CLASS ORDER #1 (Licensed Long-term Care Facilities) re: COVID-19

NOTICE TO OWNERS, LICENSEES, DIRECTORS OF FACILITY, DIRECTORS OF CARE OF LICENSED LONG-TERM CARE FACILITIES IN THE VANCOUVER COASTAL HEALTH REGION (CLASS)

ORDER OF THE MEDICAL HEALTH OFFICER
(Pursuant to Sections 30, 31, 32, 39(3) and 54(1) of the *Public Health Act*, S.B.C. 2008)

THIS ORDER REPLACES MY CLASS ORDER #1 WITH RESPECT TO LONG TERM CARE FACILITIES WITHIN THE VCH REGION MADE MARCH 31, 2020 AND APRIL 8, 2020.

The *Public Health Act*, S.B.C. 2008, c. 28 and the regulations issued thereunder are available at: http://www.bclaws.ca/civix/content/complete/statreg/1922970521/08028/?xsl=/templates/browse.xsl

TO: All owners, licensees, Directors of Facility and Directors of Care of Licensed Long-Term Care Facilities ("LTCFs") (such persons referred to collectively as "LTCF Operators")

FACILITIES: All LTCFs within the Vancouver Coastal Health Authority ("VCH") Region

WHEREAS:

A. A communicable disease known as COVID-19 has emerged in British Columbia;

B. SARS-CoV-2, an infectious agent, can cause outbreaks of serious illness known as COVID-19 among the public;

C. A person infected with SARS-CoV-2 can infect other people with whom the infected person is in contact;

D. On March 17, 2020, the Provincial Health Officer, Dr. Bonnie Henry (the "PHO"), declared the COVID-19 pandemic to be an emergency pursuant to Part 5 of the *Public Health Act*, S.B.C. 2008, c. 28;

E. On March 17, 2020, the PHO issued a letter to all LTCFs advising that the residents of LTCFs, being individuals who are elderly and who may have underlying conditions that compromise the immune system, are particularly at risk of developing severe illness upon becoming infected with COVID-19, and that visitors to LTCFs should be restricted;

F. Multiple LTCFs within the VCH region have experienced an outbreak or incidence of COVID-19 infection, such that it has become necessary to implement more extensive and restrictive protective measures in order to limit the possibility of further spread of COVID-19 and to protect the residents and staff of LTCFs;

G. On March 27, 2020, the PHO issued an order with respect to the collection of LTCF staff personal and employment information;

H. You belong to a class of people who are the owners, licensees, Directors of Facility, Directors of Care and/or healthcare staff of a LTCF that is situated within the VCH Region;

I. I have reason to believe and do believe that the risk of further outbreaks of COVID-19 in LTCFs constitutes a health hazard under the *Public Health Act*; and

J. The purpose of the collection of staffing lists from LTCF Operators by VCH is to enable a Medical Health Officer employed by VCH ("VCH MHO") to respond immediately as outbreaks occur in facilities and to enable VCH Public Health to, in an expedited manner, trace and communicate with contacts.

I HEREBY MAKE THE FOLLOWING ORDER PURSUANT TO SECTIONS 30, 31, 32, 39(3) and 54(1) OF THE *PUBLIC HEALTH ACT*:

1. Effective immediately on receipt of this Order, LTCF Operators are directed to:

   a) Carry out enhanced cleaning of facilities and enhanced screening of all persons entering the facility, in accordance with the guidance document issued by the BC Centre for Disease Control ("BCCDC Guidance Document") which may be updated at any time, and in accordance with any additional direction or directive which may be provided by a VCH MHO. This BCCDC Guidance Document can be accessed on the BCCDC website at the following link: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/clinical-care/long-term-care-facilities-assisted-living. The most recent version of this document as of the date of this Order's issue is enclosed for reference.;

   b) Report to a VCH MHO immediately where one (1) incidence of an Influenza-Like Illness ("ILI") or two (2) cases of cold-like symptoms are identified in residents or staff at the LTCF. Reports must be submitted in accordance with the most recent directives issued by a VCH MHO.;

