and Prince George. These warehouses serve as the regional supply hubs for regional/local distribution, under direction from PHSA Supply Chain.

Any PPE stored in PHSA distribution warehouses must be either known PPE from known suppliers, or PPE that has been assessed, tested and categorized (see step M) for use under the appropriate stage of the PPE Allocation Framework. To avoid sub-standard PPE making its way into the health system, there shall be no PPE in the PHSA distribution warehouses that is inappropriate for distribution to health facilities. Categorized PPE must be clearly labelled, organized and inventoried (see Step O) to ensure items outside of Category 1 are not distributed without explicit approval from the Ministry of Health.

Deliver to Health Authorities

Delivery to health authorities is managed by PHSA Supply Chain. Health authorities are responsible for identifying need (orders) to PHSA and PHSA Supply Chain, with advice from the PPE supply working group.

Health authorities are encouraged to order PPE based on needs over the next five to seven days. With scarcity of PPE and unreliability of supply chains, providing PPE stock to health authorities for more than one week is not possible.

Health authorities must have central locations to secure their PPE inventory and must allocate PPE to facilities and health-care workers based on the guidance and direction found in the Framework.

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BCCDC: B.C. Personal Protective Equipment (PPE) Supply, Assessment, Testing and Distribution Protocol

8.5 Work Place Health and Safety COVID-19 Q&A

IH Only: Workplace Health and Safety COVID-19 Immunizations Questions and Answers
For any questions, contact Workplace Health and Safety (WHS):
workplaceinjury.prevention@interiorhealth.ca

Q7. Does Interior Health endorse health care providers purchasing their own Personal Protective Equipment (PPE)?

- **Interior health (IH) does not endorse employees or physicians purchasing or procuring their own personal PPE.** In order to ensure the health and safety of health care providers, it is essential that PPE used within IH be selected and implemented according to regulatory requirements. Using PPE provided by IH helps to ensure that: it will provide you with the level of protection required; you are trained on

its appropriate use; disposal and/or cleaning/reprocessing protocols are in place; and that is appropriate for the care environment. There are specific minimum requirements for selection of gowns, masks and respirators that must be met to ensure your safety in the workplace.

- With respect to respirators, these requirements include education, hands-on training and fit testing for all respirators (except PAPRs). The Workplace Health and Safety department is actively working to implement both standard and alternate respirators across IH. In order to do this successfully and effectively utilize available resources, a targeted centralized approach is being used. Implementation of alternate PPE will be based on risk, availability and usage rates.
- The PPE shortages and backorders are universal, and PHSA Supply Chain is working closely with Health Authority stakeholders and various vendors to purchase products that are suitable for use in our healthcare environment and meet the Occupational Health and Safety (OHS) and Infection Control requirements to ensure the safety of health care providers and their patients/clients.

Q8. What if I already purchased my own eye protection, can I still use it?

- Yes, if your eye protection is CSA Z94.3 approved, latex-free and able to be cleaned and disinfected you may use it. Remember:
    - **Prescription eyeglasses are not appropriate eye protection**
    - Select close-fitting eye protection that provides maximum coverage of your eyes

- **Q9. Can we make our own procedure masks or respirators?**

Interior Health does not recommend or approve making your own personal protective equipment. There are certain standards which regulate PPE items and ensure its efficacy. For example, procedure masks are certified by ASTM F2100 standard for fluid resistance, particle filtration efficiency and bacterial filtration efficiency. Self-made masks are not certified by the standard thus they are not appropriate to use to protect staff members from being exposed to workplace hazards.

Q10. I am developing skin irritations and discomfort from wearing a procedure mask (or N95) throughout my shifts; is it ok to use a headband with notches or buttons on which to secure my mask ear loops?

We recognize that depending on the fit of your mask, it could rub the skin and start to cause irritation. Employees and medical practitioners who are experiencing or at risk of PPE related adverse skin reaction should review the recommendations for PPE related skin integrity concerns memo, the Guidelines for the use of Ear Savers, and the prevention and remediation guidelines and follow recommendations.

IH: Prevention and Remediation Guidelines; Skin Integrity Concerns Related to PPE

Partner: Prevention and Remediation Guidelines; Skin Integrity Concerns Related to PPE

BCCDC: Management of PPE-Related Skin Damage for Health Care Workers

Q11. Can I wear the same procedure mask all day? How often should I change it?

Procedure masks can be used between clients, regardless of client's COVID-19 status, as long as the mask is not removed between clients. Keep your mask on, removing and safely discarding only when it is damp or soiled or you take a break. Any time you remove your mask, replace it with a new mask. Use the same mask for interactions with multiple COVID-19 patients in the same cohort and replace when moving to non-patient care areas.

Government BC Mandatory Masking Requirements

If you need to remove the mask with shield at any time it must be discarded and replaced with a new procedure mask and eye protection.

Important: always perform hand hygiene if you touch, adjust or remove your mask.

8.6 Workplace Health and Safety – COVID-19 Immunization Questions and Answers

- IH Staff Only: COVID-19 Immunizations Questions and Answers (Jan 8, 2021)

8.7 Up-to-date Resources for Optimal Use of PPE

- Optimal Use of PPE
- IH: Safety Huddle – Appropriate use of PPE
  Partner: Safety Huddle – Appropriate use of PPE

8.8 UPDATED - Staff and Visitors Entering or Working in Long-term Care, Assisted Living and Hospice

Masking requirements for staff and visitors to LTC, Seniors' Assisted Living and Hospice facilities have been updated by the Ministry of Health **July 19, 2021**.

- **Fully Vaccinated Staff** are no longer required to wear mask or eye protection unless their Point of Care Risk Assessment determines otherwise.
- **Non-Vaccinated or Partially Vaccinated Staff** are still required to wear both mask and eye protection, at all times, in all care areas, common areas, and when moving through the building. They may only remove their mask in the break room when eating or drinking.
- **Fully Vaccinated Visitors** are required to wear a mask when moving through the building and in common areas and are allowed to remove their mask when visiting with their loved one.
- **Non-vaccinated or Partially Vaccinated Visitors** must wear a mask at all times.

Definitions:
Fully Vaccinated: Has received two doses of the Pfizer, Moderna, or Astra-Zenica Vaccine or 1 dose of the Johnson & Johnson Vaccine and are 14 days past the final dose received
Partially Vaccinated: Has received only one dose of Pfizer, Moderna, or Astra-Zenica Vaccine or is within the 14 day period following their final dose received.

Exceptions to allow for people who cannot wear a mask for medical reasons or those who cannot put on or remove a mask on their own. Infants under two years of age should not wear a mask. Please continue to practice compassion and assess other safe options for these individuals. All health care facilities must provide medical masks for all health care workers, non-clinical staff and visitors.

Key reminders

- Surgical/procedure masks should be:
  - Worn according to this poster (cover mouth and nose fully).
  - Changed if the masks become wet, damaged or visibly soiled.
  - Used for multiple COVID-19 patients in the same cohort, and replaced when moving to a non-patient care area.
- Learn about the:
  - IH: Difference between a surgical and procedure mask
  - Partners: Difference between a surgical and procedure mask

- Staff must always complete a point of care risk assessment prior to all client interactions and follow droplet and contact precautions when entering COVID-19 units or rooms on droplet and contact precautions.
- Droplet and Contact Precautions require the following PPE – Mask, Goggles/Face Shield, Gown and Gloves.

Resources:

IH: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(July 6, 2021)**

Partner: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(July 6, 2021)**

- If an airborne precautions sign is posted, wear an N95 respirator.
  - Use of a fit-tested N95 respirator is only required when performing aerosol-generating medical procedure (AGMPs) on a person with suspected or confirmed COVID-19.

- In LTC and AL settings, AGMPs on clients suspected or confirmed to have COVID-19 should only be performed when medically necessary to reduce the need for N95 respirators. Complete an assessment on any clients with AGMP procedures to determine if other treatment options are available with their physician.
  - If an AGMP is performed, ensure the fewest number of staff necessary to perform the procedure are present.
  - Ensure 50% of staff are N95 fit tested and that adequate supply planning is in place for an outbreak.

Resources:

IH: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(July 6, 2021)**

Partner: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(July 6, 2021)**

Definitions:

- **Medical mask:** A medical grade face mask that meets ASTM International and ISO (or equivalent) performance requirements for bacterial filtration efficiency, particulate filtration efficiency, fluid resistance, pressure differential, flame spread, skin sensitivity and cytotoxic testing.
- **Must:** A mandatory requirement based on BC Ministry of Health directive (MHO Order).
- Non-clinical staff: All staff that are not providing clinical care including, but not limited to, administrative and office staff, facilities staff, contracted staff and volunteers.

Resources:

BCCDC - How to Wear a Mask

IH: Guidelines for the use of Ear Savers

Partner: Guidelines for the use of Ear Savers

8.9 Gloves

Gloves are **not** required to be worn for every task. Glove use should be in alignment with the BCCDC PPE Allocation Framework and based on a Point of Care Risk Assessment. Wearing gloves for extended periods of time can increase the risk of skin irritation from moisture within the gloves.

Resources:

IH: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(July 6, 2021)**

Partner: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(July 6, 2021)**

IH: Selection Guide for Non-Sterile Exam Glove
Partner: Selection Guide for Non-Sterile Exam Glove

8.10 Eye Protection/Face Shields/Safety Goggles

Eye protection is worn to protect the mucous membranes of the nose, mouth and eyes during procedures or activities likely to generate splashes of blood, body fluids, secretions or excretions or within two metres of a coughing patient.

Eye Protection can be any one of the following:

- Face shield,
- Goggles
- Safety glasses
- Procedure mask with attached visor
- **Prescription eye glasses are not acceptable as eye protection**

Remove and discard the eye protection after use if disposable; if re-usable, clean with a disinfectant after each use.

- The outside of the mask and eye protection are considered contaminated.
- Clean hands after removing the mask and eye protection.

Cleaning:
BCCDC: Cleaning and Disinfection Instructions for Eye/Facial Protection
IH: Instructions for Cleaning Face Shields, Eye Goggles or Safety Glasses
Partners: Instructions for Cleaning Face Shields, Eye Goggles or Safety Glasses

How do I clean my face shield/goggles?

Instructions for cleaning eye protection:

- Doff other PPE as per usual procedures and perform hand hygiene with an alcohol-based hand rub.
- Open a blue pad, place the pad on a clean surface (e.g. vehicle seat) and perform hand hygiene with an alcohol-based hand rub.
- Carefully remove the eye protection and place on blue pad and perform hand hygiene with an alcohol- based hand rub.
- Don gloves and wipe the inside (portion facing face), followed by the outside of the face shield with a clean cloth saturated, with neutral detergent solution or a cleaner wipe (e.g. baby wipe).
- Carefully wipe the outside of the face shield with the ACCEL wipes, to visibly dampen it, and allow one minute of contact time on the blue pad.
- Avoid using ACCEL wipes on the foam and elastic band of face shields or eye goggles.
- Wipe the outside of the face shield with clean water or alcohol wipe to remove residue.
- Allow face shield to air dry on the blue pad.
- Remove gloves and perform hand hygiene.
- Once face shield is dry, move to a storage container or bag, being careful not to touch inner surface and perform hand hygiene with an alcohol-based hand rub.
- Eye protection can stay on in a congregate housing environment between clients if HCW does not touch their face and practices diligent hand washing.

8.11 Gowns

BCCDC: The Association for the Advancement of Medical Instrumentation (AAMI) standards are designed to help medical-device companies meet global standards for the safe use of medical devices. *ANSI/AAMI PB70:2012, Liquid Barrier Performance and Classification of Protective Apparel and Drapes Intended for Use in Health-Care Facilities* classifies gowns according to four levels of barrier performance.

Gowns will be assessed against the AAMI barrier protection certification criteria for appropriateness.

IH: Gown Selection Guide

Partner: Gown Selection Guide

8.12 UPDATED- N95 Respirators

Effective June 25, 2021, the annual fit test frequency requirement goes back into effect. All employees and medical staff wearing N95 respirators must review their fit test status, expiration date, and complete a fit test, if required.

- WorkSafeBC temporarily extended the fit test frequency requirement from one year to two years for N95 respirators at the onset of COVID-19 in 2020, but has now returned to an annual requirement.

Grace Period

A grace period to March 31, 2022 is in effect to allow appropriate time for those whose last fit test occurred between one and two years ago. As of March 31, 2022, everyone who requires the use of an N95 respirator, or any other respiratory protection, must have received a fit test in the past year and must maintain an annual fit test frequency going forward.

Check Your Fit Test Status

Determine your fit test status:

- **IH Employees:** Check fit test status using the Fit Test Self Look-up Report (IH network required)
- **IH Medical Staff:** can check fit test status by emailing workplaceinjury.prevention@interiorhealth.ca
- **Contracted Partner Employees:** Check your fit test status with your site leadership

Determine which of the following situations apply to you and proceed accordingly:

- If you have been fit tested in the past year, no immediate action is required. Effective immediately, you will be required to ensure you receive your next fit test within one year of your previous fit test.
- As required, book your fit test session using your current site fit test process.

Date of last fit test	Is fit test required now?	Recommendation for next fit test
Before June 25, 2019	**Yes**	**Immediately**
June 25, 2019 – June 25, 2020	**Yes**	**As soon as possible** (prior to 2 year fit test expiry) and no later than March 31, 2022
June 26, 2020 and onward	Annual fit test applies	Before annual fit test expires

N95 respirators are required when performing Aerosol Generating Medical Procedures, including CPR on a COVID suspected or positive Client. The number of staff to be fit tested should be 50%.

IH: N95 Fit Testing Guidelines

Partner: Respirator fit testing should follow WorkSafeBC Regulations 8.32-8.45. More information can be found in this WorkSafeBC Resource – Breathe Safer.

Note: Focus departments should be prioritized and transition as soon as possible. Users may need to be fit tested prior to their expiration date if they experience any changes (e.g., weight gain/loss, dental/facial surgery).

Interior Health Managers and Supervisors Only:

- Review your Fit Test & Insight Report to determine fit testing needs and prioritize your staff to achieve fit testing within the timelines indicated above.
- The Fit Test & PAPR Insight Report will be adjusted to reflect a 1-year fit test frequency effective June 25, 2021. Note that the grace period will be in effect until March 31, 2022. As a result, your fit test compliance may appear different, as it does not account for the grace period. Your Fit Test metrics should be used to evaluate progress towards achieving full compliance by the end of the grace period on March 31, 2022.

Resources:

WorkSafeBC – Fit testing your respirator
BC Centre for Disease Control – Personal Protective Equipment
WorkSafeBC - Occupational Health & Safety Regulation Part 8: Personal Protective Clothing and Equipment (Specifically - 8.32 – 8.45)
WorkSafeBC – Breathe Safer
IH Only: AV1900 Respiratory Protection Program Policy

8.13 N95 Supply Resources

An integrated provincial model combines centralized and decentralized business functions, always recognizing the needs of the local regions. Supply Chain has regional branch offices in each health authority to ensure local presence and attention to each authority's needs.

PHSA Contact Supply Chain

SafeCare BC provides the following information to assist organizations to locate alternate suppliers of personal protective equipment (PPE) during the COVID-19 pandemic. This is not an exhaustive list, as there may be other alternate suppliers of PPE. SafeCare BC does not in any way vet or endorse the alternate suppliers or the products they offer.

SafeCare BC Alternative Suppliers

8.14 N95 External Fit-Testers (e.g. Agencies contracted to conduct fit-testing)

Fit-testing will only be provided by:

- Fit-testers having successfully completed the WHS Department respirator fit-tester training session;
- Quantitative Fit Testing Process Training Flowchart
- Qualitative Fit Testing Process Training Flowchart
- WHS Department; or
- External contractors approved/recognized by the WHS Department.

Where a Health Authority's fit-testing (all or a portion) has been contracted to an external agency that group will:

- Ensure that fit-tests are completed in accordance with the *WSBC Occupational Health & Safety Regulation* and CSA Standard Z94.4-11.
- Ensure that fit-testing and any other relevant education/training is conducted in a manner with approval by the Interior Health.
- Utilize respirator models currently used by Interior Health.
- Provide proof of fit-testing completion that details the fit-test date, respirator brand, model and size and name of fit-tester and company.

IH: Observation Checklist Quantitative Fit Test

All: Workplace Health and Safety Respirator Fit Test Record

All: Criteria for Requiring Respiratory Protection: Airborne Infectious Agents

*Please reach out to the COVID Recovery Team or your local Regional Knowledge Coordinator for the Fit Test forms

8.15 Skin and Eye Care Tips for Prolonged Use of PPE

With emerging concerns of impacted skin integrity due prolonged wearing of personal protective equipment (PPE), we have a number of resources available to help you protect your skin and eyes.

PPE-related skin integrity concerns can include pressure and friction injuries, contact dermatitis, and moisture associated skin problems.

Adverse skin reactions are commonly seen under the contact site of PPE, such as: over the nose, around the mouth, forehead, cheeks, back of the ears, backs of the hands, sides, and tips of the fingers.

Skin and Eye Care Tips:
Employees and medical staff, who are experiencing or at risk of PPE related adverse skin and eye reactions should review:

- The Prevention and Remediation Guidelines and follow recommendations. It's important that the skin is allowed to fully heal before trialing other models of PPE.

Partners: Prevention and Remediation Guidelines

Resources:
IH: Hand Care Tips
Partners: Hand Care Tips
IH: Eye Care Tips
Partners: Eye Care Tips
IH: Face Care Tips
Partners: Face Care Tips
BCCDC: COVID19_Skin Damage PPE Poster.pdf

Action for Managers:
Please discuss as a Safety Huddle topic with employees and teams.

Partners: COVID-19 Safety Huddle – PPE Related Skin Integrity Concerns

8.16 Donning & Doffing

BCCDC: COVID-19 Additional PPE Poster

IH: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(July 6, 2021)**

Partner: PPE Risk Assessment Guidelines during COVID-19 Pandemic **(July 6, 2021)**

IH: Donning-&-Doffing-PPE-for-COVID-19-Instruction-and-Video

Partners: 5 Steps for Putting on Personal Protective Equipment - Poster

Partners: 9 Steps for Taking off Personal Protective Equipment - Poster

BCCDC – 9 Steps for Taking off Personal Protective Equipment for Airborne Precautions (AGMP) - Poster

PHSA - Masking Requirements

BCCDC - How to Wear a Mask

Elastomeric masks: Use-of-Respiratory-Protection-with-Exhalation-Valve(1).aspx

8.17 Signage for Droplet & Precaution Signage

IH: Droplet & Contact Precautions Signage

IH: Droplet & Contact with Enhanced PPE Signage

Partner: Droplet & Contact Precautions Signage

Partner: Droplet & Contact with Enhanced PPE Signage

9.0 Clinical Practice Resources

9.1 Nasopharyngeal Swab Toolkit

Note: In May the Provincial Health Officer temporarily removed the requirement For Licensed Practical Nurses to have a client-specific order prior to performing nasopharyngeal swabs if being done as part of a screening program approved by a Medical Health Officer.

As per the PHO orders of November 16, 2020 registrants other than nurses may also perform the Screening Activity, without undue risk to the health or safety of the patient or any other person.

Health Authority Regulated Health Professionals SARS-CoV-2 Swabbing

Midwives and Certified Practice Speech Language Pathologist SARS-CoV-2 Swabbing

British Columbia Emergency Health Services SARS-CoV-2 Swabbing

To support staff in collecting a nasopharyngeal swab, please click on the link:

- IH: Nasopharyngeal Swab-Toolkit
- IH: Nasopharyngeal Swab-Competency Validation Instructions
- Partners: IH Practice Skills – Specimen Collection : Nose and Throat – CE
  Partners: Nasopharyngeal Swab Collection Instructions poster
  Partners: Clinical Skills – Nose and Throat Swab Collection – CE - Elsevier Extended Text
  Partners: Nasopharyngeal Swab Competency Validation Instructions – *This is a sample validation document – some links cannot be opened.*
  Partners: Nose and Throat Swab Collection – Elsevier Nursing Skills Competency Checklist
- IH Only: Nasopharyngeal Swab Collection Competency Validation iLearn 2498
- BCCNM: Scope of Practice Standards (RN/LPN/RPN)

The following **video** demonstrates how to perform a nasopharyngeal swab:

- How to perform a Nasopharyngeal Swab

To order swabs, please contact: SwabsCOVID@interiorhealth.ca

9.2 Suture Kits

During the COVID-19 pandemic, Long-term Care (LTC) clients have been identified as a vulnerable population requiring protective measures. In an effort to minimize transfers and provide treatment in place, when appropriate and safe, all LTC sites will be required to have a suture kit available for MRP's, at all times by September 18th, 2020.

The kits should contain the following items:

- Medline Laceration Tray ER standard x1 (Item #0000368)
- Ethilon Suture 3-0 suture x1 (Item #0225806)
- Ethilon Suture 4-0 each x1 (Item #0225807)
- Suture removal tray x 1 (Item #0441407)
- Stanhexidine 450ml x 1 (000064)
- Adhesive skin mini Dermabond-check with physician (order from your pharmacy)

- Lidocaine 2% with AND without epinephrine x 1 each (order from your pharmacy)
- Glasses (Item # 0003010) (not available at this time)

Interior Health Sites: supplies ordered through your regular weekly order and from your pharmacy.
Contracted Provider Sites: suture kits are considered part of the funding for extraordinary costs relating to the COVID-19 pandemic response, funding for which was distributed the week of August 3, 2020. The list of items is the same for contracted providers, however; the item numbers will not be applicable.

Please ensure the location of kits is clearly communicated and the kit content is replenished as needed and checked for expired/missing items on a regular basis.

9.3 Interior Health Transportation of Dangerous Goods Policy

Please click on the link below to access IH policy for the transportation of dangerous goods. This document should be referenced to ensure proper handling of nasopharyngeal swab.

- AV0500 - Transportation of Dangerous Goods

9.4 Online Education for TDG Part 1-Transportation of Human Specimens by Ground

Before employee(s) ship (or offer for shipping), transport, deliver, receive, handle dangerous goods, or write up transportation documentation, follow TDG Training and Certification Requirement to have your employees receive TDG training and certificates accepted by Interior Health.