   c) Deny access to any and all visitors to the LTCF, with the limited exception of the immediate family members of a resident who is clinically assessed to be at the end of his or her life and the spiritual advisor to this resident, in which case such individuals will be subject to enhanced screening for COVID-19. Where the resident is not at the end of life, in exceptional circumstances it is possible to seek a compassionate exemption, further to the process set out in Section 3 of this Order.;

   d) Any LTCF where an outbreak has been declared by a VCH MHO ("Outbreak LTCF") must refrain from accepting new admissions or transferring a resident to any other healthcare facility, including without limitation another LTCF or a hospital as defined in the *Hospital Act*, RSBC 1996, c. 200, without prior notice to and authorization of a VCH MHO. The exception is that urgent or emergent care for the resident should not be delayed by the LTCF in order to comply with this section of this Order. In urgent or emergent situations, a resident may be transferred to an acute care hospital and the Medical Health Officer should be notified by the Outbreak LTCF as soon as practically possible. The Outbreak LTCF must also notify the acute care hospital, prior to the patient arriving at the acute care hospital, that the patient is arriving from an Outbreak LTCF.;

   e) An LTCF not experiencing an outbreak of COVID-19 ("Outbreak Free LTCF") must refrain from transferring a resident to any other LTCF, including LTCFs licensed under the *Hospital Act*, RSBC 1996, c. 200. This Order does not restrict admissions to an LTCF from hospitals or from the community. An Outbreak Free LTCF does not need to notify a VCH MHO prior to transfer of patients to hospitals.;

f) Ensure that all residents who have been temporarily removed from the Outbreak LTCF to live elsewhere in the community (e.g. with family members) are not permitted to return to the Outbreak LTCF for the duration of the COVID-19 outbreak. A VCH MHO determines when an LTCF is no longer experiencing a COVID-19 outbreak. The LTCF must inform family members seeking to temporarily re-home residents of this prohibition on returning to the Outbreak LTCF, and discuss the care plan for the resident prior to the resident's removal from the Outbreak LTCF.;

g) Cancel or postpone indefinitely all group social activities within the LTCF and any planned community social activities unless the LTCF can maintain a two (2) meter separation between residents during these activities.;

h) Submit to the VCH Licensing Officer by **April 2, 2020 at midnight** a staffing list for Staff. See section 2 of this Order for the definition of Staff. The staffing list must include the following:

   a. a list of the full names and positions of all Staff;

   b. identification of the category that each Staff member belongs to (i.e. employee, contracted worker, volunteer); and

   c. a means to contact the staff member, such as a phone number or email address.

   The staffing list must be submitted to the Licensing Officer listed below:

   Nader Massoud, Senior Licensing Officer (Residential)
   Email: nader.massoud@vch.ca
   Phone: 604-675-3859

i) Refrain from scheduling a Staff member to provide services at the LTCF if the LTCF is aware that the Staff member is providing services at the LTCF and at another healthcare facility;

j) Post a copy of the attached Medical Health Officer Dr. Althea Hayden Amended Class Order #2 dated April 9, 2020 ("Amended Class Order #2") in a location visible to Staff of the LTCF.;

k) Deliver by email or facsimile to all LTCF Staff the attached Amended Class Order #2.; and

l) Comply with further directives or guidance issued by a VCH MHO regarding any of the above sections of this Order.

2. The definition of "Staff" in this Order includes all employees, contractors, volunteers, and others who are routinely physically present at the LTCF, except for any other professions, occupations, or care teams which have been exempted by a VCH MHO through a VCH MHO directive, or otherwise exempted by a VCH MHO.

3. With respect to sections 1(c), 1(d), 1(e), 1(f), 1(g), and 1(i), in exceptional circumstances and where an appropriate safety plan is in place to manage health hazard risks, a VCH MHO may grant an exemption to these aspects of this Order. LTCF Operators must apply for the exemption by contacting the VCH Licensing Officer listed in section 1(h) of this order and setting out the exceptional circumstances in writing.

4. The terms of this Order are in addition to, and not in replacement of the BCCDC Guidance Document. Where, however, there is a conflict or inconsistency between this Order and the BCCDC Guidance Document, the terms of this Order shall take precedence.

This Order remains in effect until cancelled, suspended or varied by me or another VCH MHO.

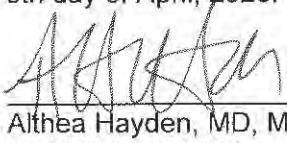
You are required under section 42 of the *Public Health Act* to comply with this Order. Failure to comply with this Order is an offence under section 99(1)(k) of the *Public Health Act*. If you fail to comply with this Order, I have the authority to take enforcement action against you under Part 4, Division 6 of the *Public Health Act*.

Pursuant to section 54(1)(h) of the *Public Health Act*, and in accordance with the emergency powers set out in part 5 of the *Public Health Act*, no VCH MHO will be accepting requests for reconsideration, requests for review, or requests for reassessment of this Order.

You may contact me at:

Althea Hayden, MD, MPH, FRCPC
Medical Health Officer, Vancouver Coastal Health
800-601 W Broadway, Vancouver, B.C.
Telephone: 604-675-3900 and Fax: 604-731-2756

DATED THIS: 9th day of April, 2020.

SIGNED: 

Althea Hayden, MD, MPH, FRCPC
Medical Health Officer, Vancouver Coastal Health
800-601 W Broadway, Vancouver, B.C.
Telephone: 604-675-3900 and Fax: 604-731-2756

DELIVERED: by email to all LTCF Operators.

Enclosures: Excerpts of *Public Health Act* and Regulations

BC Centre for Disease Control, *Infection Prevention and Control for Novel Coronavirus (COVID-19): Interim Guidance for Long-Term Care and Assisted Living Facilities*

Medical Health Officer Dr. Althea Hayden Amended Class Order #2 dated April 9, 2020

Enclosure

Excerpts of the PUBLIC HEALTH ACT and Regulations

Definitions

1 In this Act:

"health hazard" means

(a) a condition, a thing or an activity that

(i) endangers, or is likely to endanger, public health, or

(ii) interferes, or is likely to interfere, with the suppression of infectious agents or hazardous agents, or

(b) a prescribed condition, thing or activity, including a prescribed condition, thing or activity that

(i) is associated with injury or illness, or

(ii) fails to meet a prescribed standard in relation to health, injury or illness;

Division 4 — Orders Respecting Health Hazards and Contraventions

When orders respecting health hazards and contraventions may be made

30 (1) A health officer may issue an order under this Division only if the health officer reasonably believes that

(a) a health hazard exists,

(b) a condition, a thing or an activity presents a significant risk of causing a health hazard,

(c) a person has contravened a provision of the Act or a regulation made under it, or

(d) a person has contravened a term or condition of a licence or permit held by the person under this Act.

(2) For greater certainty, subsection (1) (a) to (c) applies even if the person subject to the order is complying with all terms and conditions of a licence, a permit, an approval or another authorization issued under this or any other enactment.

General powers respecting health hazards and contraventions

31 (1) If the circumstances described in section 30 *[when orders respecting health hazards and contraventions may be made]* apply, a health officer may order a person to do anything that the health officer reasonably believes is necessary for any of the following purposes:

(a) to determine whether a health hazard exists;

(b) to prevent or stop a health hazard, or mitigate the harm or prevent further harm from a health hazard;

(c) to bring the person into compliance with the Act or a regulation made under it;

(d) to bring the person into compliance with a term or condition of a licence or permit held by that person under this Act.