- IH: Transportation of Dangerous Goods Training & Certification
- Partners: Canadian Centre for Occupational Health and Safety (Government of Canada – Transportation of Dangerous Goods)
- Basic Competency Checklist for Transporting Dangerous Goods

9.5 Interior Health Manager's Guide to Transportation of Dangerous Goods

The Managers' Guide to TDG (IH Only) is intended to provide resources to help managers take correct actions to comply with the Transportation of Dangerous Goods (TDG) Regulations. Whenever Interior Health's employee(s) will be involved in any part of transportation of an item or product outside the boundary of an Interior Health's facility, the manager is responsible to verify if the TDG Regulations will apply and to ensure adequate compliance with the Regulations as per policy AV0500 - Transportation of Dangerous Goods

10.0 COVID-19 Clinical Resources for Long-term Care, Assisted Living and Hospice

10.1 Strategies for Supporting Resident

Many of our residents are unable to appreciate the risks involved in the COVID-19 pandemic. Those who do may feel anxious or fearful of co-residents invading their space or spreading disease in our vulnerable population.

- Advanced neurocognitive impairment prevents many clients from understanding these risks and the need to adapt their behaviour; it is simply not within their cognitive capacity.
- During these exceptional circumstances, our role is to support our clients as best we can without added restraints or distress. Be kind and accept what is within the capacity of our clients, our teams, and yourselves

Strategies for Supporting Resident: Anxiety and Restlessness

10.2 Supporting Communication and Connection between Resident/Client and Family

Being separated from family members and socialization with others is difficult for everyone especially during uncertain times. Our residents and clients may not understand the reasons why this is happening but are likely to feel the sense of emotional distance and isolation.

Never before have clients in long-term care and retirement communities felt more isolated and removed from normal life. The mental and emotional wellbeing of many are at stake.

What We Can Do:

- Assign a staff member to contact all primary health-care contacts to notify them of the ways the site is able to support maintaining communication between resident/client and their loved one.
- Document on Resident/Client Health-care Record/Care Plan as choice for communication.
- Also obtain method by which they wish to remain in contact with their loved one

Supporting Communication and Connection between Client/Client and Family

10.3 Dementia & Communication

Communication about COVID-19 for clients with cognitive impairment can be challenging.

- How will we explain what is happening to our clients?
- How can we seek their cooperation when asking them to physical distance, wash hands, and not have visitors?
- It is important to always remember that many of the people we are working with have cognitive impairments and losses in brain function – and can no longer communicate, process and comprehend what is happening in the external world.
- As the care team, we need to continue to work together to do the best that we can to reduce the risks to our clients and adhere to protocols. Our clients are doing the best that they can, and if we become too restrictive, we can evoke the emotional and behavioural responses we see.

Dementia & Communication

10.4 Traumatic Brain Injury & Communication

Communication is often more difficult for persons who have sustained a traumatic brain injury. It is common for them to have challenges with processing information, attention and concentration, speech and language, learning and memory, reasoning, planning, and problem-solving.

- Emotional and behavioural difficulties often occur when there is injury to the frontal lobes of the brain.
- It is important we recognize they may become overwhelmed, anxious, and stressed when our expectations or messages are more than they can manage. This contributes to the responsive behaviour we see.

Traumatic Brain Injury & Communication

10.5 Meaningful Activities to Support Distraction and Engagement

Being separated from family members and socialization with others is difficult for everyone, especially during uncertain times. Our residents and clients may not understand the reasons why this is happening, but are likely to feel the sense of emotional distance and isolation.

- Providing meaningful activities: keeps people engaged in a positive way; offers a proactive outlet for restless energy; and helps to decrease emotional triggers of boredom, loneliness, fear, sadness, anxiety, and isolation, which contribute to the responsive and challenging behaviours we see.
- Purposeful activity can be used to distract people away from known risks and provide an opportunity for physical separation from others, as well as supervision to mitigate risks of conflicts.

Meaningful Activities to Support Distraction and Engagement

10.6 Physical Distancing/Isolation, Non-Compliance

Residents who are unable to follow physical distancing/isolation orders may present a risk of infection within congregate living facilities; whether due to impaired capabilities or other.

- Teams may be able to mitigate risks by developing an interdisciplinary care plan including Resident/family, as appropriate, to address the root cause of behaviours, such as unmet needs and environment.
- Pharmacological interventions and/or Least Restraint may be used only as directed by MRP and/or MHO, if all other reasonable interventions have been tried and are unsuccessful.
- Interdisciplinary teams will negotiate and plan care for continued residency for all individuals. As a last resort, exit planning may be considered for those residents who are capable of understanding the risks of their actions and modifying their behaviour, but choose not to.

These guidelines and recommendations will aid clinicians to provide excellent client-centered care while balancing the safety of the facility community.

What we can do

When a client is not maintaining recommended physical distancing/isolation to prevent the spread of COVID-19, the following investigations and considerations are required:

- Are they capable of understanding the risks of the COVID-19 infection?
- Have any barriers preventing the client from achieving capability been identified and mitigated?
- Have deficits such as language, vision, hearing or mental ability been considered?
- What is their understanding of physical distancing/isolation requirements asked of them?
- Are you able to negotiate behaviour change?
- If they are non-compliant with the physical distancing/isolation policies, what are the options to support them inside of the LTC facility?

- If they are incapable of understanding the risks of COVID-19 or unable to modify their behaviours, what resources do we have to develop a plan of care?
- Who are the members of the interdisciplinary team and family that need to be involved? Consider providing 1-1 if staffing compliment allows.
- What other resources do we have in the event that all our on-site planning is not successful?

Additional Resources:

- AH2500 Policy: Least Restraint
- Health Care (Consent) and Care Facility (Admission) Act
- COVID-19 Ethical Decision-Making Framework BCCDC/BC Ministry of Health
- Ethical Considerations for Managing Clients Who Lack The Cognitive Ability to Adhere to IPAC Protocols in Long-term Care Settings, Regional Geriatric Program, Toronto
- Thinking About Removing Your Loved One from Long-term Care during COVID-19?, Canage.ca via BrainXchang

Support Services/Persons:

IH: RKC – Complex Behaviours – Contact and Site Responsibility
Partners: RKC – Complex Behaviours – Contact and Site Responsibility
All: Long-term Care Complex Behaviour Referral
Brett.Butchart@interiorhealth.ca (Knowledge Facilitator Vulnerable/Incapable Adults)

10.7 Serious Illness Conversations: Tool for Clinicians

Conversations between patients and clinicians about what matters most lead to higher quality care and improved quality of life for patients and those who care for them. The COVID-19 pandemic makes communication both more difficult and more important than ever, particularly for people who are at highest risk of becoming very sick.

Specific script adaptation for COVID-19 from Ariadne Labs:

- Serious Illness Care Program COVID-19 Response Toolkit

Additional Resources:

- IH: Serious Illness Conversation Document
  Partner: Serious Illness Conversation Document
- Healthcare Provider Serious Illness Resources
- Clinician Reference Guide: Strategies for Common Scenarios
- Public Advance Care Planning Resources
- BC Centre for Palliative Care Serious Illness Conversations

10.8 Palliative Approach in Long-term Care

A palliative approach takes the principles of palliative care and adopts them earlier in the course of a person's advancing life-limiting condition, adapts care strategies to meet the whole needs of the person and family, and embeds this type of care into care settings that do not specialize in palliative care. Comprehensive resources can be found here:

- IH: Palliative Approach in LTC Toolkit
- Partners: Palliative Approach Resources

10.9 Essential Conversations in a Palliative Approach

Effective communication is at the core of the Palliative Approach. It supports collaboration within the team and ensures the wishes and concerns of those in care are being addressed and respected. Care Aides often spend the greatest amount of time with the individual and their family and are important members of the Circle of Communication within Long-term Care.

- IH: Essential Conversations – Fact Sheet
  Partners: Essential Conversations – Fact Sheet
- IH: In-the-Moment Essential Conversations for HCAs – Fact Sheet
  Partners: In-the Moment Essential Conversations for HCAs – Fact Sheet
- IH: Circle of Communication
  Partner: Circle of Communication
- IH: Essential Conversations - Tips
  Partners: Essential Conversations – Tips
- IH: Essential Conversations: Substitute Decision Maker-Worksheet
  Partners: Essential Conversations: Substitute Decision Maker-Worksheet
- IH: Essential Conversations: Client - Worksheet
  Partners: Essential Conversations: Client - Worksheet
- IH: Responding to Common Serious Illness Comments
  Partners: Responding to Common Serious Illness Comments

10.10 Clinical Criteria Recommendations

Clinical Markers to recognize and identify individuals who are living at the End of Life (weeks to months) *and* Last Days/Last Hours (imminently dying) in various care settings:

People coming into Community Hospice Beds (CHBs) from acute care and community care:

- End of Life: meet the CHB Access eligibility criteria:
  IH: Community Hospice Bed Access Referral Form # 821097 – see page 2.
  Partners: Community Hospice Bed Access Referral Form # 821097
- Last Days/Last Hours Care:
  IH: Palliative Performance Scale (PPSv2) is 10-20% (Form #811178)
  Partners: Palliative Performance Scale (PPSv2) is 10-20% (Form #811178)

People who live in a LTC facility:

- End of Life: a sudden or significant decline in condition/function with a RAI CHESS Outcome Scale of 4 or greater
- Last Days/Last Hours Care: Palliative Performance Scale (PPSv2) is 10-20% (Form #811178)
- Medical Assistance in Dying (MAiD)

Additionally, sites should recognize that visitor access will be required for individuals who are facing their end-of-life through the MAiD process. The end-of-life and last days/hours visitation recommendations apply to persons requesting MAiD.

Further Palliative resources can be located here:
IH: Clinical Decision Support Tools
Partners: Clinical Practice Supports

10.11 Afterhours Palliative Care Nurse Consult Line

The IH Afterhours Palliative Care Nurse Consult line is a new service for clinicians who require an

urgent consult with a Palliative Care Nurse for clinical assistance or direction for persons with palliative needs.

For Urgent Assistance Afterhours Call:

- **1-844-851-4192** to speak with the on-call Palliative Care Nurse

For Urgent Assistance Monday to Friday - 08:00 –16:00

- Elisabeth Antifeau - 250-354-2883
- Vicki Kennedy - 250-212-7807

For non-urgent support please email: IH Palliative CNS

Partners: Afterhours Palliative Nurse Consult Line – Memo
Partners: Afterhours Palliative Nurse Consult Line – Clinical Resource Bulletin

10.12 Clinical Decision Pathway COVID-19 in Long-Term Care Clients

Caring for the client with COVID-19 is most appropriate in a familiar setting. Our Long-term Care staff knows the care needs, wishes and priorities of the clients and their families well.

The COVID-19 Patient/Client Inter-Facility Transfers memo provides guidelines and an algorithm to aid clinicians to manage care of clients with COVID-19. It acknowledges that while there may be exceptions, on site supportive measures will ensure we are providing excellent supportive care as well as minimizing transfers to Acute Care.

For more information:

Clinical Decision Pathway COVID-19 in LTC Clients algorithm
IH: Resources Supporting Clinical Decision Pathway COVID-19 Clients in LTC
Partners: Resources Supporting Clinical Decision Pathway COVID-19 Clients in LTC

10.13 CPR in LTC – When a Client is Suspect/Confirmed Positive for COVID

The Code Blue Clinical Algorithm has been updated to reflect the safe provision of CPR in Long-term Care when a client is suspect/confirmed positive for COVID-19. Chest compressions, as part of CPR, are **NOT** considered to be an aerosolizing generating medical procedure (AGMP). During AGMP in COVID-19 infected clients, smaller droplets are produced, which can remain airborne and travel farther distances from the client. Without appropriate personal protective equipment (PPE), these aerosolized droplets could be inhaled, potentially causing infection.

Summary of the changes to CPR in LTC during COVID-19 Pandemic:

N-95 mask and **full face shield** is required as part of enhanced PPE *prior to* intubation when a client is suspected/confirmed positive for COVID-19.

- Donning and Doffing of enhanced PPE prior to intubation.
- Chest compressions only.
- Do Not Assist respirations.
- Additional signage for Aerosolizing Generating Medical Procedure (AGMP) Signage to be posted outside of room.
- Allow up to 2 hours for air to clear from AGMP/CPR.
- Enhanced cleaning of room/area post incident.

- The Infection Prevention and Control team offers the following guidance to ensure safe handling of patient records during the COVID-19 pandemic:
  - **NO** patient charts should be going into patient rooms.
  - Complete charting with clean hands.
  - Health Information Management staff are not to go into identified COVID units. Call into unit and have RN/LPN bring charts out.
  - Charts should be kept in a clean space when awaiting pick-up.
  - Wipe down charts daily or more frequently as needed.
  - Charts may be transported between facilities as per current practice.
  - Clean hands frequently.

Please Note:

- CPR is to be provided for WITNESSED ARREST ONLY.
- CPR is only initiated on clients with a C2 MOST when it is a witnessed arrest.
- CPR is not initiated on clients for an unwitnessed arrest.
- Workplace Health Safety (WHS) will make direct contact with sites that have been identified as needing additional fit testing.

10.14 UPDATED - Aerosol Generating Medical Procedures (AGMP)

Aerosol Generating Medical Procedures (AGMP) are performed in some Long-term Care (LTC) and Assisted Living homes. During AGMP in COVID-19 infected clients, smaller droplets are produced, which can remain airborne and travel farther distances from the client. Without appropriate personal protective equipment (PPE), these aerosolized droplets could be inhaled, potentially causing infection.

- Chest compressions, as part of CPR, are **NOT** considered to be an aerosolizing generating medical procedure (AGMP).

Examples of AGMP include:

- Bi-level Positive Airway Pressure (BiPAP)
- Continuous Positive Airway Pressure (CPAP)
- Intubation
- Nebulized medication therapy
- Suctioning airway (deep suctioning or open suctioning)
- Tracheostomy care
- Any humidified oxygen delivery systems
- High flow oxygen systems delivering ≥15L/min (including Optiflow and Airvo)

Resource:

IH: PPE Risk Assessment Guideline during COVID-19 Pandemic **(July 6, 2021)**
Partners: PPE Risk Assessment Guideline during COVID-19 Pandemic **(July 6, 2021)**

The CD Unit Agency of Canada has recommended that, in addition to routine precautions, healthcare workers (HCWs) follow droplet and contact precautions when caring for patients meeting clinical and exposure criteria for 2019-nCoV, unless performing an AGMP.
2019 Novel Coronavirus: Aerosol Generating Medical Procedures in Healthcare Settings
BCCDC Aerosol Generating Medical Procedure (AGMP) Door Poster

Enhanced Personal Protective Equipment (PPE) for AGMP should only be used for clients with **suspected or confirmed COVID-19.**

- Do Not Enter AGMP Signage
- IH: Airborne Precautions Signage

Partner: Airborne Precautions Signage

- BCCDC: Doffing Enhanced PPE - Aerosol Generating Medical Procedures (AGMP) Signage

Additional information can be found on the following memos:

- Additional Signage for AGMP in Droplet & Contact with Enhanced PPE
- High Flow Oxygen and Mechanical Ventilators as Aerosol Generating Medical Procedures (documents have changed to greater than 15/min)

10.15 Hypodermoclysis in Long-term Care

Resources on the Long-term Care Clinical Care Resource Page on InsideNet for IH Owned, Operated Sites and on the Extranet for Contracted Partners. This resource is to support all Long-term Care sites to meet the needs for hydration if a client is COVID-19 positive; thereby promoting care in place if safe and appropriate:

We need to first assess **the suitability for hypodermoclysis:**

- Is fluid replacement due to diminished thirst sensation or dehydration due to illness?
- Are they not able to consume adequate amounts orally?
- Is the fluid to be infused isotonic (normal saline, D5NS, Ringer's lactate)

For fluid replacement, even frail elders are able to absorb at a single site 30-50ml/hour (for a total of 720-1200 mls/24 hours). If additional fluid is required, a second site can be initiated.
Note: Addition of the enzyme hyaluronidase to the infusion solution to improve absorption, has not been shown consistently in the literature to justify its use.

Hypodermoclysis is **NOT appropriate if:**

- Aggressive fluid replacement is required (greater than 3 litres/24 hours)
- Infusion fluids are hypertonic or hypotonic. Note: in D5W, the dextrose is absorbed quickly and thus the solution becomes hypotonic within subcutaneous tissue
- Infusion fluids will contain medication. If medication such as opioids are added to the solution run continuously, an infusion pump is required.

Resources:

IH: Hypodermoclysis Toolkit

Partners: Hypodermoclysis Toolkit

10.16 Oxygen Therapy

It is within regulatory scope of practice for nurses (Registered Nurses (RNs), Registered Psychiatric Nurses (RPNs), and Licensed Practical Nurse (LPNs)) to initiate oxygen therapy without an order to treat hypoxemia. IH has developed the Oxygen Therapy-Initiating without an Order guideline to meet this requirement. It also provides an excellent review resource for RNs and RPNs. For external partners, follow your organization's directives; refer to BCCNP LPN Scope of Practice, and request a copy of the IH guideline (contact a Regional Knowledge Coordinator-LTC).

Note: LPNs are required to complete additional education, competency validation and follow this CDST, prior to administering oxygen therapy without an order:

IH Only Document: Competency Validation Instruction: Initiation of Oxygen Therapy without an Order

Additional Education for IH Only: Autonomous Nursing Practice (i-Learn # 2412)

- Required for LPNs
- Recommended for RPNs and RNs

Partners: Oxygen Therapy-Initiating without an Order (IH Guideline for Partner consideration)

10.17 Diabetes Management End of Life Guidelines

The Regional Diabetes and Palliative Care and End of Life Services teams have recently released the IH Diabetes Management at End of Life Guidelines. The purpose of the guidelines is to provide best practice guidance for clinicians providing care for individuals with diabetes through their palliative journey.

Principles to manage diabetes at end of life:

- Balancing diabetes interventions with goals of care and prognosis;
- Minimizing interventions and monitoring to keep the individual comfortable without compromising safety;
- Involving individuals and families in decisions about diabetes management;
- Ensuring the effective symptom control is provided;
- Tailoring glucose-lowering therapy and minimizing diabetes-related adverse treatment effects;
- Avoiding complications, symptom distress and diabetes-related emergencies;
- Providing an appropriate level of intervention according to the stage of illness, symptom profile, and respect for the individual's dignity; and
- Supporting and maintaining the empowerment and autonomy of individuals and caregivers for as long as possible.

Partners: IH Diabetes Management at End of Life Guidelines (IH Guideline for Partner consideration)

10.18 Bodies of Deceased Patients with Suspected or Confirmed COVID-19 – Safe Handling

The process outlined below provides interim guidance for the safe handling of deceased persons with suspected or confirmed COVID-19 in LTC, AL and Congregate Living Sites:

Contact IH's Communicable Disease Unit, at CDunit@interiorhealth.ca for any deceased client with either suspected or confirmed COVID-19.

- Include the client's name, Personal Health Number, and date of birth.
- Indicate whether the site is awaiting swab results or the deceased has confirmed COVID-19.

Care of the Deceased:

- Complete a Point of Care Risk Assessment to identify the PPE required.
- At minimum, wear long-sleeved gown and gloves.
- If risk assessment indicates additional precautions are required (e.g., risk of splashes from the client's body fluids or secretions onto the health worker's body or face), then wear a procedure mask, goggles or face shield, and a fluid-resistant gown
- Follow BCCDC's: Provincial guidance to ensure the safety of workers handling COVID-19 suspected or positive decedents (Sept 2020).

Notifying Funeral Home:

- Remind families to inform the funeral home if the deceased is either suspected or confirmed COVID-19 when the family contacts the funeral home to transport the body.
- Long-term Care, Assisted Living, and Congregate Living staff will verify the deceased person's COVID-19 status with funeral home staff on their arrival.

As with current practice, the funeral home will transfer/transport the deceased in the appropriate

body bag and the medical certificate of death will be completed by the physician.

Long-term Care homes should keep a very limited supply of fluid resistant gowns, LEVEL 2, for high-risk situations and re-order as needed

IH: Gown Selection Guide

Partner: Gown Selection Guide

Health-care sites will follow standard organizational guidelines and processes regarding environmental cleaning and disinfection of the patient area, handling of linens and waste management.

Recommendations for Care of Person's Clothing and Belongings

Safe Handling of belongings includes the following precautions:

- Donning appropriate PPE for safe handling
- Box/bag/Rubbermaid bin all unneeded belongings (recommend having 5 bins or boxes per resident on hand if needed) as resident status changes to end-of-life to support required quarantine measures
- Wipe the outside of the box/bag/bin and seal
- Quarantine for 3 days (could be stored on a clean surface in the resident's room with the door locked)
- Bring to the front entrance and have family collect by appointment

10.19 Direction for Sudden Unexpected Death with Suspicion for COVID-19

During the COVID-19 pandemic, sudden unexpected deaths will still occur as they did pre-pandemic, but consideration will be increasingly given to COVID-19 as a possible cause.

Many sudden unexpected deaths occur outside of the healthcare system, while others present for medical attention with inadequate time to perform laboratory testing prior to death. The 'Post Mortem Investigation Algorithm' outlines the appropriate steps for obtaining post-mortem COVID-19 testing and additional investigations as indicated to assist in ruling in and ruling out other potential causes of death.

Key Messages:

- Report all COVID-19 suspected deaths to the Medical Health Officer.
- Post-mortem testing for COVID-19 may be done at the request of the BC Coroners Service or the Medical Health Officer, with the latter requiring consent from the next of kin.
- Additional post-mortem investigations up to and including complete autopsy, may also be requested in consultation with pathology to accurately determine the cause of death.

Additional Resources:

- Reporting a Death to the BC Coroners Service
- Collecting a Nasopharyngeal (NP) Swab

IH: Autopsy Consent Form

IH: Autopsy Consultation Request

10.20 Additional Clinical Resources

Watch a 35 minute video interview with Teepa Snow titled Managing dementia care in the time of COVID-19:
https://www.beingpatient.com/teepa-snow-managing-dementia-care-in-the-time- of-covid-19/.