(2) A health officer may issue an order under subsection (1) to any of the following persons:

(a) a person whose action or omission

(i) is causing or has caused a health hazard, or

(ii) is not in compliance with the Act or a regulation made under it, or a term or condition of the person's licence or permit;

(b) a person who has custody or control of a thing, or control of a condition, that

(i) is a health hazard or is causing or has caused a health hazard, or

(ii) is not in compliance with the Act or a regulation made under it, or a term or condition of the person's licence or permit;

(c) the owner or occupier of a place where

(i) a health hazard is located, or

(ii) an activity is occurring that is not in compliance with the Act or a regulation made under it, or a term or condition of the licence or permit of the person doing the activity.

Specific powers respecting health hazards and contraventions

32 (1) An order may be made under this section only

(a) if the circumstances described in section 30 *[when orders respecting health hazards and contraventions may be made]* apply, and

(b) for the purposes set out in section 31 (1) *[general powers respecting health hazards and contraventions]*.

(2) Without limiting section 31, a health officer may order a person to do one or more of the following:

(a) have a thing examined, disinfected, decontaminated, altered or destroyed, including

(i) by a specified person, or under the supervision or instructions of a specified person,

(ii) moving the thing to a specified place, and

(iii) taking samples of the thing, or permitting samples of the thing to be taken;

(b) in respect of a place,

(i) leave the place,

(ii) not enter the place,

(iii) do specific work, including removing or altering things found in the place, and altering or locking the place to restrict or prevent entry to the place,

(iv) neither deal with a thing in or on the place nor dispose of a thing from the place, or deal with or dispose of the thing only in accordance with a specified procedure, and

(v) if the person has control of the place, assist in evacuating the place or examining persons found in the place, or taking preventive measures in respect of the place or persons found in the place;

(c) stop operating, or not operate, a thing;

(d) keep a thing in a specified place or in accordance with a specified procedure;

(e) prevent persons from accessing a thing;

(f) not dispose of, alter or destroy a thing, or dispose of, alter or destroy a thing only in accordance with a specified procedure;

(g) provide to the health officer or a specified person information, records, samples or other matters relevant to a thing's possible infection with an infectious agent or contamination with a hazardous agent, including information respecting persons who may have been exposed to an infectious agent or hazardous agent by the thing;

(h) wear a type of clothing or personal protective equipment, or change, remove or alter clothing or personal protective equipment, to protect the health and safety of persons;

(i) use a type of equipment or implement a process, or remove equipment or alter equipment or processes, to protect the health and safety of persons;

(j) provide evidence of complying with the order, including

(i) getting a certificate of compliance from a medical practitioner, nurse practitioner or specified person, and

(ii) providing to a health officer any relevant record;

(k) take a prescribed action.

(3) If a health officer orders a thing to be destroyed, the health officer must give the person having custody or control of the thing reasonable time to request reconsideration and review of the order under sections 43 and 44 unless

(a) the person consents in writing to the destruction of the thing, or

(b) Part 5 *[Emergency Powers]* applies.

Contents of orders

39 (1) A health officer must make an order in writing, and must describe all of the following in the order:

(3) An order may be made in respect of a class of persons.

Duty to comply with orders

42 (1) A person named or described in an order made under this Part must comply with the order.

(2) Subsection (1) applies regardless of whether the person leaves the geographic area for which the health officer who made the order is designated.

Part 5 — Emergency Powers

Division 1 — Application of this Part

Definitions for this Part

51 In this Part:

"emergency" means a localized event or regional event that meets the conditions set out in section 52 (1) or (2) *[conditions to be met before this Part applies]*, respectively;

"localized event" means an immediate and significant risk to public health in a localized area;

"regional event" means an immediate and significant risk to public health throughout a region or the province.

Conditions to be met before this Part applies

52 (1) A person must not exercise powers under this Part in respect of a localized event unless the person reasonably believes that

(a) the action is immediately necessary to protect public health from significant harm, and

(b) compliance with this Act, other than this Part, or a regulation made under this Act would hinder that person from acting in a manner that would avoid or mitigate an immediate and significant risk to public health.