British Geriatrics Society. March 25, 2020. Managing COVID-19 Pandemic in Care Homes. Good practice guide. Available at:
https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes

DementiAbility© (2020). Hand & personal hygiene in dementia care. Available at:
https://www.dementiability.com/resources/Hand-Hygiene-in-dementia-care.pdf

11.0 Employee and Human Resources

11.1 Human Resources – Employee COVID-19 Q&A

- Human Resources: COVID-19 Q & A Sept 10,2020 – located on IH Public Webpage
- Human Resources Questions and Answers Information related to COVID-19 (Nov 12, 2020)

11.2 Employee Vacation Planning

Vacation and COVID-19 Information (For IH O&O):
Employees returning to Canada following international travel are subject to the *Federal Government's Quarantine Act and the BC Provincial Health Officer's Order* requiring 14-day self-isolation. This self-isolation period applies to all staff, including those who perform essential work. This can have a significant impact on our ability to staff departments and care for our patients, residents and clients. **The 14-day self-isolation period does not qualify employees for sick leave.**

Please read Leave Planning Requirements for International Travel for more information.

Leave Planning Requirements for International Travel
During this extended and challenging period of Pandemic response, it is important that all employees take their vacation to rest and recharge. IH must also ensure that we can schedule staff appropriately at all times to maintain safe patient care.

Leave Requests:
Effective immediately and for 2021, any employees planning to travel outside of Canada are required to request and receive approved leave for their planned time away and the 14-day self-isolation period once they return to Canada.

This may be inconvenient for some employees, but Interior Health must abide by the Provincial and Federal government requirements and ensure sufficient staffing. We will update this requirement in accordance with Federal or Provincial changes to the isolation period as they occur.

Because travel outside of Canada may increase exposure to COVID-19 and will result in a 14 day isolation period, employees should be aware of implications associated with booking insufficient time off to account for the isolation period.

Exceptions
Employees whose work can be completed while self-isolating from home, and have been approved by their manager to work from home, may do so without requesting additional leave.

11.3 Employee Wellness Resources

IH Employee and Family Assistance Program (EFAP):
Interior Health's EFAP provider has counseling services and other resources online and through the app 'My EAP'. For more information on the EFAP program see Guide to Employee Health and Wellness Services or workheatlhlife/com or call 1-844-880-9142

A list of physical and psychological wellness resources is available on the Employee Wellness & Psychological Health page on InsideNet.

Psychology works for COVID-19. Psychologists giving back to front line health providers:
If you are a front-line health service provider, and would like to contact a psychologist, please use the following link from the Canadian Psychological Association to see the list: https://cpa.ca/corona-virus/psychservices/. It is a listing of psychologists who have volunteered to provide psychological services to front line health care providers. The listing of psychologists is organized into province and territory as well as languages spoken. It is important that you choose one who is on the list of the province or territory in which you are located. The psychologists on the listing have agreed to return calls for requests for service within 24 hours of their receipt and to provide services at no charge.

- "Psychology Works" Fact Sheet: Emotional and Psychological Challenges Faced by Frontline Health Care Providers during the COVID-19 Pandemic
- Medical Staff Peer Support
- The Working Mind; COVID-19 Self-care & Resilience Guide
- A quick guide to wellness: Psychological First Aid for Frontline Health Care Providers during COVID-19
- Faculty of Medicine COVID-19 Wellness Series: Psychological PPE: Exploring Compassion Fatigue and Learning How to Keep Ourselves Psychologically Well

11.4 NEW Provincial Health Officer Order for Creation of Facility Staff Clusters

Provincial Health Officer Order - July 28, 2021 permits fully vaccinated staff to work in health authority assigned site clusters to promote and support sites through the summer months to reduce staffing shortages; review the new Provincial Health Officer Order and the Ministry of Health guidance for the supporting creation of the facility clusters below:

NEW - Provincial Health Officer Order – **July 28, 2021**
NEW – MoH and Provincial Health Officer Guidance on the Creation of Facility Clusters – **July 28, 2021**

11.5 Reinstatement of Permanent Postings for Single-Site Facilities

Effective Oct. 19, 2020, Interior Health will post all new permanent vacancies as permanent postings. The only positions posted as temporary will be those that meet the collective agreement definition of temporary postings. Positions that were previously posted as temporary under the SSTF will remain as they are and only be posted permanently once vacated by the current occupant. This means that employees will be able to apply on postings at any site where they are internal candidates and not just the single site to which they were assigned.

Applying for Permanent Positions

- All employees are encouraged to apply for internal postings on i-Site as they would normally.
- The parties to the agreement also negotiated a job board that is open to internal applicants on the Province's WorkBC website. However, Interior Health employees are encouraged to apply, as they normally would, through IH i-Site system which is accessible remotely.
- NBA employees who hold a temporary position, which would have been permanent if the temporary posting restriction in the SSTF was not in place, are not required to wait until their temporary appointment ends before starting a new permanent position. *(Reference: NBA Article 17.02)*

Right to Retain Employment
Employees who held multiple positions at multiple sites before the Single Site Order will be required to give up their combined full-time equivalent (FTE) when posting into a permanent position, but they may retain their employment at the other employer worksite where they were employed prior to the Single Site Order. Employees will be asked to advise the manager of that position, in writing, if they wish to resign or maintain their employment with a previous employer. The employee will also be required to acknowledge their decision on their internal offer letter.

Actions Required for Managers

- Effective Oct. 19, 2020, please post all permanent vacancies as permanent.
- Successful applicants are expected to commence work on the posted start date unless directed otherwise by the Medical Health Officer or the Provincial Health Officer. As such, managers must carefully consider the start date on their postings and postpone start dates if warranted by the circumstances.

For Questions & More Information:
Employees are encouraged to contact their managers with questions about permanent postings, or the Recruitment team if there are questions specific to the job board or posting process.
Managers who have questions or require more information should contact their Employee Relations Advisor.

11.6 Principles for Definition of Essential Health-care Workers

Principles to guide managers in determining whether an employee is essential to the delivery of patient care and life-saving services:

The Provincial Health Officer (PHO) has defined **essential health-care workers** as those who are ***essential to the delivery of patient care and life-saving services***. Further, the PHO indicates that workers in essential services vary between organizations in the public and private sector.

Within the health sector, workers who provide direct patient care cannot do so without the support of other workers who do not provide direct patient care. Examples include those workers who provide support services such housekeeping, food services, laundry and supply chain services, or administrative employees who schedule employees for work and ensure employees are paid.

It is possible that a worker may be essential to the delivery of care on one day and not essential on another day (e.g. patient volume is below census due to service cancellations). In those cases, determination and designation of an essential worker is the responsibility of the worker's manager.

The following principles should be applied in advance of the worker's scheduled shift and are to be applied during the COVID-19 pandemic and until such time as the PHO declares an end to the pandemic:

- The worker provides direct patient care and, without the worker, safe direct patient care delivery and/or worker safety would be compromised (e.g. nurse, physician, care aides, etc.).
- The worker provides clinical support to direct patient care workers and, without the worker, safe direct patient care delivery and/or worker safety would be compromised (e.g. laboratory technicians, pathologists, pharmacists, etc.).

- The worker provides non-clinical support to direct patient care workers and, without the worker, safe direct patient care delivery and/or worker safety would be compromised (e.g. housekeeping, supply delivery, security, etc.).
- The worker provides administrative support to direct patient care workers and, without the worker, their duties would fall to the direct patient care worker. This would take the direct patient care worker away from providing direct safe patient care delivery and/or worker safety would be compromised (e.g. patient registration clerks, staffing clerks, etc.).
- The worker provides critical environmental support services that support the delivery of direct patient care providers (e.g. physical plant engineers; information technology workers, etc.).
- The worker provides direct support for the emergency response to COVID-19 (e.g. medical health officers, epidemiologists, planning leads, etc.).

All non-essential health-care workers – such as human resource, payroll, and financial services workers, etc. – who do not exhibit symptoms of illness must either work from home or follow the PHO's directions for non-essential worker environment constraints (such as self-isolation after international travel). It is important to note that these health-care workers may at some point during the COVID-19 pandemic be identified as essential, since they may be required to provide non-clinical support to direct patient care workers. Without these workers, these duties would fall to the direct patient care worker, taking them away from providing direct patient care and compromise safe patient care and worker safety.

11.7 UPDATED July 19, 2021 - Employee (Staff) Screening for COVID-19

Employees are to ensure they are self-monitoring for COVID-19 symptoms before each shift and responding appropriately using the following guidelines:

IH Workplace Health and Safety COVID – 19 Employee and Medical Staff Self-Screening Guidelines
Guidance for COVID-19 Testing by Nucleic Acid Tests (NATs):

Employees and Medical Staff
• Before coming to the facility, providing services on behalf of IH or starting your shift complete a daily COVID-19 self-screening health check in accordance with the processes established by your supervisor
• If symptoms of COVID-19 are identified during your COVID-19 self-screening health check that require immediate COVID-19 testing make arrangements to get tested as soon as possible or seek medical attention

• If symptoms of COVID-19 are identified during your COVID-19 self-screening health check that do not require immediate COVID-19 testing or medical attention: o Reach out to your supervisor who will determine if you are essential or not essential
  - Make arrangements to get tested as soon as possible
  - Follow your normal sick leave call-in procedure (e.g., call EARL 1-855-264-9515 to report your absence)

• If you develop symptoms during your shift:
  - Complete a self-screening health check - If you require immediate COVID-19 testing or medical attention, notify your manager and leave work
  - If you do not need an immediate COVID-19 test or medical attention, notify your supervisor immediately who will determine if you are essential or not essential
  - Get tested for COVID-19

Avoid the use of fever-reducing medications (e.g. acetaminophen, ibuprofen) as much as possible because medications can mask early symptoms of COVID-19

UPDATED July 19, 2021 Screening Requirements

• All employees and medical staff are required to complete a COVID-19 self-screening health check prior to the beginning of each shift (and additionally as deemed necessary) when onsite

- **As per the new directives from the Ministry of Health, July 19, 2021,** all LTC and AL sites will be implementing COVID-19 Rapid Antigen Testing for all staff who are not fully immunized against the COVID-19 Virus (frequency to be determined). See sections 4. 9 and 4.11 in the toolkit for process resources.
- Screening processes may look different based on the work area:
  - Managers will determine the most effective way to complete these screenings based on the approved screening process below:

Approved Screening Processes

Prior to Coming to Work

- Employees and medical staff complete a self-screen survey using the online portal identified for their work area. Online portal options include:
  o COVID-19 BC Self-Assessment Tool – to be used by employees in corporate or office settings
  o IH COVID-19 Staff Screening Tool

Prior to Starting Shift, When on Site

- For corporate or office settings:
  o Employee completes COVID-19 BC Self-Assessment Tool and informs their supervisor via email, verbal, or other communication with results

- For patient/client care settings: o Employees and medical staff complete the COVID-19 Daily Health Check Criteria and tracker prior to starting a shift, and periodically throughout if deemed necessary (e.g. there is an outbreak in the department/site); **or**
  o Build the review of the COVID-19 Daily Health Check Criteria into current processes (e.g. add a Y/N column into current sign in sheets to confirm that the health check has been completed)

Temperature Screening

- In order to monitor for fever symptoms, temperature screening is required as part of the employee screening process for employees working in long term care facilities; it is optional in all other areas
- Fever (≥38°C) or a temperature that is above normal for that individual without other known cause. This does not include fevers with a known cause.

***In LTC - Test all individuals with new symptoms compatible with COVID-19, however mild**.
Clinical judgement remains important in the differential diagnosis and work-up of individuals presenting with these symptoms (e.g., people with allergies).

NEW July 19, 2021, Staff who have not been immunized for COVID-19 are required to wear masks and eye protection as previous guidelines and in addition non-immunized staff are required by the Ministry of Health to receive COVID-19 Rapid Antigen Testing (frequency to be determined) upon entry to the LTC/AL facility prior to initiating work.

For more information on the diagnosis and management of COVID-19 infection, please refer to the clinical guidelines on the BCCDC website.

Resources:
BCCDC COVID-19 IPC Guidance for Long-term Care and Assisted Living
BCCDC COVID-19 Self-Monitoring Poster
BCCDC COVID-19 Testing Guidelines for British Columbia
BCCDC Health Care Worker Self-Check and Safety Checklist
BCCDC Interim Guidance on Return to Work for Health Care Workers with Symptoms of COVID-19
BCCDC Recommendations for Risk Assessment and Management of Health Care Worker Exposures to COVID-19 Patients
When to get Testing for COVID-19
IH Human Resources - COVID-19 Questions and Answers

Facility Screening for Entrance to Site Requirements:
All Home Health and Assisted Living Staff are required to sign in, be screened for COVID-19 and have their information recorded on the Long-term Care and Assisted Living Staff Screening Sheet. **(Updated July 14, 2021)**
Partners: Long-term Care and Assisted Living Staff Screening Sheet **(Updated July 14, 2021)**
Screeners will screen all staff entering the building before the start of their shift. Screening consists of asking the COVID-19 questions and recording the answers. Taking of Staff temperature is not part of the Screener role but the staff's temperature MUST still be taken daily and recorded.

NEW July 19, 2021, Staff who have not been immunized for COVID-19 are required to wear masks and eye protection as previous guidelines and in addition non-immunized staff are required by the Ministry of Health to receive COVID-19 Rapid Antigen Testing (frequency to be determined) upon entry to the LTC/AL facility prior to initiating work.

Effective July 19, 2021, All staff are required to submit full name, PHN and Vaccination Status information to the Site Manager as per Ministry of Health tracing requirements.

Reminder: All staff and visitor screening documents are submitted to the manager or designate at the end of each day for safety and security. It is mandatory for site management to securely store the Staff Screening Sheet for a minimum of 28 days in the event these are required by the Medical Health Officer for COVID–19 exposure tracing.

Staff who have symptoms as per the BCCDC (see: BCCDC Health Professionals Clinical Resources Viral Testing) will identify themselves to their supervisor. As per existing requirements any staff member who answers YES to any COVID-19 question will not be permitted to proceed past the Screener location and will need to contact their immediate supervisor who will provide direction. Supervisor reviews, with the individual staff, the list of assessment centres and gives contact information of the assessment centre site that is chosen by the staff (phone or link). The full list of BC Assessment Centres can be found here:

- Collection centre finder (Mobile and desktop)
- Collection centre finder for Internet Explorer users

Staff member contacts the assessment centre directly to book an appointment and identifies themselves as a health care worker.

- Call 8-1-1 or use the BC COVID-19 Self-Assessment Tool

Additional Resources:
Staff Respiratory Infection Outbreak Policy – AV1300
Q&A – WHS and HR Information for IH Employees

If you have any questions or concerns, please contact your Workplace Health & Safety Advisor
Recommendations for Risk Assessment and Management of Health Care Worker

11.8 Priority COVID-19 Testing for Essential Health-care Workers

Priority testing is now being offered for essential health-care workers. If you are a health-care worker who requires a COVID-19 test, follow these steps:

1. Go online and attempt to book a test within 24 hours through the online process and be sure to select the option that you are a **health-care worker.**

2. If you are unable to book a test online within 24 hours, you may drop-in for a test at your nearest collection centre (see list of IH collection centres). You must present your IH identification badge and Care Card in order to have a drop-in test.

NOTE: Please only drop-in if you cannot book online.

See BCCDC Testing Information for more information on COVID-19 tests. Updated information is also available:
IH: Human Resources Questions and Answers Information related to COVID-19.
Need Partner Link

11.9 Employees Presenting with Symptoms

1. If symptoms are mild and consistent with seasonal allergy (known allergic condition AND staff member is fairly confident the symptoms are related to their allergy), staff can continue working with expected PPEs.

2. Anyone with cold, influenza or COVID-like symptoms can be assessed and get a COVID-19 test**. If you are not experiencing symptoms**, a COVID-19 test is not effective or recommended.

3. If staff contact the manager/designate with COVID-19 like symptoms, prior to a shift:
    - Instruct staff to stay home, self-isolate and get tested.

4. If staff develops COVID-19 like symptoms during work:
    - Instruct staff to keep wearing PPE in all areas of work site until they can be relieved from work.
    - Ask individual to take breaks separate from all staff.
    - Ask if any critical work is still required
    - Manager/delegate to send staff home, as soon as possible. Direct staff to isolate and get testing

Testing:

- Anyone with cold, influenza or COVID-like symptoms can now be assessed and get a COVID-19 test. There is no longer a requirement to be referred by a health care provider or by calling
  8-1-1.
- Testing should occur as soon as possible - no sooner than 24 hours after the onset of their symptoms.

Managers: Please advise staff to call their local testing centre for an appointment, as opposed to dropping in (last resort option only). IH's testing centres, and a link to centres across B.C, can be found on IH's COVID-19 testing webpage. It takes from 1-3 days for results once tested.

Request staff to report results

If negative: Return to work:

- At the discretion of the employer, may return to work once well enough to work and symptom free
- Follow COVID-19 and routine infection control practices, including mask, eye protection, and gloves

If positive, remind staff:

- Public Health will follow up and provide further guidance.
- Typically the HCW will be asked to self-isolate until the following criteria are met:
    - At least 10 days have passed since the start of their symptoms, AND
    - Fever is resolved without the use of fever-reducing medications (e.g., Tylenol, Advil), AND
    - Staff is feeling better (e.g., improvement in runny nose, sore throat, nausea, vomiting, diarrhea, fatigue).
- If public health provided staff with different advice, follow their instructions. A repeat swab is not required provided the above conditions have been met.

11.10 Expanded Lab Booking Options to Support COVID-19 Safety Measures

A new, online lab appointment booking tool and phone booking option was launched Nov. 9 in several IH communities, which help support COVID-19 physical distancing measures and enhance patient safety. These new options will prevent crowds, minimize wait times, and allow patients to book their appointments from the comfort of home.

The roll out for online and phone booking is initially for patients in Castlegar, Trail, Williams Lake, Cranbrook, and Merritt. Following the launch of the new booking options in these pilot communities, the system will gradually become available throughout Interior Health.

The online booking tool can be found at https://www.labonlinebooking.ca/login (requires Chrome). The phone booking option is available at 1-877-740-7747, seven days a week, from 8 a.m. to 7 p.m.

11.11 BC Health Care Worker Exposure

Risk assessment and management of health care workers exposed to COVID-19 patient is summarized in the BCCDC: BC Health Care Worker Exposures Risk Assessment Tool

BCCDC: Exposures and Return to Work for Health Care Workers

BCCDC: BC Health Care Worker Return to Work Decision Tree

BCCDC: Interim Guidance on Return to Work for Health Care Workers with Symptoms of COVID-19 (Apr 28, 2020)

COVID-19: Long-Term Care Audit

Site:		Manager/Contact	
Audit Date		Auditor	

Y = yes N = no P = partially in place

1. Entrance					
	Item	**Y**	**N**	**P**	**Comments**
1.0	Current COVID-19 LTC sign posted at entrance				
1.2	Active screening of visitors with sign-in sheet at entrance				
1.3	Screening/precautions applied to deliveries entering facility				
1.4	Access to other entrances closed				
1.5	Masks and hand sanitizer available at entrance points for visitors				
1.6	Masks and hand sanitizer secured in a manner to prevent loss				

2. PPE/Supplies					
	Item	**Y**	**N**	**P**	**Comments**
2.0	PPE including masks, gloves, gowns and facial protection readily available in each department for staff.				
2.1	PPE are available in appropriate sizes at point of care (eg. gloves)				
2.2	PPE secured in a manner to prevent loss				
2.3	Staff fit tested for N95 masks				
2.4	N95 respirator readily available for those who are fit tested				
2.5	Other supplies available at required point-of-use (e.g. disinfection wipes, ABHR, tissues, waste bin)				

3. Surveillance					
	Item	**Y**	**N**	**P**	**Comments**
3.0	There is a procedure/process in place to identify cases of acute respiratory infection				
3.1	Do you know where to obtain information regarding: • Testing • Infection control • A high index of suspicion • Patient transfer to acute care				
3.2	There is a written plan in place to manage COVID positive patient				
3.3	Staff are being provided the most current COVID-19 procedures				
3.4	Staff know where to access most current COVID-19 information				
3.5	Staff do not work at more than one facility				

COVID-19: Long-Term Care Audit

4. Routine Precautions					
	Item	**Y**	**N**	**P**	**Comments**
4.0	Alcohol-based hand rub (ABHR) located at point-of-care				
4.1	Dedicated hand washing sinks (not multi-purpose) provided at key/strategic locations				
4.2	Cleaning and disinfection of shared equipment, (eg. goggles, stethoscopes) with evidence that this is being done (eg. green-is-clean method)				
4.3	Appropriate infection prevention and control signage is located at key locations as needed (e.g., covering coughs, hand hygiene)				
4.4	PPE are easily accessible near the point of care				
4.5	Hand hygiene is performed before PPE is donned				
4.6	PPE is donned in sequence, as per BCCDC policy, where hand hygiene is performed before first step				
4.7	PPE is doffed in sequence, as per BCCDC policy, where hand hygiene is performed after each step				
4.8	PPE is doffed immediately following the activity for which it was put on				
4.9	There is clear separation between the location where clean PPE is donned and soiled PPE is doffed				
4.10	A gown is worn, as indicated by the risk assessment following current PPE procedures				
4.11	A mask and eye protection (or a face shield) is worn, as indicated by the risk assessment following current PPE procedures				
4.12	Gloves are worn, as indicated by the risk assessment following current PPE procedures				
4.13	Staff change out of street clothes/shoes upon arrival at facility, and change back on leaving facility, as per current guideline				

5. Equipment/Cleaning					
	Item	**Y**	**N**	**P**	**Comments**
5.0	High touch surfaces are cleaned/disinfected at least 2x daily				
5.1	Clean and soiled equipment and devices are transported and stored separately (eg. trolleys, carts, linen hampers, non-perforated bags, nurse-on-a-tree/stick, BP cuffs, monitoring equipment, food trays, dishware)				
5.2	Shared, reusable non-critical equipment (eg, wheel chairs, transporting equipment, commode chairs) are cleaned and disinfected between clients/patients/residents, with evidence that this is being done (eg. green-is-clean)				
5.3	Operating instructions posted for cleaning/disinfecting machines (eg. bedpan washer)				
5.4	All linen is bagged or otherwise contained at point of care to prevent contamination of other areas				
5.5	Soiled linen is contained in leak-resistant bags that are not overfilled (e.g., closed off when 2/3 full) and tied securely				
5.6	Clean and soiled linen are handled separately, as per current guidelines				
5.7	Clean and soiled linen are stored separately, as per current guidelines				
5.8	Clean and soiled clothing are handled separately, as per current guidelines				
5.9	Clean and soiled clothing are stored separately as per current guidelines				
5.10	Waste containers are sufficient in number and are not overfilled				

6. Disinfectants					
	Item	**Y**	**N**	**P**	**Comments**
6.0	Disinfectants are appropriate for intended use				
6.1	Are bottles properly labelled				
6.2	Disinfectant test strips available				
6.3	Test strip results documented				

COVID-19: Long-Term Care Audit

7. Social					
	Item	**Y**	**N**	**P**	**Comments**
7.0	Social distancing achieved in dining room				
7.1	If a care worker is feeding more than one resident at a time, proper hand hygiene is performed between feeding residents				
7.2	Social distancing achieved in activity room				
7.3	Exercise/fitness rooms closed				
7.4	Personal services suspended				

8. Indoor Air Quality					
	Item	**Y**	**N**	**P**	**Comments**
8.0	HVAC system is on a routine maintenance program by technical expertise				
8.1	HVAC system equipped with higher MERV rating, pending system evaluation for suitability (MERV 10+) *Note: system must be able to handle a higher MERV rating filter or damage may occur to system.*				
8.2	Facility has an IAQ program that includes testing for general parameters (CO2, CO, Relative Humidity, Temperature, Radon) • High CO2 can point to dead zones • Maintaining Relative Humidity in the upper zone of 40-60% is best for COVID-19 prevention *Note: Most HVAC companies can test these parameters*				
8.3	EHO to obtain further information for IAQ and air flow assessment: • Flow from clean to not-so-clean • Avoid cross-patient flow • Boost make-up air to 100% (this may come at an energy cost if not equipped with a heat recovery ventilator (HRV) or energy recovery ventilator (ERV))				

Additional Comments:

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COVID-19 UPDATE

COVID-19: Fraser Health Outbreak Response Lead Checklist

Status	Activity	Responsible	Refer to *Response Lead Folder on SharePoint*
Standard Operating Procedures: Response Lead Activation			
☐	A. RION received. Outbreak Response Lead (ORL) identified and deployed. Outbreak Management Response Leadership sends out activation email.	Outbreak Management Response Leadership ORL	Response Lead Activation Resources
Standard Operating Procedures: Immediate Actions			
☐	1.1 Contact Site Leadership/designate via phone to establish connection. *Use initial questions document and daily site check in log to gather/track the information/current situation at the site* **1.2 Ask if the site needs help with calling family members to notify of an outbreak. If required, link Site Leadership to FHA PCQO Lead and provide resident lists** • Confirm with Site Leadership that the Facility Medical Director (FMD) is notified of the outbreak **within 4 hours** from the time an outbreak is declared • Ensure facility has set up site Emergency Operations Centre and are aware to attend daily check in by email or phone with ORL. Include any contracted agencies for staffing, housekeeping, food services, laundry in the daily check-in • Ensure site has staff lists prepared for swabbing purposes	ORL	Initial Questions for Outbreak site.docx

Produced by FHA LTC-AL Outbreak Management Response Team
Sept 02, 2020
Revised March 2021

Status	Activity	Responsible	Refer to *Response Lead Folder on SharePoint*
☐	1.2. Arrange on site initial visit with Infection Prevention & Control (IPC), Clinical Nurse Educator (CNE) as available. • <u>If activated before 1200</u> - Organize same day site visit. Refer to Section 2, Initial Site Visit, below. • <u>If Activated after 1200</u> - Arrange and chair COVID-19 EOC teleconference with members below (if doing same day site visit, the t-con can occur next day): - Public Health Case Investigator - Facility Medical Director (FMD- if applicable) - Facility Leadership (DOC or designate) IPC)CNE *Ensure key priorities identified and have an action plan assigned to appropriate individuals - ORL, IP and CNE to plan for next day on site visit - Refer to Section 2, Initial Site Visit, below	ORL	4. Initial EOC Meeting Agenda Template.doc 5. Initial EOC Meeting Talking Points.docx
☐	1.3 Ensure active staff screening is in place. If site needs FH screener support, connect with screener lead with details of request.	ORL	Scheduling Screeners Active Screening Process

Produced by FHA LTC-AL Outbreak Management Response Team
Sept 02, 2020
Revised March 2021

Status	Activity	Responsible	Refer to *Response Lead Folder on SharePoint*
☐	1.4 Identify need for staff and resident cohorting in consultation with Site Leadership, IPC and Public Health	MHO/Public Health/ IPC	COVID Resource Toolkit
	Standard Operating Procedures: Initial Site Visit		
☐	2.1 **Pre-Site Visit:** ○ Review previous Prevention Assessment results ○ Review corrective action plan if applicable ○ Save a copy of most recent Prevention Assessment from Completed Prevention Assessments into Current Outbreak Site folder in Prevention Assessments on Share Point to use as a resource. **During initial site visit:** ○ Complete Prevention Assessment ○ The goal is to observe practices and environment and develop Integrated Action Plan for areas requiring follow up. Document findings in the Integrated Action Plan (in partnership with CNE/IPC/Facility Leadership) ○ Assess containment strategies as stipulated by IPC / Public Health and/or MHO. Refer to COVID Toolkit for outbreak management resources ○ Review key areas: staffing plan, PPE supplies, staff education needs ○ Share Site Duties Template with Site Leadership (optional)	ORL	Prevention Assessment Folder Site Duties Template

COVID-19 UPDATE

Status	Activity	Responsible	Refer to *Response Lead Folder on SharePoint*
	Continue daily check-in with Facility Leadership, IPC, PHN, FMD, and CNE to gather information/updates on key areas (staffing plan, PPE supplies, enhanced cleaning, education needs, screeners, audit results, etc.)		
☐	2.2 **Post Site Visit:** o Upload Prevention Assessment tool on SharePoint in Current Outbreak Site folder and Completed Prevention Assessment folder o Liaise with IPC and CNE to further discuss Integrated Action Plan for unmet or partially met indicators o Provide completed Integrated Action Plan with due dates of action items to Site Leadership	ORL	Prevention Assessment Folder Integrated Action Plan Quick Reference Guide
Standard Operating Procedures: Actions within 6 hours			
☐	3.2 Confirm with Site Leadership that site is maintaining single site restrictions during the outbreak	ORL	
☐	3.4 Ensure site continues to have safe staffing plan. If FH staff is requested, use guiding questions document to ensure facility has exhausted their ability to get required. If FHA staffing support is required: - Site to submit staffing request form after consultation with ORL	ORL	Staffing Request COVID Resource Toolkit
☐	3.5 Complete contact tracing for positive case(s)	Public Health	
☐	3.6 Post signage of outbreak status at access points and throughout the facility. Post reminder about protecting yourself at work from COVID-19 in area visible to all staff (e.g. staff breakroom)	Facility	

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Sept 02, 2020
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COVID-19 UPDATE

Status	Activity	Responsible	Refer to *Response Lead Folder on SharePoint*
☐	3.7 Develop isolation and cohorting plan for suspected ill or confirmed resident cases	MHO/Public Heath/IPC	
☐	3.8 Confirm if there are other services located on the same site, e.g. Assisted Living, Long Term Care, REHAB, PATH	Facility	
☐	3.9 Check potential supply shortages and work with vendors if resources limited. If supplies are required, despite exhausting all resources, submit request for supplies.	Facility	
☐	3.10 Confirm adequate number of swabs available.	Facility	Guidelines for Ordering Swabs
☐	3.11 Ensure control measures are in place to conserve the use of Personal Protective Equipment	Facility	PHSA Template Order Form PPE Weekend Process
☐	3.12 Facility to share communication letter templates provided by Public Health with staff/residents/families/tenants Prioritize family notifications based on resident proximity to affected staff/physicians/residents	Facility	
☐	3.13 Facility or PCQO staff to make phone calls to resident/families after letters have been distributed notifying of the outbreak	Facility/PCQO Staff	
☐	3.14 Confirm with FH PCQO Lead/Site Leadership to follow up if communication letters have been distributed and all resident/families have been called and notified of the outbreak.	ORL	

Produced by FHA LTC-AL Outbreak Management Response Team
Sept 02, 2020
Revised March 2021

Status	Activity	Responsible	Refer to *Response Lead Folder on SharePoint*
☐	3.15 Information Bulletin to Media	FHA EOC/Communications	
☐	3.16 Confirm with site that active screening for all staff, visitors and contractors is ongoing.	ORL	
☐	3.17 Check in with site regarding Site Leadership coverage plan to avoid burnout	ORL	
☐	3.18 Perform audits (PPE / Hand Hygiene / Environmental/ Declutter / Soiled Utility) using FH audit tools as per IPC schedule for the duration of the outbreak.	Facility	Audit Frequency Table
Standard Operating Procedures: Day 1-2			
☐	4.1 Ensure Site Leadership is prepared to initiate Point Prevalence Testing if directed by MHO and PH 4.1.1 Ensure site has adequate supply of Testing Kits 4.1.2 Ensure that site has adequate number of staff to collect the swabs. If more staff needed, request LPNs for swabbing from FH staffing deployment coordinator. 4.1.3 Provide Site Leadership with information about the Excel spreadsheet for Epi to follow test results. 4.1.4 Provide information needed to Site Leadership for secure file transfer via Cerberus. *If site requires further support, refer to algorithm 4.2 Share Coloured Floor Plan sample (optional)	ORL	Point Prevalence Testing Cerberus Instructions Testing Tracking Tool Colour Coded Floor Plan and Process
Ongoing Actions for the Duration of the Outbreak			

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Sept 02, 2020
Revised March 2021

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Status	Activity	Responsible	Refer to *Response Lead Folder on SharePoint*
☐	5.1 **Reporting:** - Complete Daily Check In Log on "N" drive after site daily meetings. - Complete Outbreak Management Report on SharePoint by 1200 pm.	ORL	
☐	5.2 Attend Outbreak Management Response Daily Situation meeting as scheduled to identify and report issues that require further discussion/escalation	ORL	
☐	5.3 Provide handover to next ORL as required	ORL	Response Lead Handover Process
	Standard Operating Procedures: Mid Outbreak		
☐	6.1 Perform mid outbreak Prevention Assessment as indicated by complexity of outbreak (Consult with IPC, CNE as indicated) to ensure facility is maintaining Action Plan • *Note:* Re-evaluate need for on site presence in partnership with Outbreak Management Response Leadership.	ORL	Prevention Assessment Folder Integrated Action Plan Quick Reference Guide
☐	6.2 Send communication letter as required to the Site Leadership updating the status mid outbreak. Site Leadership can then, share with their residents and families/staff	ORL	Resources-Communication Letter Template

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Sept 02, 2020
Revised March 2021

COVID-19 UPDATE

Status	Activity	Responsible	Refer to *Response Lead Folder on SharePoint*
	6.3 Complete Readiness Checklist prior to Step Down	Site/ORL	Readiness Checklist
	6.4 Review Step Down Protocol with Site Leadership • Site to complete and submit any plans required for Step Down Protocol	ORL	Step Down Protocol
Standard Operating Procedures: Step Down / Outbreak Over			
☐	7.1 Public Health to provide anticipated end date of when Outbreak will be declared over	Public Health	
☐	7.2 **Step 1:** ORL completes site visit with Site Leadership to ensure Integrated Action Plan items are completed. - Consult with IPC/CNE when planning visit to complete audit - If there are unmet indicators and risks indicated post Prevention Assessment, engage key stakeholders (PH, FMD, IPC, Outbreak Management Response Manager) and joint recommendations made when outbreak is to be declared over	ORL	Prevention Assessment Folder Integrated Action Plan Quick Reference Guide
☐	7.3 Public Health liaises with MHO	Public Health	
☐	7.4 MHO declares outbreak to be over at the site	MHO	
☐	7.5 Sends RION declaring Outbreak over	Public Health	
☐	7.7 Response Lead completes Debrief with Outbreak Management Response Leadership and all other stakeholders involved in the outbreak (IPC, CNE, Facility leadership).	ORL	Outbreak Debriefs
☐	7.7.1 Save Debrief on Sharepoint.	ORL	

Status	Activity	Responsible	Refer to *Response Lead Folder on SharePoint*
☐	7.8 Document Lessons Learned and share with the LTC/AL/IL Coordination Centre	Outbreak Management Response Leadership	

		Combined Review of LTC, AL, IL Prevention Assessment			
COVID-19 Prevention Assessment (Long-Term Care/Assisted Living/Independent Living) - (Version 8) - July 6- Prevention Steering Committee					
Site Name and Type: _____ **Site contact Name and email:_____** **Administrator Email:_____** **IPC Contact:_____** **Date of Assessment and Time:_____**					**Assessor Name:** **_____** **Assessment Type:** **_____**
#	**LEVEL**	**REVISED STANDARDS**	**REVISED RISK**	**REVISED TIPS for ASSESSORS**	**Rating by Assessor and Comments**
Note: "Site" or "home" used throughout to indicate Long Term Care, Assisted Living, or Independent Living where residents/clients/tenants live. Where a standard is applicable to some but not all of LTC, AL, or IL, this is indicated.					
Signage					**Rating by Assessor and Comments**
1	H	Signage is posted and easily visible at all entrance points advising staff and visitors of COVID-19 precautions.	High	TIPS: - Keep signage minimal, e.g., respiratory etiquette, physical distancing , PPE, do not to enter if symptomatic; - Signage aligns with FH/BCCDC signage AL/IL: Signs to include at entrances are (1) visitor policy, (2) If applicable, "Covid Outbreak in home" and (3) "Do not enter if sick" - Outbreak signage visible during outbreaks	

Legend for Scoring: Fully Met, Partially Met, Unmet or N/A

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				- Enhanced monitoring signage visible during enhanced monitoring.	
2	H	Precaution signage must clearly identify those on precautions and is posted outside the room/suite prior to entry. If no resident/tenant on precautions ensure that all signage is readily available for residents/tenants on precautions.	High	TIPS: Examples of Precaution signage are Droplet Precautions sign, Donning and Doffing sign (Donning and doffing is not an Additional Precautions sign), etc. Review if anyone on droplet precaution, and ensure signage is appropriately posted. For IL, site has a plan for placing Additional Precautions (or the donning and doffing) signs inside suites for any residents who do not want a Droplet Precautions sign outside their door.	
				In AL/IL, if resident/tenant gives consent, post Additional Precaution signage on the outside of the door to resident/tenant's suite. If resident/tenant does not consent to signage outside suite, post the signage inside the resident/tenant suite near the door.	

Entrance / Reception / Waiting Area - OBSERVATIONAL					Rating by Assessor and Comments
3	H	At all access/entrance points, the following is available and accessible: • Alcohol-based hand rub • Medical masks and eye protection for staff • Medical masks for visitors.	High	TIPS: to be used by all who enter the home/site. Check expiration dates. Supply should be available to staff, in the event staff member shows up without eyewear. **Answer this set of questions with "Yes, no or N/A"*	
4	H	A screening process is in place at all applicable entry points to the site.	High	TIPS: Refer to current active screening process •for all individuals, following processes in COVID-19 Toolkit, aligning with BCCDC guidelines. There is a controlled access point to home. This controls flow of staff and visitors, and helps with screening processes. Some homes may have more than one stand-alone building, so there will be more than one access point. Homes may also chose to have a separate entrance to control flow of visitors, to keep visitors separate from staff. This is acceptable if approved screening occurs at all these entry points. AL/IL: Assessor to ask if there is someone available to provide active screening. AL: is there active screening availabe after hours. IL: active screening in EM and Outbreak	

Visits - Essential, Family/Social, and External Contractors					Rating by Assessor and Comments
5	M	Essential visitation is in alignment with current Provincial and Public Health guidelines and orders.	Medium	TIPS: Refer to guidelines and orders from Provincial Health Officer, Medical Health Officers, BCCDC and Fraser Health. Resource: Essential visitation protocol and visitation table. The Home has a written plan for essential visits. Outbreak – Compassionate care visits for imminently dying residents by one person at a time are permitted. If one visitor cannot visit without support, two visitors may be permitted. Essential visits for reasons other than end of life might occur but requires MHO approval.	
6	M	Social visitation is in alignment with current Provincial and Public Health guidelines and orders.	Medium	TIPS: Refer to guidelines and orders from Provincial Health Officer, Medical Health Officers, BCCDC and Fraser Health. Resource: Visitation table. The home has a written plan for social visits.	

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7	L	Residents/clients/tenants have access to essential clinical services following FH Guidelines. These include services provided by private agencies (e.g., physiotherapist, foot care provider) and Fraser Health (e.g., home support worker, community health nurse, physiotherapists, and occupational therapist). There is a written site-specific plan.	Low	TIPS: Individuals in AL/IL might arrange their own care and AL/IL site does not have access to the written plan. Either the site or service provider can write the plan, but it is site's responsibility to ensure that there is plan in place for all essential clinical services	

Furniture & Hallways					Rating by Assessor and Comments
8	L	Furniture is cleaned on a regular scheduled basis.	Low	TIPS: All furniture is cleaned as part of the regular daily clean. There is a cleaning schedule for fabric furniture and a process in place to replace torn furniture. If furniture is visibly soiled or torn, it must be immediately removed until cleaned or replaced. Replacement is not urgent, however site should have an ultimate plan in place for replacement. This standard might not be applicable to IL; discuss with site. Reference: Environmental cleaning guidelines and best practices by FH IPC & BCCDC. PICNET link: https://www.picnet.ca/wp-content/uploads/British-Columbia-Best-Practices-for-Environmental-Cleaning-for-Prevention-and-Control-of-Infections-in-All-Healthcare-Settings-and-Programs.pdf	
9	L	Hallways are free of clutter (e.g. personal items, non-care or activity items that can be removed).	Low	TIPS: Personal items cannot be in hallways. In AL/IL, during outbreak, tenants are encouraged to bring personal items inside suites.	

Staff Screening					Rating by Assessor and Comments
10	H	Active Screening is conducted once per shift (at the beginning). In Outbreak and Enhanced Monitoring, staff screening increases to twice daily (at the beginning and again at mid-shift).	High	Tips: Staff screening strictly follows current screening process in the COVID Toolkit.	
11	H	All staff are provided with information on how to self-monitor for COVID symptoms and the correct process to follow if they have COVID symptoms. Staff are aware to not come to work if sick.	High	Tips: Staff who have COVID symptoms during their shift, are aware of correct processes to: report to the supervisor immediately, remove themselves from work, refer to a COVID testing assessment center, and self-isolate pending test results.	
12	M	Staff screening documentation must be retained (for 28 days).	Medium	TIPS: Documentation is accessible for review.	

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Resident/Client/Tenant Screening & Swabbing					Rating by Assessor and Comments
13	H	There is daily active screening for all residents/clients/tenants, including upon return to site. For IL tenants: active screening while on Outbreak. Screening process and frequency as per the COVID Toolkit and BCCDC guidelines	High	TIPS: Follow COVID Toolkit - active screening once per day, unless symptomatic. Isolation is not required for new admissions and residents returning from outings - symptoms include fever, chills, cough, Shortness of breath, sore throat, loss of sense of smell, nausea/vomiting, diarrhea, fatigue. - AL/IL: staff are not always aware when residents come and go - Assessor to check Home has a process.	

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14	H	Staff are aware of public health and IPC measures to follow when residents/clients/tenants become symptomatic.	High	TIPS: Review IPC measures in place for droplet precautions (signage, carts, equipment, supplies) and isolation. - Accessibility of supplies determined at site-level based on any behaviour concerns. If fabric/ reusable isolation gowns in use, staff utilize laundry hampers near rooms for disposal of soiled laundry. If IL Tenant is experiencing COVID symptoms, site staff will advise tenant of options for accessing COVID testing (e.g., Fraser Health Home Health or Community Testing Site, or physician) and if required will assist resident to access COVID testing. Site will provide symptomatic tenant with a medical mask and ABHR, and encourage tenant to isolate.	
15	M	Staff are knowledgeable of process and practices for performing required COVID testing. AL/IL staff and tenants know how to access COVID testing.	Medium	TIPS: LTC/AL - Refer to COVID Toolkit or BCCDC website. See KYI for Transportation of Dangerous Goods. IL - Site is knowledgeable on how to access COVID testing for residents, i.e., location of nearest community testing centre, how to access Home Health services, and will assist to arrange testing.	

Resident/Client/Tenant Movement					Rating by Assessor and Comments
16	M	LTC and AL: Site leaders and designated staff can demonstrate or describe the requirements about the current process and requirements for resident/tenant transfers, admissions, readmissions, discharges home from hospital. IL for new move-ins *IN PROGRESS* Further review for IL.	Medium		
Recreation & Outings					**Rating by Assessor and Comments**
17	M	Site follows FH LTC/AL COVID Toolkit and can describe current Provincial and Public Health guidelines for community outings, gatherings and entertainment including guidelines for visitors and volunteers.	Medium		

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18	L	Recreation programming follow FH LTC/AL COVID Toolkit and current Provincial and Public Health guidelines.	Low	TIPS: - implement IPC measures, HH before activities - During outbreak, all group recreation activities must be suspended. Only 1:1 can continue with cohorted staff. - use wipe-able or dedicated items for recreation programming or group activities *Individualized*- something that always goes back to the same resident each group (ex. their personalized art supplies that cannot be sanitized – pencil crayons, colouring sheets) *Dedicated*: used for the duration of a single group and sanitized afterward – or vice versa	
Education					**Rating by Assessor and Comments**
19	H	All staff have completed Hand Hygiene education (minimum annually).	High	TIPS: Refer to current education/training package and policy for modules and required scores and accountabilities.	
20	H	All staff have completed PPE education within the last 6 months	High	TIPS: PPE education (including donning and doffing) completed on a regular basis New staff: completed Orientation/PPE education Existing staff: refresher/education every 6 months	

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21	H	All staff are wearing PPE appropriately (as per Guidelines).	High	TIPS: Guidelines as per BCCDC, MOH and Fraser Health. Assessor to observe that staff are wearing appropriate PPE e.g. mask and eye protection.	
Nursing Units/ Medication Room / Care Station (can be on multiple floors and all need to be checked) - OBSERVATIONAL					**Rating by Assessor and Comments**
22	M	a) Area is clean, orderly and free of clutter.	Medium	TIPS: Areas include nursing units, medication carts, and applicable care offices. **Answer this set of questions with "Yes, no or N/A""*	
		b) Area has regular cleaning schedule (once per day, unless on outbreak).			
		c) Area is clear of personal items.			
		d) Medication carts (if applicable) have ABHR and wipes			
		e) Medication carts are cleaned each shift.			
23	L	Area is free of food and beverages.	Low	TIPS: No food or drink as masks must be worn. FH Food and Beverage policy: Food shall not to be displayed, served or eaten anywhere in or around the care station, reception desks and clinical patient areas. Beverages may be consumed in care stations, charting rooms, or other clean areas, provided they are in closed or sealed containers) During an outbreak, ensure staff are physically distanced (at least two metres) when consuming their beverage near others".	

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24	M	Area has a dedicated HH sink, or Alcohol Based Hand Rub (ABHR) (easily accessible).	Medium		
Soiled Utility Room/Housekeeping Room/Laundry Room					**Rating by Assessor and Comments**
25	M	Site implements strategies to restrict access to the soiled utility room, housekeeping room and laundry room (e.g. keep door to area closed). These rooms are orderly and free of clutter. Clean items cannot be kept in soiled utility room.	Medium	TIPS: Clutter should not detract from function of room. Garbage cans are easily accessible inside the rooms and not overflowing. AL/IL: Residents/tenants common garbage and recycling room has ABHR available. Clean garbage bags cannot be stored in soiled utility rooms.	
26	H	Hand hygiene sinks have paper towels and *plain* liquid soap dispensers in close proximity. The soap dispenser container is not empty. The hand hygiene sink is completely free from clutter.	High	TIPS: Hands-free sinks are optimal but not mandatory. HH sink - with soap and paper towel or ABHR is available in soiled utility room. If there are no HH sinks, staff can use the utility sink as back up, followed up by the immediate use of ABHR**.**	

27	M	If the site has on-site Laundry, all staff must follow Routine Practices when handling soiled laundry.	Medium	TIPS: Site applies correct principles for use of the laundry area; maintains one-way work flow, cleanliness and safety precautions in the laundry room, especially if site is a campus of care, and laundry area considered a "common area" for buildings that share space between LTC, AL, and or IL. Laundry hampers are available and are not overflowing and are inside the room wherever possible.	
28	M	If the site has a Resident/Tenant/Family Laundry Area, communal laundry rooms must have ABHR and cleaning and disinfection wipes available, and maximum occupancy sign is at entrance.	Medium		
PPE/Clean/Sterile Supply Room Storage					**Rating by Assessor and Comments**
29	M	a) PPE and other clean supplies must be stored in a designated secured, safe and clean area accessible only to staff	Medium	TIPS: - If PPE is stored in the clean supply room or in resident care areas, it must be removed from the cardboard boxes and placed in PPE carts or wipe-able containers.	

		b) Clean supply rooms (that include items such as dressing supplies) shall be clean, locked and accessible only to staff.		- PPE supplies in clean supply rooms must be kept at least 18 inches below the ceiling, at least 8 inches above the floor and at least two inches from the outside wall. - PPE that is not stored in either the clean supply room or resident care areas may remain in cardboard boxes and does not need to be stored away from the wall. As per CSA standards, if shipping pallets are used forstorage of unopened containers (e.g. shipping boxes); the clearance from the floor may be reduced to 10 cm (4 inches), provided that the pallets are lifted and the floor underneath is cleaned at specified intervals (every 6-12 months). For d) If does not apply to site, select "yes" **Answer this set of questions with "Yes, no or N/A"*	
		c) There is a cleaning frequency established for cleaning shelves/carts/containers that store clean and sterile supplies (i.e. every 3 months)			
		d) Sterile packages are routinely checked for expiry dates and integrity			

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30	H	PPE is available, stored appropriately and accessible for all staff and staff have access to required PPE for direct care to residents or tenants.	High	TIPS: Site PPE supplies are adequate (minimum 7-day supply) to ensure that the home is prepared in the event there is an outbreak. Site has proactively sourced and obtained PPE carts, which are readily available and on the unit if an outbreak is declared. AL and IL: It is possible residents/tenants might not have disclosed CPAP/BiPAP/AGP to site. Follow Standard Operating Procedure for AGP. For LTC: This includes N95 respirators for sites who have residents requiring aerosol-generating procedures.	
Dining Areas (e.g. kitchenettes, serveries, eating area)					**Rating by Assessor and Comments**
31	M	During Outbreak and Enhanced Monitoring, kitchenettes, bistros and dining rooms are not accessible to residents/clients/tenants, and only accessible to designated staff.	Medium	TIPS: Food and beverage service must be monitored. Self- service is allowed with regular monitoring, good hand hygiene and regular cleaning.	
32	M	Site has a documented schedule to ensure cleaning of all surfaces in dining area following every meal/sitting.	Medium	TIPS: Sites must demonstrate they have a schedule for cleaning. Outbreak: dining rooms are closed. Enhanced monitoring: dining room may be closed, PH to provide more specific guidance depending on risk.	
33	H	a) Shared dining is within a unit, floor, or consistent group with assigned seating.	High	During Outbreak: no shared dining. During Enhanced Monitoring: shared dining may	

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		b) Dining area/kitchenette/bistro has hand hygiene sink available and/or ABHR is accessible to staff.		occur, PH to provide more specific guidance depending on risk.	
		c) Site has a process to clean resident hands or prompt tenants to clean their hands, before and after mealtime.		**Answer this set of questions with "Yes, no or N/A"*	
Housekeeping					**Rating by Assessor and Comments**
34	H	Site has a regular daily cleaning place for the entire site.	High	TIPS: AL/IL make attempts to clean individual suites on droplet precautions (with recognition that tenants in AL/IL may refuse housekeeping service).	
				If a resident is on Additional Precautions (Contact or Droplet), their suite is be cleaned last. During an Outbreak/Enhanced Monitoring, enhanced cleaning must be performed (Enhanced cleaning: a regular site clean plus an extra clean (a second clean) of high touch surfaces (6 - 8 hours after initial clean).	

35	H	Any cleaning equipment that is shared between rooms/suites is cleaned and disinfected between rooms/suites. Recommend individual toilet brushes unless BSTN.	High	TIP: Replacement of toilet brushes every three months (same as privacy curtains) - unless visibly soiled, broken, etc. If a resident is on Additional Precautions (Contact or Droplet), their suite is be cleaned last.	
36	L	Garbage bins in common areas and staff areas are hands-free. When not hands-free, there are effective strategies in place to ensure staff have ability to perform hand hygiene after touching the dirty garbage can.	Low	TIPS: Home Support workers dispose of PPE immediately after use in single use plastic bag for IL. Garbage cans without lids are acceptable. Garbage cans are easily accessible and not overflowing.	
37	H	Site uses a cleaner/disinfectant that has a Drug Identification Number (DIN) and comes from the Health Canada list of approved disinfectants. The site follows Canada's manufacturer's instructions for use, including wet contact time.	High	TIPS: Sites may not use sprayers or foggers - does not meet cleaning and disinfection process, plus this is a WorkSafe safety risk. No spray is allowed	

Staff Break Rooms					Rating by Assessor and Comments
38	H	a) Signage in breakroom includes occupancy limit, breakroom instructions and hand hygiene sign by sinks.	High	TIPS: Scoring: Fully met = meet all 6 (A-F). Partially met = 5/6. Not met = 4 or less. During routine prevention, individually packaged food can be provided to staff. One individual staff may serve food with proper serving protocols using tongs/utensils. Multiple staff may not touch the serving items.	
		b) Break rooms have appropriate access to PPE, ABHR and wipes to clean and disinfect tables following use.		**Answer this set of questions with "Yes, no or N/A"*	
		c) Home has a plan for cohorted breakrooms and washrooms when on Outbreak.			
		d) High touch surfaces, including microwave, cabinet and fridge handles			

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		are cleaned daily. Interior of fridge and microwave are cleaned monthly or more often as needed. Break rooms need to have a daily clean as part of the site daily clean. During Outbreaks: a regular room clean plus an extra clean of high touch surfaces (6 - 8 hours after initial clean. (see element 34). *Remove items touched by multiple staff such as puzzles/magazines/books*		**Answer this set of questions with "Yes, no or N/A"*	
		e) Food is not be shared between staff. No serving of food of any kind in the break room during Outbreak.			
		f) Site leader(s) have a plan to ensure compliance, and regularly check for compliance.			

Reprocessing -Cleaning instructions					Rating by Assessor and Comments
39	H	Staff are aware of, and adhere to, the process of cleaning and disinfection of equipment before and after use. Signage is posted on all equipment to clean and disinfect the equipment before and after each use.	High	TIPS: LTC: Cleaning instructions are available for all shared equipment, following Manufacturer's Instructions for Use. Most LTC sites do not perform high-level disinfection. However, if they do, there must be an acceptable process for equipment requiring sterilization. AL: This might not apply to AL as individuals have their own equipment and supplies e.g. blood pressure monitor. IL: If IL has a tub/spa that is shared, this Standard would apply.	
Audits					**Rating by Assessor and Comments**
40	L	Hand Hygiene audit results are shared with team members and volunteers.	Low	TIPS: The site needs to have evidence that audit results are shared with staff, such as posted and shared verbally or by email. Audit results should be publically posted in accredited settings according to Accreditation Canada guidelines. All settings need to have evidence that audit results are shared and communicated with staff, and have the audit results available upon request.	

41	H	Audits are completed as per Infection Prevention and Control Guidelines:	High	TIPS: Refer to IPC Audit Frequency Table. Hand hygiene audit frequency will increase to three times a week during outbreaks or daily if a complex outbreak) In AL: assessor to observe staff complete hand hygiene or ask about most recent hand hygiene activity **Answer this set of questions with "Yes, no or N/A"*	
		a) Hand Hygiene			
		b) PPE			
		c) Environmental			
		d) Declutter			

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Hand Hygiene (HH)					Rating by Assessor and Comments
42	M	A)Four Moments of Hand Hygiene signage in applicable areas B) How to wash your hands (Step-by-step guide)signage are posted in applicable areas	Medium	TIPS: TIPS: Examples of applicable areas are - communal washrooms, activity rooms and other areas where hand washing is available. Hand Hygiene (step-by-step) poster should be near sinks. 2-3 ABHR posters required per neighbourhood/area. For some sites - 4 moments in care areas/ nursing stations. - Quantity based on site layout. - Reusable signs to be wipe-able and wet/soiled signs replaced. - In AL, 4 moments poster is not posted in resident suites, but can be posted in care office and possibly tub room for staff reference. - For IL, use signage that describes how to perform Hand Hygiene, not 4 Moments poster.	

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43	H	Sites have general plans/strategies for residents/tenants/visitors who are non-compliant with prevention measures. Staff are provided with information and training on how to address concerns with residents/tenants who are not following IPC recommendations.	High	TIPS: Individual care plans may be required for resident specific triggers. There should be a risk mitigation plan for residents who wander - in adherence to FHA Guidelines. AL/IL: This standard (including care plan) may not be applicable. Assessor to ask if there are any wandering tenants, tenants who might not comply with isolation requirements, and/or tenants who are waiting for a higher level of care because of cognition concerns.	
44	H	ABHR or Hand Hygiene sink is readily available in required locations.	High	TIPS: Sinks or ABHR are needed at Point of Care locations, elevator entrances, entrances, dining rooms, shared recreation areas, etc. Minimum: Approximately, one wall mount (Wall mount is preffered over portable).ABHR accessible per every grouping of 3 resident rooms in LTC; Personal ABHR is acceptable. Key is to implement HH as per 4 moments of hand hygiene. If using resident room sinks, wash your hands if visibly soiled and then use ABHR after using the sink. For IL: ABHR dispenser or hand hygiene sink needs to be readily accessible in all common areas, doorways and at all elevator entrances.	

Staffing					Rating by Assessor and Comments
45	H	Site has a written contingency staffing plan in order to ensure that essential services can be sustained.	High		
Other					**Rating by Assessor and Comments**
46	M	Leadership – There is a designated leader present on the site 7 days a week. The leader is actively engaged with team members, residents/tenants, and families in the implementation and sustainment of prevention measures.	Medium		
47		*Stand Alone Item* Staff COVID-19 vaccination rate. First dose immunization - under 80% high risk; 80-90% medium risk; 90+ low risk.		TIPS: Site has a process for tracking and reporting client and staff vaccination rates	

Vaccine Info Needed:

The current number of residents/tenants at this care home:

(Total Number) _____ (Number with 1st vaccine) _____ (Percentage Vaccinated) _____

The current number of ACTIVE STAFF who have worked in the past 3 months (includes full-time, part-time and casual – direct care, support staff, administrative and leadership)

(Total Number) _____ (Number with 1st vaccine) _____ (Percentage Vaccinated) _____

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Vancouver CoastalHealth
Promoting wellness. Ensuring care.

November 25, 2020

To: Directors of Care, Licensed Long Term Care Facilities in the Vancouver Coastal region

Re: Preventing the Introduction and Spread of COVID-19 in Long Term Care – 5 Critical Actions

With recent increases of COVID-19 cases in the community, Licensing is reminding long term care operators of the importance of focusing on the following **five critical actions** to prevent the introduction and spread of virus into facilities:

1. **Clinical Leadership**

The Director of Care has overall accountability for ensuring all processes are in place as outlined in this letter. Facilities must also ensure that a **Nursing Supervisor (DC2 Level)** provides on-site clinical leadership on days, evenings and weekends, ideally 12 hours per day, 7 days per week. Critical functions include ensuring staff symptom screening before each shift, monitoring staff compliance with infection prevention and control practices including consistent and appropriate use of personal protective equipment (PPE), and active surveillance and swabbing of residents as appropriate.

2. **Maintaining Appropriate Staffing Levels**

All facilities must **maintain adequate staffing levels** as per the approved hours per resident day allocation that support care needs being met and the operation of the facility. Care should be paid to ensuring all shifts are appropriately staffed and that there is one Registered Nurse per 100 patients on night shifts, 7 days per week. If working short, staff are more likely to have lapses in their infection prevention and control practices, which is why staffing levels are critical to preventing the introduction and spread of COVID-19.

3. **Screening of Staff Before Every Shift**

All staff (clinical and non-clinical) must be **screened and assessed for signs and symptoms of COVID-19** at the start of each shift using the latest VCH approved tools. A screener with clinical expertise should be available at all times for screening and assessment; staff should not be self-assessing for symptoms. The screening station should be located at the front of the facility and in such a way that staff are not able to bypass the screener or station. Screening forms must be retained and made available if needed for the purposes of public health contact tracing.

4. **Active Surveillance of Residents**

All residents must be **monitored daily** (twice daily during outbreaks) for signs and symptoms of COVID-19, or any change in their clinical status, and swabbed accordingly. Use the VCH LTC resident

assessment tool for surveillance purposes and document results in each resident's chart. Facilities must maintain appropriate PCR swabs for resident testing.

5. **Appropriate Use of Personal Protective Equipment (PPE)**

Maintain an adequate supply of medical grade, Health Canada-approved masks, gowns, gloves and eye protection. Supplies must be readily accessible to staff and visitors as per current provincial guidelines and should not be rationed e.g. new masks must be available and donned by staff after eating. Ensure all staff are **trained in the appropriate use of PPE**, and our monitored throughout their shift by their supervisor to ensure appropriate practices. Staff should wear medical masks at all times, including in break rooms and change areas, except when eating or drinking. While eating or drinking, staff should maintain 2 metres distance from others.

In addition to these five critical actions, facilities are reminded of the importance of maintaining environmental services/housekeeping during day, evening and night shifts, and of ensuring access to alcohol-based hand rub or hand hygiene sinks at all nursing stations and in all resident rooms.

Finally, a reminder that facilities must report any new cases of COVID-19 amongst residents or staff to the Medical Health Officer at 604-675-3900, or after-hours 604-527-4893.

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Brief Report

Serological survey following SARS-COV-2 outbreaks at long-term care facilities in metro Vancouver, British Columbia: Implications for outbreak management and infection control policies

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A B S T R A C T

A cross-sectional serological survey was carried out in two long-term care facilities that experienced COVID-19 outbreaks in order to evaluate current clinical COVID-19 case definitions. Among individuals with a negative or no previous COVID-19 diagnostic test, myalgias, headache, and loss of appetite were associated with serological reactivity. The US CDC probable case definition was also associated with seropositivity. Public health and infection control practitioners should consider these findings for case exclusion in outbreak settings.

BACKGROUND

Long-term care (LTC) facilities are high-risk settings for transmission of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the causative agent of coronavirus disease 2019 (COVID-19). Given the high mortality rate associated with COVID-19 among LTC residents,[1] timely and evidence-informed interventions are critical for mitigating transmission risk. Serological testing may be useful to evaluate and inform public health infection control practices by uncovering cases missed during an outbreak using current laboratory-based and clinical case definitions.[2]

Communicable disease case definitions can be utilized in public health for a variety of purposes (ex. surveillance). In the context where diagnostic tests are not rapidly available or have limited sensitivity, symptom-based case definitions are essential. In LTC outbreaks, uncontrolled introduction of infections not identified through testing may perpetuate transmission despite outbreak control measures. Currently, various national probable/epidemiologically-linked (clinical) case definitions largely focus on respiratory symptoms (ie, cough and shortness of breath), with varying inclusion of systemic/generalized symptoms (ie, fever, chills, loss of appetite)(Appendix A). Given LTC residents often present with nonspecific generalized symptoms for other respiratory pathogens,[3] potential cases of COVID-19 are likely missed and potentially contribute to propagation within LTC facilities.

Our analysis aims to provide a descriptive overview of a serological survey of LTC residents and staff members following outbreaks at 2 facilities and evaluate clinical case definitions of COVID-19 used in LTC outbreaks against serological results.

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METHODS

A cross-sectional serological survey of LTC residents and staff members was administered from May 4th to 14th, 2020 at 2 adult LTC facilities located in the Metro Vancouver area, British Columbia. These LTC facilities experienced large outbreaks, in which 107 residents and 59 staff had become COVID-19 cases at the time of serological sample collection. The onset of the outbreaks at the 2 facilities were March 5th (Facility A) and March 17th (Facility B), 2020. Individuals (or their substitute decision maker) working (staff) or living (resident) in the LTC facility during the outbreaks were included after providing informed verbal consent for venous blood specimen collection.

Venous specimens were tested using an orthogonal approach[4] with 5 different commercially-available SARS-CoV-2 antibody assays with varying target immunoglobulin and epitopes (Appendix B), in accordance with manufacturers' recommendations. Each individual was assigned by a medical microbiologist into "reactive", "nonreactive" or "equivocal" category based on degree of agreement/disagreement of aggregate antibody results from all tests.

All nucleic acid amplification tests (NAAT) for SARS-CoV-2 performed on nasopharyngeal swab samples testing were carried out in fully accredited clinical laboratories for clinical purposes, following routine best practice guidelines. Specimens were tested utilizing either a fully validated laboratory developed test targeting the E-gene and RdRP gene regions of SARS-CoV-2 (BC Center for Disease Control Public Health Laboratory), a fully validated laboratory developed test targeting the E-gene region of SARS-CoV-2, or a fully validated commercially developed cobas SARS-CoV-2[5] test targeting the orf-1a/b and E-gene regions of SARS-CoV-2 (St Paul's Hospital).

Clinical information (symptomatic/asymptomatic history, symptoms recorded, medical comorbidities, medications) for each individual was gathered by abstracting data from a standardized case report form (Appendix C), medical charts of LTC residents, and phone interviews. Resident symptoms were documented through a combination of resident report/staff observation and utilization of a standardized symptom checklist(Appendix D). Symptom onset dates were captured using both clinical information and diagnostic test data (Appendix E). Participants were classified as immunocompromised or immunocompetent using provincial criteria (Appendix F). Data on clinical information and diagnostic test results were abstracted from May 22nd to June 5th 2020.

Descriptive statistics of the study population were summarized in R (v.3.6.2) and STATA (v.15). Multivariable logistic regression (adjusting for age, gender, and facility) was used to generate adjusted odd ratio (aOR) estimates of associations between serological results and different individual symptoms, symptom clusters (Appendix A), immunocompromise status (yes vs no) and history of negative NAATs (<3 vs ≥3). Covariate selection accounted for differences between staff and residents (age, gender) and facility characteristics. Individuals for whom we could not access a clinical history were excluded from regression analyses (n = 6).

Research ethics board review was not required, as this study was part of routine public health operations for quality improvement and program evaluation.

RESULTS

Serological testing was offered to all residents and staff in both facilities, with 44% (303/691) consenting to participate (48% staff, 39% residents). A total of 303 LTC residents (n = 127) and staff (n = 176) were included in the study. After excluding 12 individuals with equivocal serological results, 39% (n = 113) were reactive and 61% (n = 178) were nonreactive. Table 1 provides a descriptive epidemiological summary of study participants. The median time between symptom onset and serological collection was 50 days (IQR = 15) for the entire cohort, 52 days (IQR = 9.5) for NAAT positive cases, and 48 days (IQR = 23.5) for no or negative NAAT cases.

Among the entire study cohort, loss of smell/taste (aOR = 45.98, 95% confidence interval [CI]: 5.12-412.72), shortness of breath (aOR = 21.22, 95%CI: 5.91-76.22), headache (aOR = 13.00, 95%CI:5.47-30.86), loss of appetite (aOR = 10.94, 95%CI:1.27-94.53), fatigue (aOR = 10.90, 95% CI: 4.48-26.48), and myalgia (aOR = 10.80, 95%CI: 4.55-25.60) were most prominently associated with increased odds of reactive serology (Fig 1A). All symptom cluster case definitions were significantly associated with seropositivity (Fig 1C). Participant immune status was not associated with seropositivity (aOR = 0.29, 95%CI: 0.05-1.66), even among residents only (aOR = 0.83, 95%CI: 0.08-9.07). At last, the absence of recorded symptoms was associated with decreased odds of being seropositive (aOR = 0.08, 95%CI: 0.04-0.15).

Among, individuals with a negative or no previous NAAT, only myalgias (aOR = 7.51, 95%CI:2.00-28.25), headache (aOR = 14.27, 95%CI:3.78-53.90), loss of appetite (aOR = 33.23, 95%CI:3.19-345.90),

Table 1
Characteristics and epidemiological summary of study participants

Cohort demographics	Reactive (n = 113)		Non-reactive (n = 178)		Overall (n = 291)	
	Residents N (%)	Staff N (%)	Residents N (%)	Staff N (%)	Residents N (%)	Staff N (%)
Total cases	68	45	54	124	122	169
Facility						
Facility A	31 (46)	23 (51)	5 (9)	48 (39)	36 (30)	71 (42)
Facility B	37 (54)	22 (49)	49 (91)	76 (61)	86 (70)	98 (58)
Age (y)						
Median (IQR)	86 (14)	50 (20)	86 (14)	49 (18)	86 (15)	49 (18)
Sex						
Female	51 (75)	32 (71)	33 (61)	94 (76)	84 (69)	126 (75)
Male	17 (25)	13 (29)	21 (39)	30 (24)	38 (31)	43 (25)
Symptomatic						
Symptoms reported	58 (85)	37 (82)	22 (41)	39 (31)	80 (66)	76 (45)
No symptoms reported	10 (15)	8 (18)	32 (59)	85 (69)	42 (34)	93 (55)
NAAT result						
Positive	50 (74)	30 (67)	0 (0)	0 (0)	50 (41)	30 (18)
Negative	9 (13)	7 (16)	51 (94)	84 (68)	60 (49)	91 (54)
No Result*	9 (13)	8 (18)	3 (6)	40 (32)	12 (10)	48 (28)
Immunocompromised						
Yes	14 (21)	1 (2)	7 (13)	1(1)	21 (17)	2 (1)

*Indicates that no specimen was collected to be sent for NAAT.

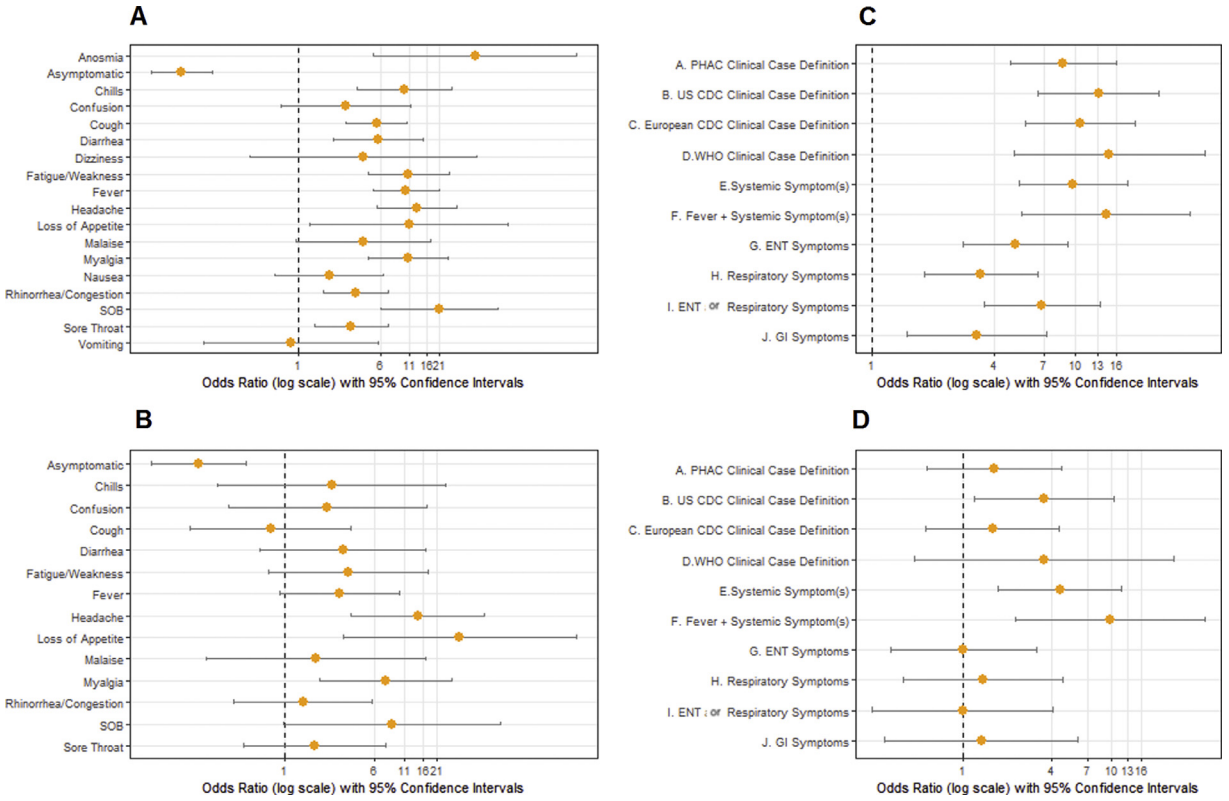

Fig 1. Odds of serological reactivity based on symptoms and symptom clusters. (A and B) Depict (age, gender and facility) adjusted odds ratios (aORs) on a log10 scale for seropositivity of individual symptoms among the entire population (1A) or among individuals with a negative or no NAAT test prior to serological testing (1B). Anosmia, dizziness, nausea, and vomiting are not reported in 1B due to extremely broad confidence intervals. (C and D) Depict aORs (on a log10 scale) for seropositivity of symptom clusters (Appendix A) among the entire population (1C) or among individuals with a negative or no NAAT test prior to serological testing(1D). Anosmia, loss of smell/taste; SOB, shortness of breath/difficulty breathing; PHAC, Public Health Agency of Canada; US CDC, United States Centre for Disease Control; European CDC, European Centre for Disease Prevention and Control; WHO, World Health Organization.

and ≥3 negative NAAT (aOR = 29.04, 95%CI:5.60-150.57) were significantly associated with increased odds of reactive serology (Fig 1B).

Various national clinical case definitions were evaluated (Fig 1D) for individuals with no or negative prior NAAT in the context of a high-risk outbreak setting. No significant association with serological reactivity was observed using the Canadian (aOR = 1.64, 95%CI: 0.58-4.62), European (aOR = 1.59, 95% CI: 0.57- 4.49), or World Health Organizations'(WHO) (aOR = 3.55, 95% CI: 0.48-26.46) definitions; however, a significant association was observed for the US CDC case definition (aOR = 3.56, 95% CI: 1.21-10.45). Other significant case definitions included having at least one systemic symptom (aOR = 4.54, 95%CI: 1.74-11.82) and fever with one additional systemic symptom (aOR = 9.89, 95% CI: 2.28-42.84).

DISCUSSION

Findings of this study are consistent with the results published by Menni et al, which also demonstrated a strong association between COVID-19 diagnosis and systemic symptoms[6]; however, our findings provide additional insight to inform outbreak management practices and policies in LTC facilities. Our study also contributes to the growing evidence for mild/atypical presentations of COVID-19 particularly among the elderly, such as falls, dizziness, and confusion.[7] In other LTC settings, poor identification of these atypical symptoms has contributed to ongoing transmission of SARS-CoV-2.[8] Serological studies of COVID-19 have largely focused on cluster identification and characterization,[9] assessment of seroprevalence,[10] and patterns of seroconversion.[11] A recent study among hospitalized patients also utilized serology to identify cases with negative NAAT or asymptomatic infections[12]; however, no studies to date have used serology to inform clinical case definitions and subsequently infection control measures in LTC facilities.

Our findings support using a low threshold for symptoms in LTC settings (particularly nonrespiratory symptoms) when considering exclusion and isolation of symptomatic staff and residents. Given the nonspecific nature of symptoms found to be highly predictive, such as headache, myalgia, and loss of appetite, implementation of universal contact/droplet precautions early in the outbreak may be effective in curbing transmission within facilities, rather than relying on isolating residents when they present with fever and/or respiratory symptoms. Moreover, staff and residents with several negative NAATs for COVID-19 should warrant further investigation with serology and/or be considered a clinical case if repeat NAAT testing is due to persisting symptoms. At last, ongoing evaluation of the Canadian, European, and WHO probable case definitions in outbreak settings is necessary, given gaps in COVID-19 diagnosis highlighted by this and other serological studies.[12] Amendment to align more closely with the US CDC definition, which was more sensitive to historical infection in this analysis, may be appropriate in LTC outbreak settings.

Strengths of this study include serological testing on several platforms and utilization of multiple sources (ie, phone interviews, medical charts, and public health data) to gather reliable clinical histories immediately after the outbreak; however, the study was limited by the small sample size, preventing further regression analysis stratified by case type. Given that systematic collection of clinical histories was refined over the duration of the outbreaks, symptoms may have been underreported for some resident cases. Our findings should be

generalized to other settings with caution, as the study was conducted in an outbreak setting with a high pretest probability for COVID-19.

The use of serological testing introduced some additional limitations. Baseline serological testing was not available at the start of the outbreaks and thus prior cases may not have been identified; however, both LTCF facilities represent the earliest COVID-19 outbreaks and cases in Canada, reducing the theoretical probability of prior infection to the start of the outbreak. Due to the rapid and evolving nature of the pandemic response, there is also potential risk for misclassification bias, as the clinical and diagnostic laboratory data structures used to compare and interpret serology results underwent continual quality improvement and reconciliation. While diagnostic misclassification may also occur due to the performance characteristics of COVID-19 serological assays, tests used in this evaluation were found by the performing laboratory to have specificity of 97%-99.5% and sensitivity of up to 98% at >14 days from symptoms onset. An orthogonal approach to the interpretation of test results further improved the overall specificity.

CONCLUSION

Our serological survey demonstrates that generalized/nonspecific symptoms and repetitive negative NAAT testing are highly associated with seropositivity. The findings of this survey can help inform case identification when managing COVID-19 outbreaks in LTCFs.

CONTRIBUTION STATEMENT

All authors made substantial contributions to the manuscript, including the conception/design (RV, AH, IS, MMu, PL), data acquisition (IS, MMu, MMc, PL, MK, AM, NC, SB, MS), data analysis (RV, CG), and interpretation of data for the work (all authors). RV initially drafted the manuscript, with all authors revising it critically for important intellectual content. All authors provide final approval of the version to be published and agreed to be accountable for all aspects of the work.

SUPPLEMENTARY MATERIALS

Supplementary material associated with this article can be found in the online version at https://doi.org/10.1016/j.ajic.2020.10.009.

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Original Article

Evaluation of a multisectoral intervention to mitigate the risk of severe acute respiratory coronavirus virus 2 (SARS-CoV-2) transmission in long-term care facilities

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Abstract

Objective: A Canadian health authority implemented a multisectoral intervention designed to control severe acute respiratory coronavirus virus 2 (SARS-CoV-2) transmission during long-term care facility (LTCF) outbreaks. The primary objective was to evaluate the effectiveness of the intervention 14 days after implementation.

Design: Quasi-experimental, segmented regression analysis.

Intervention: A series of outbreak measures classified into 4 categories: case and contact management, proactive case detection, rigorous infection control practices and resource prioritization and stewardship.

Methods: A mixed-effects segmented Poisson regression model was fitted to the incidence rate of coronavirus disease 2019 (COVID-19), calculated every 2 days, within each facility and case type (staff vs residents). For each facility, the outbreak time period was segmented into an early outbreak period (within 14 days of the intervention) and postintervention period (beyond 14 days following the intervention). Model outputs quantified COVID-19 incidence trend and rate changes between these 2 periods. A secondary model was constructed to identify effect modification by case type.

Results: The significant upward trend in COVID-19 incidence rate during the early outbreak period (rate ratio [RR], 1.07; 95% confidence interval [CI], 1.03–1.11; $P < .001$) reversed during the postintervention period (RR, 0.73; 95% CI, 0.67–0.80; $P < .001$). The average trend did not differ by case type during the early outbreak period ($P > .05$) or the postintervention period ($P > .05$). However, staff had a 70% larger decrease in the average rate of COVID-19 during the postintervention period than residents (RR, 0.30; 95% CI, 0.10–0.88; $P < .05$).

Conclusions: Our study provides evidence for the effectiveness of this intervention to reduce the transmission of COVID-19 in LTCFs. This intervention can be adapted and utilized by other jurisdictions to protect the vulnerable individuals in LTCFs.

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Long-term care facilities (LTCFs) have been disproportionately affected by coronavirus disease 2019 (COVID-19). The high incidence and case fatality rate of LTCF residents highlights the vulnerability of frail individuals with numerous comorbidities in a congregate setting with a long duration of stay.[1,2] Across Canada and Europe, most COVID-19–related deaths have occurred in LTCFs.[1-3] In British Columbia, 59% of COVID-19–related deaths were in LTCFs, compared to 75% in Canada overall and 30%–60% across Europe.[3,4] In the United States, a single COVID-19 outbreak in an LTCF facility in Washington State resulted in 62% of the LTCF residents becoming infected, of whom 56.8% were subsequently hospitalized and 27.2% died.[5]

Many large COVID-19 outbreaks have been attributed to a failure in proactive surveillance and early recognition of potentially infected patients, as well as a failure to rapidly implement appropriate infection control measures.[3,5] A national Canadian military report of 5 LTCFs experiencing COVID-19 outbreaks highlighted serious concerns regarding infection control practices, frontline working conditions, limited supplies, and poor policies and procedures.[6] Additionally, increased crowding, use of communal spaces, low staffing ratios, and documented index infection in staff members all increase the risk of a COVID-19 outbreak in LTCFs.[7] Given the significant mortality among residents, proactive infection

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prevention measures, as well as effective outbreak management by public health, are necessary to reduce and/or prevent subsequent COVID-19 cases when they are detected in the facility.

The first Canadian LTCF COVID-19 outbreak and resident death occurred in British Columbia, within the Vancouver Costal Health (VCH) region.[8] As a result, mitigating the transmission of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in LTCFs quickly became a top priority. A rapid, coordinated, and multistakeholder outbreak control response was developed to specifically support LTCFs. A multifaceted intervention containing a bundle of outbreak control measures was developed and immediately implemented following the initiation of each facility's outbreak response. This was accomplished through collaboration between LTCF leadership and regional residential care, infection prevention and control (IPAC), and public health programs.

The objectives of this study were (1) to provide a descriptive overview of LTCF COVID-19 outbreaks, (2) to evaluate the effectiveness of the intervention (a bundle of outbreak control measures) in terms of reducing subsequent transmission among residents and staff, and (3) to inform the ongoing public health approach to managing COVID-19 outbreaks in LTCFs.

Methods

Setting

In British Columbia, acute, community, residential care as well as public health are delivered by 5 geographically defined regional health authorities (RHA), one of which is VCH. A unique and important feature of public health in British Columbia involves the licensing and regulation of LTCFs.[9] Moreover, RHAs can also be responsible for directly operating or financially supporting many LTCFs within their region.

VCH is responsible for providing care to ~1.25 million people (25% of the BC population). There are 75 LTCFs located within the VCH region (19% of all facilities in the province), of which 21% and 57% are respectively owned or financially supported by VCH. As of May 2020, 35% (76 per 100,000 population) of all COVID-19 cases in the province were located in the VCH region. The study period of our analysis spanned February 28, 2020, through May 24, 2020.

Study population

All LTCFs with a documented exposure to a laboratory-confirmed case of COVID-19[10] among staff members or residents that resulted in <2 subsequent cases in the facility were excluded because there would not be enough data to carry out a segmented regression analysis. Asymptomatic cases (n = 19.6%) were excluded from the analysis because their incidence could not be clearly reliably attributed to the early outbreak period versus the postintervention period. Eligible facilities varied in size, ranging from 108 to 259 staff and from 107 to 210 residents (Appendix 1 online).

Data collection

All COVID-19 cases residing within VCH were contacted by public health staff for case management and contact tracing through a standardized data collection form.[11] Staff collected case information including demographics, symptom onset date, exposure details, association with high-risk settings, and high-risk contacts through patient and family interviews and medical chart review. Data were centrally compiled to form a master case list and an individual facility line list. Cross validation of data for each case was carried out between the master case list and individual facility line lists. Conflicting or missing values were reconciled and corrected through a review of these cases. Total resident and staff numbers within each LTCF during the outbreak period were obtained from licensing records (ie, staff and resident census lists).

Study intervention

A bundle of outbreak control measures were imposed by public health upon outbreak declaration and are summarized in Table 1.

Primary outcome

Our primary outcome of interest was the COVID-19 incidence rate within each facility, which was calculated for staff and residents using case counts over 2 days, divided by the total population in the facility at-risk (removing individuals who became cases in previous time periods). Symptom onset dates (instead of case report dates) were used as a marker for incidence because of the inherent delays between exposure and case identification.

Potential confounders

Staffing levels for IPAC were similar across facilities as it was delivered by an outreach team that would deploy immediately following declaration of a facility outbreak. A daily meeting between regional LTCF operation leads, public health representatives, and the LTCF administration ensured consistent resource allocation, maintenance of staffing levels, and adherence to consistent IPAC recommendations during each LTCF outbreak. Lastly, our model accounted for background community infection rates (Appendix 2 online).

Study design

The study was a quasi-experimental before-and-after study based on a segmented time-trend regression analysis of interrupted time-series data. Segmented regression analysis of time-series data is a widely used method to evaluate the effect of population-level interventions or policy changes implemented at a discrete point in time.[12] For these reasons, we used this method to evaluate the impact of this intervention on preventing further transmission and spread of severe acute respiratory coronavirus virus 2 (SARS-CoV-2) within LTCFs experiencing an outbreak.

Our expectation was that the effect of these measures on the rate of new cases would be fully apparent, 14 days after implementation since individuals could incubate up to 14 days from their exposure to SARS-CoV-2 before showing COVID-19 symptoms.[13]

Statistical analyses

COVID-19 case demographics (age and sex) and case status by case type (staff vs resident) within LTCFs were summarized. Attack rates and case fatality rates for each facility were calculated using public health and licensing data. These statistical analyses were carried out using Stata version 15 software.[14]

A mixed-effect segmented Poisson regression was fit to our facility-specific COVID-19 case data against time to assess the association between the intervention and the COVID-19 incidence rate. The model was built using a standard approach for segmented

Table 1. Description of the Multisectoral Intervention Implemented in Long-Term Care Facilities

Intervention Category	Outbreak Measures	Details
Case and contact management	Notification of all long-term care staff members for assessment of symptoms and linkage to testing	All staff members were sent communication the day an outbreak was declared prompting all symptomatic individuals to call public health and be directed for testing.
	Rigorous case follow-up, contact tracing and exclusion of high-risk contacts (even if asymptomatic)	A standardized data collection form was utilized to carry out case and contact tracing. Review with long-term care administration team to identify additional contacts was conducted. Individuals that met our high-risk exposure criteria (ie, >15-minute contact, with inadequate personal protective equipment) were asked to isolate even if not symptomatic. Daily follow-up of all excluded contacts was conducted, and if symptomatic, they were directed to testing.
	Line listing of all new cases and proactive follow up of SARS-CoV-2 test results for all residents and staff tested the day prior	A standardized and updated list of COVID-19 cases was created for each facility outbreak to track all cases that were confirmed or under investigation.
Proactive case detection	Daily monitoring of staff and residents for symptoms	Staff had routine symptom and temperature checks at the start of their shift. Residents were assessed for signs and symptoms at least twice daily.
	Low threshold for SARS-CoV-2 testing (mild/atypical symptoms)	Individuals that presented with any symptoms (ie, deviation from baseline) were immediately swabbed or sent for testing. Universal testing (regardless of symptoms) was carried out in select facilities where exposures from contact investigations were widespread or difficult to determine.
Infection control practices[a]	Universal personal protective equipment (PPE) precautions for all facility staff	Long-term care staff were required to wear masks, eye protection, and gloves universally for all care provided. Details are provided in Appendix 9 (online).
	Contact and droplet precautions for confirmed, suspected or exposed cases of COVID-19; universal precautions implemented intermittently	All COVID-19 cases (asymptomatic or symptomatic), newly symptomatic residents, or residents with significant exposure were placed under contact and droplet precautions. Airborne precautions were used if an aerosol-generating medical procedure was carried out. Universal contact and droplet precautions for all residents were implemented in circumstances where a staff exposure was widespread and/or difficult to contact trace.
	Assessment, education, and ongoing support from a dedicated COVID-19 mobile IPAC team	A mobile IPAC team was deployed to outbreak sites to ensure the facility was trained and adhering to IPAC guidelines set out by our health region[a] (Appendix 9 online).
	Closure of facility to all admissions or community discharges	Admissions or transfer of residents back to the long-term care facility were stopped. Individuals were transferred out to higher acute-care settings if medically required and consistent with the goals of care. Transfer of COVID-19 cases to a designated COVID-19 facility was used in exceptional circumstances where only 1–2 cases were identified at the start of the outbreak.
	Restriction of residents to rooms with in-room dining	All residents were asked to isolate in their room. Communal dining was suspended.
	Cohorting of staff to specific floors, wards, or units	Where logistically feasible, separation of staff between COVID-19 and non–COVID-19 floors was carried out, as well as dedicated care staff to COVID-19–positive patients specifically.
	Cohorting of COVID-19 resident cases to specific floors, wards, units, or rooms	Where logistically feasible, new COVID-19 resident cases were moved to COVID-19–specific wards or single occupancy rooms. However, in cases where individuals could not be cohorted, universal contact and droplet precautions were applied to all residents in the room, irrespective of COVID-19 case or symptom status.
	Enhanced cleaning of the facility (ie, each room, common spaces and high-touch surfaces)	Strategic cleaning was also implemented with cleaning non–COVID-19 units, wards, or rooms first and COVID-19 units, floors, or rooms second.
Resource prioritization and stewardship	Proactive daily check-in with regional long-term care operation leads around staff and PPE levels	Each long-term care facility on outbreak provided daily updates on PPE supply and staffing levels to the regional long-term care operations lead. If shortages were encountered, immediate action was taken to provide resources and staff.
	Deployment of necessary resources (ie, additional staff) and PPE in a timely fashion	PPE was centralized in the health region and distributed based on a daily supply assessment. Hazard pay or additional staff were deployed to outbreak facilities with diminishing human resources.

(*Continued*)

Table 1. (*Continued*)

Intervention Category	Outbreak Measures	Details
	Low barrier/preferential access to SARS-CoV-2 testing and rapid processing of test specimens	Regular communication between public health and regional laboratories, public health and long-term care administration allowed for rapid collection and processing of test specimens for both staff and residents.
Multisectoral collaboration	These outbreak measures were implemented and maintained by using a team-based approach.	This approach included: (1) a daily meeting between public health, the long-term care facility management and administration and regional long-term care operational leads to provide updates on new cases/contacts, discuss challenges with infection control, enhance case detection and address resource or staff shortages, (2) collaboration between public health and provincial and regional medical laboratories to prioritize processing of COVID-19 tests from outbreak facilities, and (3) deployment of a novel COVID-19 IPAC outreach team to provide support to facilities on outbreak.

Note. PPE, personal protective equipment.
[a]Additional details around infection control and outbreak control measures can be found in greater detail in the British Columbia Infection Prevention and Control Requirements for COVID-19 in Long-Term Care and Seniors' Assisted Living.[40]

regression of time series data[15] and the study followed the Outbreak Reports and Intervention Studies of Nosocomial Infection (ORION) reporting guidelines.[16] R version 3.6.2 software[17] was used to perform generalized linear mixed-effects regression and generate figures with the ggplot2 package.

For each facility, the outbreak period was segmented into an early outbreak period (from the first case until 14 days following implementation of measures) and the postintervention period (after 14 days from the implementation of measures). We estimated 4 standard components: (1) the early outbreak trend in COVID-19 rate, (2) the postintervention trend in COVID-19 rate, (3) the magnitude of change in trend from early outbreak to postintervention, and (4) the change in the average COVID-19 rate from early outbreak to postintervention (ie, level change). Random intercept models (using facility as a random effect) were used to account for variation by facility in COVID-19 rates and for the nonindependence of cases within a facility arising from the infectious spread of SARS-CoV-2. Relative effects in the form of rate ratios (RRs) were calculated through exponentiation of the relevant model coefficients. A second model was constructed to evaluate case type (staff vs resident) as an effect modifier. Two-sided tests at 5% significance levels were used to determine statistically significant differences.

A counterfactual trend during the postintervention period was generated by setting all model coefficients, except early outbreak trend, to zero and predicting the COVID-19 rate as if the intervention were not effective or were not implemented. Full details regarding the model specification and residuals examination can be found in Appendix 2 (online).

Ethics approval

Research ethics board review was not required because this study was part of routine public health operations for quality improvement and program evaluation. Data were deidentified and aggregated, and results were suppressed where counts were <5 individuals.

Results

Descriptive analyses

Between February 28, 2020, and May 30, 2020, 18 of 75 (24%) of all LTCFs in the VCH region had at least 1 documented exposure from a COVID-19 case. Among those, 10 of 18 (56%) had a single staff case of COVID-19 with no documented transmission to another staff member or resident. One facility experienced only 1 subsequent case. Among these 18 LTCFs, 7 experienced 2 or more subsequent cases and were included in the analysis.

In total, 275 COVID-19 cases (165 staff and 110 residents) were reported to public health from these 18 study facilities. Appendix 3.1 (online) shows case counts by symptom onset or episode dates for long-term care staff. Appendices 3.2 and 3.3 (online) summarize the characteristics of symptomatic and asymptomatic COVID-19 cases by facility. For all of the LTCFs, except facility C, most cases occurred among residents. The facility attack rates ranged from <4% to 25%. The case fatality rate for infected residents among individual facilities ranged from 22% to 50%.

Appendices 3.4 and 3.5 (online) outline characteristics of symptomatic and asymptomatic COVID-19 cases by case type for the study facilities, respectively. The case fatality rate was 34% among residents, and no deaths were recorded among staff. Figure 1 illustrates the size and duration of COVID-19 outbreaks by facility as well as the varied characteristics of each outbreak and non-LTCF cases in VCH.

Regression analyses

The results of the regression model are described in Table 2 and Appendix 4 (online). The segmented regression analyses are presented in Fig. 2 based on a model with the effect modification terms (model 2).

After adjusting for case type, there was a significant upward trend in the COVID-19 incidence rate during the early outbreak period (RR, 1.07; 95% CI, 1.03–1.11; $P < .001$). Following 14 days from implementation of the intervention bundle, a significant reversal in trend was identified (RR, 0.68; 95% CI, 0.62–0.75; $P < .001$). In particular, the postintervention trend demonstrated a 27% decrease in the COVID-19 incidence rate every 2 days (RR, 0.73; 95% CI, 0.67–0.80; $P < .001$). We detected a decrease (level change) in the overall average incidence rate following the early outbreak period (RR, 0.83; 95% CI, 0.52–1.36) that was not statistically significant ($P > .05$).

Effect modification by case type

The upward COVID-19 incidence trend during the early outbreak period did not differ significantly between staff and resident ($P > .05$). Neither the change in trend during the early outbreak period

Table 2. Results of Segmented Regression Analysis to Evaluate the Impact of a Multisectoral COVID-19 Intervention

Variable	Model 1[a]	Model 2[b]		
	Overall RR (95% CI)	Resident RR (95% CI)	Staff RR (95% CI)	Effect Modification By Case Type[c] RR (95% CI)
Early outbreak trend in COVID-19 rate[d]	1.07 (1.03–1.11)***	1.07 (1.03–1.12)***	1.07 (1.03–1.12)**	1.00 (0.96–1.03)
Level change after intervention[e]	0.84 (0.51–1.36)	1.20 (0.69–2.10)	0.36 (0.14–0.93)*	0.30 (0.10–0.88)*
Trend change after intervention[f]	0.68 (0.62–0.75)***	0.67 (0.60–0.75)***	0.72 (0.60–0.85) ***	1.07 (0.88–1.31)
Postintervention trend in COVID-19 rate[g]	0.73 (0.67–0.80)****	0.72 (0.65–0.80)****	0.77 (0.65–0.90)**	1.07 (0.88–1.30)

Note. RR, Rate Ratios; CI, confidence interval; *$P < .05$; ** $P < .01$; ***$P < .001$; ****$P < .0001$.
[a]Model 1 adjusts for baseline trend, change in rate, change in trend and case type (resident vs staff), and allows a random baseline COVID-19 rate among facilities.
[b]Model 2 adjusts for the same covariates as model 1 as well as interactions between case type and baseline trend, change in rate, and change in trend. It also allows for a random baseline COVID-19 rate among facilities.
[c]Ratio of relative rate between staff and residents.
[d]Average 2-day (daily) change in the rate of COVID-19 during the early outbreak period (prior to public health measures, plus 14 days).
[e]Difference in the average COVID-19 rate between the early outbreak period and the postintervention period (ie, level shift).
[f]Change in slope from the early outbreak period to the postintervention period.
[g]Average daily change in the rate of COVID-19 during the postintervention period (starting 14 days after the intervention).

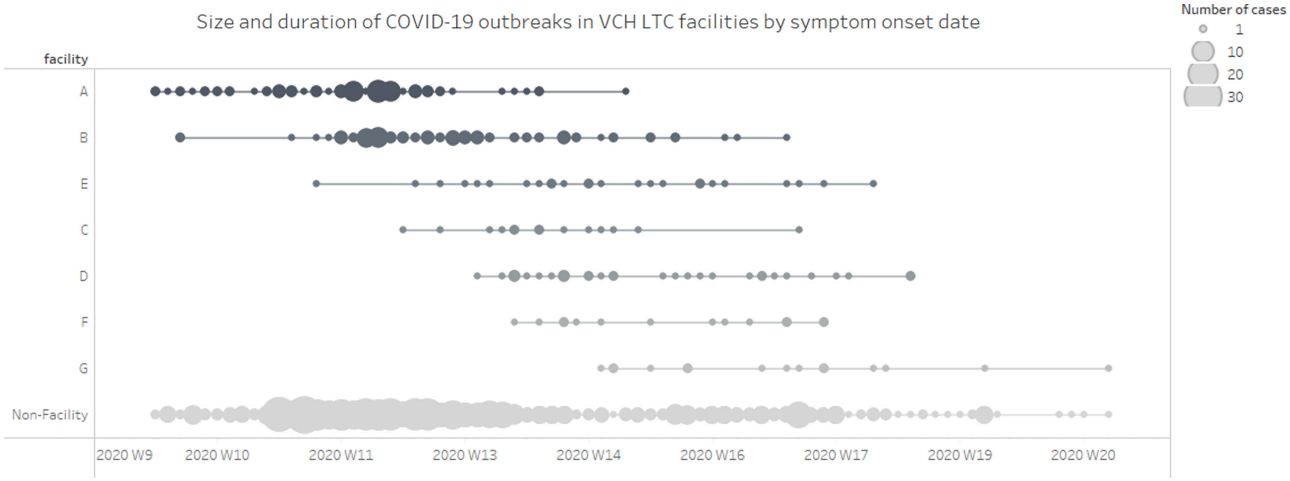

Fig. 1. Size and duration of COVID-19 outbreaks in study long-term care facilities by symptom onset date. Dots indicate cases and the dot size is proportional to the number of cases. Prior to April 8, 2020, testing was restricted to individuals that were either hospitalized, likely to be hospitalized, health care workers, residents of long-term care facilities or part of an investigation of a cluster/or outbreak (as decided by public health). Therefore, nonfacility cases were likely underestimated during that period.

versus postintervention period (RR, 1.07; 95% CI, 0.88–1.31), nor the downward postintervention trend (RR, 1.07; 95% CI, 0.88–1.30), varied significantly between staff and residents.

However, the level change from the early outbreak to postintervention period was significantly different between residents and staff. Specifically, staff had a 70% greater reduction in their average rate of COVID-19 compared to residents following the early outbreak period (RR, 0.30; 95% CI, 0.10–0.88; $P < .05$).

Discussion

Summary of findings

The results of our analysis provide an overview of the epidemiology of COVID-19 within LTCFs experiencing outbreaks in the VCH region. Most cases occurred among residents of these facilities, whereas only 1 facility had more COVID-19 cases among staff than residents. Our regression analysis demonstrated that the combination of outbreak control measures (Table 1) delivered through a collaborative approach were associated with a decrease in COVID-19 incidence rates 14 days from implementation in each LTCF. This change from an upward to downward trend in COVID-19 was consistently detected among both staff and residents and across facilities, regardless of the background rates of community transmission. In addition, the impact of the intervention varied between staff and residents, with a significantly greater decrease (level change) in the average rate of COVID-19 among staff compared to residents after the early outbreak period.

Explanation of findings

The pronounced effect of the intervention among staff cases may be attributable to the lower exposure risk experienced by staff because they spend less time in the facility and they use personal protective equipment daily. Also, many of the outbreak control

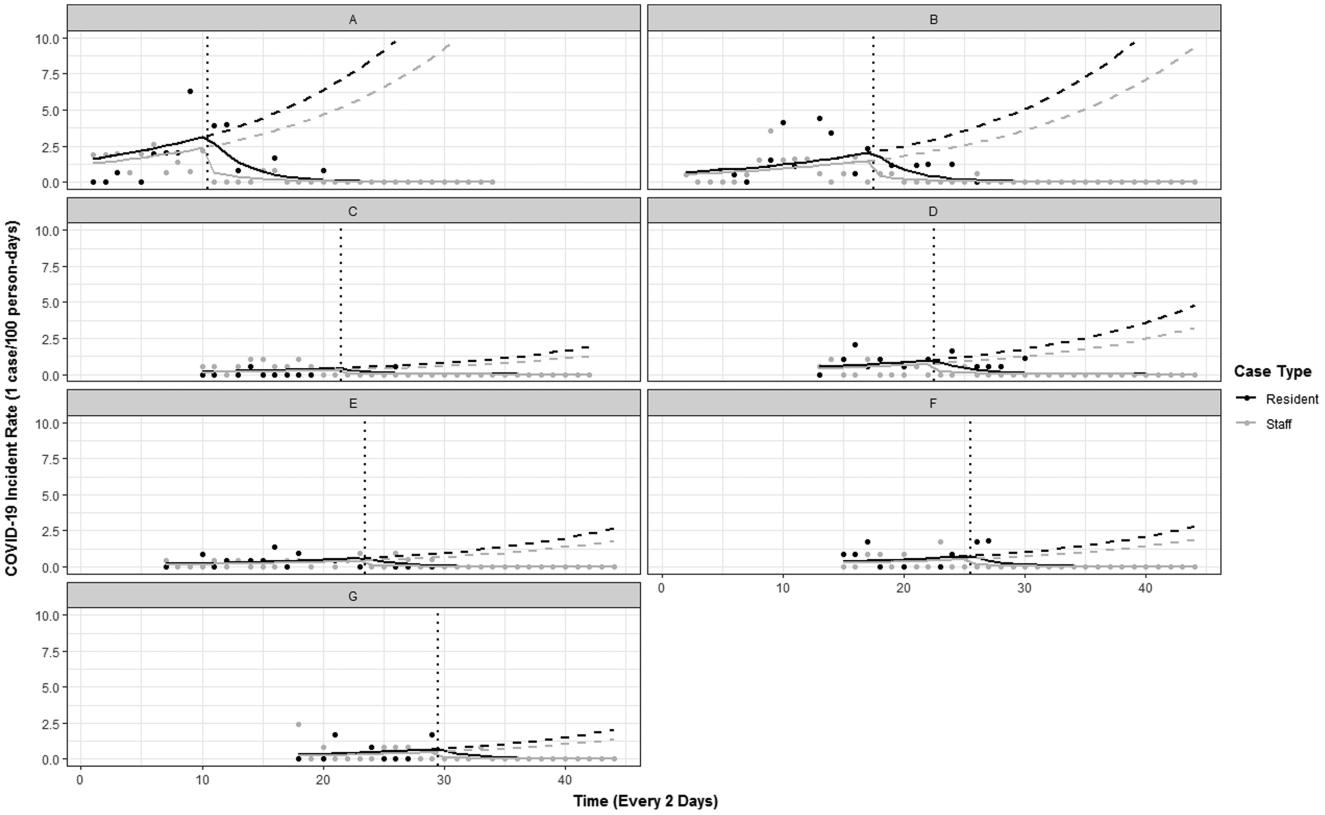

Fig. 2. Segmented regression result for all study facilities. Time is based on symptom onset date. Rates were calculated for every 2-day period. A counterfactual (dotted line) was constructed to visually represent that predicted rate of COVID-19 if public health measures were not implemented or were not effective. The results from model 2 are shown.

measures are largely focused on rapidly identifying and removing symptomatic staff from the work environment, thereby decreasing the frequency of new COVID-19 introductions into the facility. The gradual but persistent decline of new resident cases after the intervention can be explained by the increased exposure time in the facility as well as challenges with resident isolation (ie, wandering due to cognitive impairment). This pronounced effect among staff is particularly important given that documented infections among staff has been demonstrated to be a strong risk factor of long-term care resident mortality.[18]

Comparison of related studies in the literature

To the best of our knowledge, this is the first study to evaluate outbreak control measures to mitigate the transmission of COVID-19 in LTCF using a quasi-experimental design. Cheng et al[19] evaluated a regional infection control response to COVID-19 using descriptive epidemiological methods. Various studies using interrupted time series analysis and segmented regression analysis have evaluated the impact of broader interventions such as social distancing,[20] travel restrictions,[21] and lockdown policies[22] on COVID-19 incidence and mortality.

In addition, various outbreak summary reports, commentaries, and media articles have highlighted the challenges with managing COVID-19 outbreaks in LTCFs in other regions of Canada, United States, and Europe. Key barriers included poor communication and collaboration between key actors, limited access to personal protective equipment (PPE), inadequate early identification of symptomatic staff and resident cases, and challenges in infection control education and adherence.[3,5,6,23-26] In contrast, our intervention was administered through a collaborative team-based approach that fostered excellent communication between public health and LTCF operators. This approach also facilitated the implementation of public health directives and troubleshooting ongoing concerns with the facility. Working directly within a regional health authority structure, PPE levels were monitored daily and were prioritized to LTCFs facing shortages. Access to accurate resident and staff census lists (through public health licensing officials) allowed early notification, assessment, and exclusion of all symptomatic or significantly exposed staff. Prioritization and low-barrier access to SARS-CoV-2 testing allowed for timely case identification and public health action. Furthermore, our intervention included outbreak measures that have been implemented to curb transmission across the United States, such as cohorting[27] and routine symptom monitoring of staff and residents,[28] universal mask policies,[29] appropriate PPE use/ensuring no PPE shortages.[30] As a result, our analysis provides additional support for the effectiveness of outbreak measures not implemented in large LTCF COVID-19 outbreaks in other jurisdictions and are comparable to recommended approaches in the United States and Canada.[2,28,31-33]

However, important difference exists in our approach compared to what has been reported and recommended in the United States. First, the rapid creation and deployment of a government-funded COVID-19 IPAC outreach team was critical in providing effective standardized[28] education to staff, carrying out infection control audits, and diminishing a substantial burden on the LTCF IPAC educators and administrators. Also, we did not

conduct weekly, biweekly or bimonthly testing of LTCF staff without symptoms, which is currently recommended[32,33] with reported effectiveness.[34] However, we enacted broad and stringent infection control precautions, which likely reduced the benefit of serial testing.[35] Lastly, during our study period universal facility-wide testing was not carried out following the first identified case but rather was determined by contact investigations. However, after the conclusion of our study period, the health region has adopted facility-wide testing to align with current evidence.[36,37]

Strengths and limitations

Time-based segmented regression analyses are one of the strongest quasi-experimental designs to evaluate the impact of population-level interventions targeting nosocomial infection rates.[38] A mixed-effect model also adds rigor to account for dependency (correlation) of observations within each facility. A major strength of a multigroup analysis is the ability to assess for comparability between groups on our observed covariates. Using multiple facilities also increased the number of time points, adding additional power to detect significant effects.[12] A time-based approach also allows for the control of overall secular trends in rates, which can provide an estimate of the true impact of the intervention. Our model demonstrated a consistent effect across facilities while accounting for varying COVID-19 incidence rates among facilities and across time. Lastly, LTCFs that experienced significant COVID-19 outbreaks (>2 cases) occurred unsystematically in our region, providing essentially a random sample of LTCFs for analysis.

However, with the study of any model, there are limitations. First, we assumed that the bundle of measures was imposed upon outbreak declaration; however, the actual implementation of each measure may have occurred over a few days, underestimating the true effect of the intervention. Second, although the model evaluates the bundle of measures, it cannot determine the contribution of individual measure to the overall effect nor whether the intervention improved across time as it became more cohesive and comprehensive. Third, our findings should only be generalized to LTCFs experiencing COVID-19 outbreaks (with >2 cases). Our intervention may not be easily implemented or generalizable in jurisdictions that do not utilize a regional health authority structure to deliver health services. Fourth, asymptomatic cases could not be reliably included potentially biasing our results; however, it is unlikely that these cases would significantly drive our final model due to their small size. A final limitation is the lack of a control group (ie, an LTCF where the intervention was not implemented) given that this would have been unethical. Nonetheless, the early outbreak intervention period serves as control for the post-intervention period, which still accounts for threats to internal validity and constitutes a methodologically acceptable study design for evaluating the impact of population-level intervention.[39]

In conclusion, our comprehensive, timely intervention leveraged regional partnerships to reduce the incidence of COVID-19 in LTCFs, underscoring the value and importance of collaborative approaches for effective infection control. The findings of this study can help to inform and prepare key policy makers such as public health, infection control practitioners, healthcare professionals, and LTCF operators for future COVID-19 outbreaks. We hope our intervention and its team-based approach can be adapted and utilized by other jurisdictions to effectively decrease SARS-CoV-2 transmission and protect the vulnerable populations in LTCFs.

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Lived experiences of frontline workers and leaders during COVID-19 outbreaks in long-term care: A qualitative study

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Key Words:
COVID-19
Outbreak management
Long-term care
Qualitative evaluation

A B S T R A C T

Background: Long-term care facilities across Canada have been disproportionately affected by the COVID-19 pandemic. This study aims to describe the experiences of frontline workers and leaders involved in COVID-19 outbreak management in these facilities, identify best practices, and provide recommendations for improvement.

Methods: This is a qualitative study using key informant, semi-structured interviews. Key informants were defined as individuals with direct experience managing COVID-19 outbreaks in long-term care. Thematic content analysis of interview transcripts identified key themes important for outbreak management.

Results: Twenty-three interviews were conducted with key informants from the following categories: public health, health authority leadership for long-term care, infection prevention and control, long-term care operators, and frontline staff. Eight themes were identified as critical factors for outbreak management on thematic analysis, which included: (1) early identification of cases, (2) the suite of public health interventions implemented, (3) external support and assistance, (4) staff training and education, (5) personal protective equipment use and supply, (6) workplace culture, organizational leadership and management, (7) coordination and communication, and (8) staffing.

Conclusions: Best practices and areas for improvement in outbreak response identified in this study can help to inform policy and practice to reduce the impact of COVID-19 in these settings.

INTRODUCTION

Outbreaks of COVID-19 in long-term care (LTC) facilities have resulted in a significant number of infections and deaths in British Columbia.[1] Across Canada, during the first 6 months of the pandemic, more than 80% of all COVID-19 deaths have occurred among residents of LTC facilities.[2,3] Residents in LTC are particularly vulnerable to both SARS-CoV-2 infection and severe consequences due to their congregate living settings and their multiple co-morbidities, respectively.[4,5] In response to outbreaks within these facilities and the unique vulnerabilities of this population, a regional health authority in British Columbia, Canada, implemented a range of outbreak control measures, such as restricting LTC staff to a single work site and visitor restrictions. These measures were intended to reduce the risk of introducing SARS-CoV-2 into these facilities and to reduce transmission within these facilities.[6]

The experiences of frontline workers and healthcare leaders involved in COVID-19 outbreaks in LTC facilities represent a valuable perspective that can be best captured using qualitative research methods. Qualitative approaches are well suited to provide a narrative description of the direct and lived experiences of research participants with firsthand knowledge of a phenomenon under study.[7]

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0196-6553/

Much of the existing literature on the lived experiences of frontline workers managing COVID-19 patients and outbreaks have examined the psychological impact on these frontline workers or their unique vulnerabilities.[8-11] By exploring the experiences of frontline workers, one can capture their critical perspectives. These insights can help to inform policy and practice for healthcare system improvement, such as improving the management of outbreaks in LTC settings.

The central aim of this study is to inform and improve the management of COVID-19 outbreaks in LTC facilities as part of an ongoing quality improvement project. The primary objectives of the analysis include the following:

1) Describe the lived experiences of key informants involved in COVID-19 outbreaks in LTC facilities

2) Identify best practices and areas of improvement in the approach to COVID-19 outbreak management in LTC facilities

3) Provide recommendations to improve the management of these outbreaks

METHODS

Study design

This qualitative study utilized an inductive approach informed by grounded theory. Semi-structured, key informant interviews were used for data collection. Semi-structured interviews were chosen to ensure a minimum set of topics were covered and to allow flexibility to include topics outside the scope of the interview guide.

Sampling

The sampling strategy consisted primarily of a purposive sampling framework, supplemented by snowball sampling, with the goal of obtaining data saturation among key informants involved in outbreak management. Sampling was conducted to ensure the inclusion of key informants within several role-based categories, as described in Table 1. Recruitment was conducted via email and recruitment for further interviews was stopped after data saturation was reached. Data saturation was defined as the point where further interviews with key informants did not generate significantly new findings.[12] Key informants were defined as individuals with direct experience in COVID-19 outbreaks in LTC facilities within the health authority.

Data collection

A semi-structured interview guide was developed to provide a general structure to the interviews (Appendix 1). The guide included aspects of outbreak management thought to be critical to communicable disease control such as: public health interventions, infection prevention and control (IPAC) measures, the use and availability of personal protective equipment, workplace culture and staffing issues, among others. The interview process involved the participant and 2 interviewers (BY, RV). One interviewer conducted the interview via telephone and one took notes. The participants were made aware of the interviewer's roles in public health and the general goals of the research study. Each interview lasted approximately 1 hour.

Data analysis

An inductive approach was used to identify key themes in the interview notes during thematic content analysis. Thematic analysis was conducted by a primary reviewer (BY) throughout the data collection period to conform with best practices in qualitative research methods and to further refine the interview guide.[12] Thematic content analysis involved the development and application of a coding framework and manual review of interview transcripts. General themes emerging from each interview were manually highlighted and analyzed. To ensure coding validity, a second reviewer (RV) manually coded several interviews independently. Any discordance between the 2 reviewers were compared, discussed among the team, and a uniform approach was agreed upon.

Ethics approval

Research ethics board review was not required, as this study informed quality improvement and program evaluation activities as part of routine public health operations. Key informants provided verbal consent to be interviewed and included in the study. Confidentiality was ensured by avoiding the use of facility names in the final report and avoiding the collection of informant identifiers, other than their role in outbreak management.

RESULTS

A total of 23 semi-structured interviews were conducted between June and July 2020. Key informants interviewed in each category are summarized in Table 1. Eight main themes or key factors for outbreak response were identified and are summarized in Table 2, although these themes were not entirely mutually exclusive. Within each

Table 1
Summary of key informant categories

Key informant Category	Key informant job classifications	Outbreak management roles	Number interviewed
Public Health	Public Health Nurses Environmental Health Officers Medical Health Officers	COVID-19 case and contact management Coordinate outbreak control measures Lead outbreak management team	2
Health Authority Senior leadership in LTC	Directors for LTC	Logistical support to LTC Facilitate operational compliance and preparedness	2
Infection Prevention and Control (IPAC) Professionals	IPAC Physicians, Nurses, other practitioners	On-site IPAC assessments IPAC training and education	4
LTC Operators	LTC Executive directors LTC Directors of Care LTC senior administrators	Implement outbreak control measures Manage day-to-day operations	8
Frontline staff	Residential Care Aides Registered Nurses	Provide direct care to LTC residents Operationalize outbreak control measures	7
Total			23

Table 2
Key factors in COVID-19 outbreak response for LTC facilities identified on thematic analysis

Early identification and action on new COVID-19 cases	Early identification of COVID-19 cases and the rapid implementation of public health and IPAC measures
The suite of public health interventions	The suite of public health interventions included the single site restriction for LTC staff, visitor restrictions, active symptom monitoring for staff and residents, staff and resident cohorting, mass testing, among others
Additional supports and external assistance	External assistance during outbreaks may have included IPAC supports and training, relief staffing, and public health and logistical support
Staff training and education	Staff training on IPAC principles and education on COVID-19
PPE use and supply	Access to PPE and its appropriate use
Workplace culture, organizational leadership and management	The relationship between frontline staff and managers/senior administrators, the management styles of LTC operators, and overall workplace culture and staff morale
Communication and coordination	Communication between teams involved in outbreak response and the level of coordination and consistency in the approach to outbreak management
Staffing levels	Frontline staffing levels of residential care aides and nursing staff

main theme, key informants described both best practices and areas for improvement related to that theme.

THEME 1: EARLY IDENTIFICATION AND ACTION ON NEW COVID-19 CASES

Best practice

Facilities with greater success in preventing the introduction and transmission of SARS-CoV-2 had a high index of suspicion for COVID-19 among residents and staff, along with a low threshold for testing. A high index of suspicion meant that residents or staff who exhibited mild or even nonrespiratory symptoms were considered suspect COVID-19 cases and tested appropriately. As one LTC operator stated, *"a protective factor [for our facility] was that staff were fairly alert early on to COVID-19."* In addition to a high index of suspicion/low threshold for testing, facilities that rapidly notified public health authorities about potential exposures and the rapid implementation of control measures before case counts within facilities increased significantly were considered effective approaches. Several LTC operators specifically identified the early adoption of certain IPAC measures, such as universal mask use for all staff, as best practices.

Areas for improvement

Alternatively, delays in identifying a case of COVID-19 and implementing control measures were characterized as early and critical failures. In some cases, delayed action was the result of overconfidence in the level of preparedness, leading to poor infection control practices. One residential care aide commented:

> "I think [the outbreak] could have been prevented if we listened and paid attention to the lessons coming out of [earlier outbreaks], my manager did not seem very interested in changing things to prepare us for a possible outbreak of COVID-19."

An important factor in the delayed identification of the first case of COVID-19 in a facility was a failure operationalizing the "high index of suspicion/low threshold for testing" principle. Specifically, monitoring for a limited set of symptoms and a more restrictive testing strategy delayed effective control. One residential care aide, reflecting on their facility outbreak, stated how *"early on, [there was a] cluster of residents with diarrhea but [we] never recognized [this] as a possible COVID-19 outbreak, because no one suspected this symptom could be COVID-related."* Further transmissions of COVID-19, as well as the subsequent scale of the outbreaks, were considered a direct result of delayed identification and action. One LTC operator commented:

> "I was alerted to a resident with [symptoms]. I instructed that this resident should be isolated, but there was a failure to post signs for PPE and to isolate. Had we better isolated that resident and had they been swabbed early, that would have changed the course of the outbreak."

THEME 2: SUITE OF PUBLIC HEALTH INTERVENTIONS

Best practice

There was broad support for the range of public health interventions implemented and an understanding of the rationale behind these measures. Frontline staff and LTC operators generally supported visitor restrictions and understood the importance of active symptom assessment and attempts to cohort staff members. For some, mass testing was considered a critical turning point. This involved testing asymptomatic individuals residing or working in the facility and often identified early or unrecognized cases of COVID-19, which was considered an important factor in preventing further transmission. Environmental testing was another important intervention in outbreak management. Testing environmental surfaces for the presence of SARS-CoV-2 virus identified surfaces and medical equipment that may have been contaminated or poorly sanitized, leading to immediate changes in local IPAC practice.[13]

Areas for improvement

Support for some of the public health interventions was tempered with a recognition of their unintended consequences. The restriction of staff to a single LTC site created local staffing challenges and reduced the causal employee pool. This measure exacerbated what was described as a persistent, pre-existing, and sector-wide staffing shortage at baseline. One LTC operator stated, *"[The single site restriction] left us with 3 causals. It is really hard for employers to make up for that lost staffing and for the staff that rely on that additional income."* There were also concerns about the visitor restriction policy. This policy restricted visitors to LTC facilities, with LTC residents having a difficult time coping with this change. Several informants advocated for a less restrictive policy to address the harms associated with social isolation of LTC residents.

THEME 3: ADDITIONAL SUPPORTS AND EXTERNAL ASSISTANCE

Best practice

Infection prevention and control (IPAC) support was noted to be a critical resource in outbreak management. This team conducted rapid, on-site assessments and provided IPAC training and COVID-19 education to frontline staff and management. By improving local protocols and addressing entrenched, problematic practices, the IPAC support team effectively reduced the risk of transmission. As one

registered nurse stated, *"the [IPAC support] team was critical – if they had not come in, there would have been way more deaths. . .this outside assistance was essential."*

Features of the IPAC support team which was important to their success included rapid deployment and an independent, nonpunitive approach. One IPAC support team member stated how *"we were able to create strong relationships with staff and provide feedback in a nonpunitive way – we worked to decrease staff anxiety and increase morale."* The external nature of the team was important, as one LTC operator noted, *"the [IPAC support] team was providing training and advice from outside the management structure, [so] the staff were more receptive to listening to them and following their directives."* IPAC support team members also directly addressed staff concerns and provided considerable moral support to frontline staff.

Involvement of the public health team and Operations Directors for LTC was identified as another important external resource in outbreak management. These teams helped clarify recommendations and assist with compliance. Important features of these teams included their ongoing and regular communication and supportive approach. One LTC operator reflected, *"[we] felt that [the public health team] was able to provide timely information, we felt that they were in our corner."*

Areas for improvement

One challenge with the assistance provided by the IPAC support team was the level of coordination and consistency between the teams. Some sites received multiple visits from the IPAC support team and the team's composition would often change, occasionally resulting in inconsistent advice and conflicting guidance. Another significant challenge regarding IPAC support was the lack of training outside of regular working hours. Many informants expressed concerns that nighttime staff were not provided the same support and training as daytime staff. One residential care aide stated,

> *"When. . . [the* IPAC support team*] . . .came in to do training, there was never training for the night [staff]. Night staff were flying by the seat of our pants. There was no organizing for other shifts or for the night staff to be cross trained."*

THEME 4: STAFF TRAINING AND EDUCATION

Best practice

Additional staff training was required for almost every facility outbreak. In-house training was supplemented with external training provided by the IPAC support team, which improved cleaning standards and IPAC protocols. One residential care aide stated how *"after [they] came in, they showed us how to properly put on PPE, many staff really needed this. [They] showed the housekeepers how to properly clean and disinfect touchpoint areas."* Several key informants described how some facilities were more prepared as a result of a recent experience in outbreak management. Among facilities that recently managed other viral respiratory and gastrointestinal outbreaks, such as influenza or Norovirus, IPAC protocols and plans were recently reviewed, resulting in better adherence to IPAC best practices.

Providing education to staff on COVID-19 was another important factor for outbreak management. Many IPAC support team members and LTC operators commented how this education was critical to reassure staff and increase morale. IPAC support team members mentioned how receptive staff were to the education and training being provided, reflecting a strong desire to both protect residents and to mitigate the risk of SARS-CoV-2 transmission.

Areas for improvement

Reported gaps in knowledge of IPAC principles highlights the need to improve the current approach to staff training and education. Many frontline staff, LTC operators, and IPAC support team members commented that a more frequent and robust approach to staff training is required. Several staff commented that their most recent IPAC training was at the time of being hired. The frequency of staff training varied widely between facilities. One LTC operator stated that, *"there is absolutely no doubt about needing more regular IPAC training."*

THEME 5: PPE USE AND SUPPLY

Best practice

During the early stages of the pandemic, there were concerns about the supply of PPE for LTC facilities. A best practice in PPE supply management was centralization of access to the supply and distribution of PPE for the LTC sector through the health authority, ensuring a stable supply for each facility. As one LTC operator commented, *"we would not have survived without the centralized supply. We were simply being told [by our suppliers] that we are not getting masks."*

Areas for improvement

Many frontline staff described challenges with access to PPE, particularly during the early stages of the pandemic. There were also conflicts with local leadership around the type of PPE available, including specific requests for N95 respirators in circumstances where they were not required based on local IPAC guidelines, such as when providing routine patient care or for cleaning staff not involved in direct patient care. Many of these conflicts were the result of staff fear, changing guidelines, and gaps in direct communication to staff. There were instances of frontline staff taking what were perceived as enhanced protective measures, which included practices that would be classified as an inappropriate use of PPE, such as double-masking or double-gloving.

THEME 6: WORKPLACE CULTURE, ORGANIZATIONAL LEADERSHIP AND MANAGEMENT

Best practice

Despite the significant culture of fear that resulted from the declaration of an outbreak, many staff continued to demonstrate a strong commitment to providing care to residents. One residential care aide said, "*My experience was very stressful. But at the same time, I kept on thinking that if I don't come in to work, no one else would.*" It was critical to address and manage staff fear through education and training, as one IPAC support team member reflected, *"staff at some facilities had a lot of anxieties and worries about new patients. I think it came down to a lack of education about COVID-19."*

Although there were few frontline staff who described the staff-management relationship as perfect, there was a recognition of the efforts of management to address the outbreak. An example of a best practice for LTC operators was for them to act as role models, particularly in following protocols they were attempting to enforce and to work alongside frontline staff. For instance, one LTC operator mentioned how management would:

> ". . .walk on the floor and [go] to the COVID-positive residents. [Having] the administrators on the floor and helping to take care

of the COVID patients really helped to set an example. The team got closer as a result of this."

Areas for improvement

Frontline staff expressed frustration with top-down, punitive management styles. This contributed to staff burnout, low morale, mistrust of management, and poor adherence to protocols and instructions from managers. For instance, one residential care aide found that *"care aides are afraid to speak [out]. If you want to improve something, you cannot suggest [it]. I do not feel like I am able to speak [openly] to my manger about [any] issues."* Additionally, frontline staff mentioned several examples where local leaders failed to role model best practices, which resulted in a further deterioration in respect and trust in management.

THEME 7: COMMUNICATION AND COORDINATION

Best practice

An explicit communications strategy between the various teams involved in outbreak management helped to facilitate effective control. Consistent and reliable lines of communication was required for success. For example, the availability of the public health team and their daily meetings with facility operators helped to ensure a consistent approach. In addition, open communication was deemed essential in building trust among frontline staff and family members. As one LTC operator noted,

> "Part of what contributed to a boost in morale was the constant and daily communication to staff. The staff expected these communications and had the opportunity to express concerns to management through a virtual comment box."

One facility implemented daily safety huddles as a strategy to ensure a common understanding among all staff. This daily huddle was an opportunity to ensure a consistent approach to outbreak management, to clarify questions, and to explain the rationale behind certain measures.

Areas for improvement

Challenges with communication was explicitly identified as a factor that impeded outbreak response for some sites. Communication breakdowns often involved frontline staff, resulting in a lack of clarity around appropriate protocols. There were some concerns that updates were not being communicated to all staff, for instance one residential care aide stated:

> "Communication breakdowns are still happening, there will be a rollout of something and a small number of people would be trained, but it doesn't reach all staff. We may get some directive from management, but there will be a general lack of clarity."

One factor that created challenges for effective communication and coordination was the rapidly evolving knowledge about the virus and, consequently, the changing public health recommendations. This resulted in confusion about which guidelines to follow.

Finally, another area of improvement was the lack of an explicit and coordinated approach between the public health team and the IPAC support team. While both teams would often be asked to provide guidance on similar topics, a lack of formal coordination between these two teams resulted in conflicting advice being provided. An IPAC support team member stated that they *"wished there were more collaboration with the [public health] team. The different advice created confusion for staff on what advice to follow."*

THEME 8: STAFFING LEVELS

Best practice

Some facilities worked aggressively to maintain staffing levels, with varying levels of success. Certain sites anticipated staffing challenges and made early efforts to maintain or increase baseline staffing. A limited number of sites with acute staffing challenges required external health authority assistance, which represented an effective, short-term solution.

Areas for improvement

For facilities that struggled to maintain baseline staffing, frontline staff, operators, and residents were significantly impacted. Many informants described staffing challenges and increased workloads precipitated by staff illness, the single site restriction for staff, sick residents, and strict adherence to IPAC protocols. Many described significant amounts of overtime hours required to ensure adequate staffing. Additionally, several key informants contextualized these acute staffing challenges within the broader, long-standing, sector-wide staffing shortages at baseline.

Another long-standing issue specifically described by a variety of key informants was the level of overnight staffing within these facilities. These facilities operate on reduced staffing overnight, leading to challenges in providing patient care during these hours. One care aide commented how:

> "During the outbreak, there were no increases in overnight staffing, despite the increased workload. The time it takes to appropriately don and doff PPE, to attend to people who are sick, to take temperatures, give extra medications, et cetera."

Another issue with limited staffing overnight was the potential for staff to cross between wards or neighborhoods within the facility, increasing the transmission risk between areas with active cases of COVID-19 and those without.

DISCUSSION

COVID-19 represents a novel threat to LTC facilities and there is emerging research that will inform the approach to outbreak management for this particular patient population and setting.[5,14,15] Existing research has identified long-term care residents as particularly vulnerable to COVID-19, highlighting the disproportionate burden of COVID-19-related morbidity and mortality among this population.[16-18] This qualitative evaluation provides complimentary data derived from the experiences of key informants, which identified eight key themes important in outbreak management. These themes represent actionable areas of improvement in outbreak management which could potentially reduce the impact of future COVID-19 outbreaks on a particularly vulnerable population. Existing research corroborates many of these best practices in COVID-19 outbreak management in LTC, such as strong leadership, rapid response to COVID-19 cases, and regular communication with stakeholders.[19,20]

Among several important findings applicable to practice improvements, key informants specifically identified early identification and rapid action as a critical factor in outbreak response. The range of public health measures implemented at the local level, in particular the testing indications for COVID-19 among residents and staff, were

considered essential factors in detecting cases of COVID-19 and subsequently initiating enhanced control measures. These measures were considered critical to both limit the introduction of the virus into these facilities and reduce transmission within them. External assistance was almost universally required during outbreaks and these external teams provided invaluable training, education, coordination, and support throughout the outbreaks. Access to a secure supply of PPE within LTC facilities was ensured through centralization by the health authority and the appropriate use of PPE was reinforced through internal and external training for frontline staff and LTC operators. The secure supply of PPE also helped to address staffing challenges that resulted from concerns about safe working conditions. The organizational culture within these facilities also played a role in outbreak response: respectful work environments that focused on team-based approaches worked best to address staff concerns and staffing shortages. Closely related to organizational culture, communication and a coordinated response characterized more effective leadership styles and effective outbreak response. Finally, appropriate staffing levels were essential to ensure safe patient care and adherence to best practices in IPAC protocols.

This study represents a timely and important evaluation of the factors important for effective outbreak management and identified best practices and areas of improvement across the sector. The diversity of key informants interviewed was a strength of this study, as data saturation was reached across the 23 interviews. However, a limitation of this study was the absence of residents or family members as key informants. Although LTC residents and their family members are not directly involved in managing outbreaks, they represent a critical stakeholder that is not included within this analysis. Future investigations of COVID-19 outbreaks in LTC should explore the experience of residents and their families. An additional limitation of this study was the small numbers of informants interviewed in some key informant roles. This was the result of a small number of individuals within certain roles, which could have led to underrepresentation of some key informant categories. There is also a potential for selection bias, as individuals were to some extent self-selected by agreeing to participate in the study.

CONCLUSION AND IMPLICATIONS

Table 3 outlines specific recommendations for action that emerged from thematic analysis. The first action is for LTC facilities to maintain a high level of vigilance for SARS-CoV-2 transmission, as the early stages of outbreaks were identified as a critical window for effective control. Public health can continue to reinforce the principles of the high index of suspicion and low threshold for testing approach to COVID-19 within these facilities. The second action is to provide regular, ongoing, and comprehensive IPAC training and education at the local level. The gaps identified in frontline staff training and education represents an opportunity to strengthen local operational readiness through a more proactive, comprehensive, inclusive and a more frequent training approach. The last action item is to develop a more formal mechanism for communication and coordination amongst the outbreak management team. Gaps in communication and coordination created confusion and frustration. Finally, local LTC operators can be encouraged to develop an explicit communications strategy in the event of an outbreak in order to provide regular updates to staff, residents, and their families. These action items do not address all of the issues identified from the thematic analysis. Many of the challenges to effective outbreak management represent legitimate, structural issues that appear to be long-standing and sector-wide, which require investigation and interventions beyond the scope of this study.

Key informants with direct experience managing outbreaks of COVID-19 in LTC facilities described a range of factors important for outbreak control, including best practices and gaps in the current public health approach. The LTC resident population are highly vulnerable to COVID-19 and LTC outbreaks have already resulted in considerable mortality.[16] By building on the experience of individuals directly involved in outbreak management, we can improve the public health approach to outbreak response within LTC facilities, prevent further infections, and save lives.

Table 3
Key public health recommendations

Key Public health actions
1. Maintain a high level of vigilance for COVID-19 at LTC facilities
2. Provide regular, ongoing, and comprehensive IPAC training and education at LTC facilities
3. Develop formal mechanisms for communication and coordination

BRIEF SUMMARY

Key informant interviews of individuals managing COVID-19 outbreaks in long-term care were analyzed. Eight factors were identified as critical to outbreak management, informing the approach to outbreak management.

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SUPPLEMENTARY MATERIALS

Supplementary material associated with this article can be found in the online version at https://doi.org/10.1016/j.ajic.2021.03.006.

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