(2) Subject to subsection (3), a person must not exercise powers under this Part in respect of a regional event unless the provincial health officer provides notice that the provincial health officer reasonably believes that at least 2 of the following criteria exist:

(a) the regional event could have a serious impact on public health;

(b) the regional event is unusual or unexpected;

(c) there is a significant risk of the spread of an infectious agent or a hazardous agent;

(d) there is a significant risk of travel or trade restrictions as a result of the regional event.

(3) If the provincial health officer is not immediately available to give notice under subsection (2), a person may exercise powers under this Part until the provincial health officer becomes available.

Part applies despite other enactments

53 During an emergency, this Part applies despite any provision of this or any other enactment, including

(a) in respect of the collection, use or disclosure of personal information, the *Freedom of Information and Protection of Privacy Act* and the *Personal Information Protection Act*, and

(b) a provision that would impose a specific duty, limit or procedural requirement in respect of a specific person or thing,

to the extent there is any inconsistency or conflict with the provision or other enactment.

Division 2 — Emergency Powers

General emergency powers

54 (1) A health officer may, in an emergency, do one or more of the following:

(a) act in a shorter or longer time period than is otherwise required;

(b) not provide a notice that is otherwise required;

(c) do orally what must otherwise be done in writing;

(d) in respect of a licence or permit over which the health officer has authority under section 55 *[acting outside designated terms during emergencies]* or the regulations, suspend or vary the licence or permit without providing an opportunity to dispute the action;

(e) specify in an order a facility, place, person or procedure other than as required under section 63 *[power to establish directives and standards]*, unless an order under that section specifies that the order applies in an emergency;

(f) omit from an order things that are otherwise required;

(g) serve an order in any manner;

(h) not reconsider an order under section 43 *[reconsideration of orders]*, not review an order under section 44 *[review of orders]* or not reassess an order under section 45 *[mandatory reassessment of orders]*;

(i) exempt an examiner from providing examination results to an examined person;

(j) conduct an inspection at any time, with or without a warrant, including of a private dwelling;

(k) collect, use or disclose information, including personal information,

(i) that could not otherwise be collected, used or disclosed, or

(ii) in a form or manner other than the form or manner required.

(2) An order that may be made under this Part may be made in respect of a class of persons or things, and may make different requirements for different persons or things or classes of persons or things or for different geographic areas.

Offences

99 (1) A person who contravenes any of the following provisions commits an offence:

(k) section 42 *[failure to comply with an order of a health officer]*, except in respect of an order made under section 29 (2) (e) to (g) *[orders respecting examinations, diagnostic examinations or preventive measures]*;

ENCLOSURE

BC Centre for Disease Control, *Infection Prevention and Control for Novel Coronavirus (COVID-19): Interim Guidance for Long-Term Care and Assisted Living Facilities*

Infection Prevention and Control for Novel Coronavirus (COVID-19): Interim guidance for Long-term Care and Assisted Living Facilities

Provincial Coronavirus Response
Mar. 13, 2020

Contents

A. Introduction

The goal of COVID-19 Infection Prevention and Control Measures in Long-term Care (LTC) and Assisted Living (CL) facilities is to, as much as possible, prevent the introduction of the virus into facility and/or prevent transmission to residents and staff within the facility.

This document provides interim guidance to health care workers (HCWs) for the prevention and control of novel coronavirus (COVID-19) in long-term care (LTC) and assisted living facilities.

This guidance document is based on the latest available scientific evidence about this emerging disease, and may change as new information becomes available. The Public Health Agency of Canada will be posting regular updates and related documents at www.phac-aspc.gc.ca. The British Columbia Center for Disease Control (BCCDC) has a healthcare professionals page with resources including posters, pamphlets and other information for health care facilities in BC regarding COVID-19.

At this time the evidence suggests that the incubation period for COVID-19 is up to 14 days. The length of the infectious period of COVID-19 has not been established. Currently, the criteria for individuals with COVID-19 should be 14 day of isolation after symptom onset or being asymptomatic and having had 2 negative tests 24 hours apart, whichever is shorter. In outbreak situations, where some symptomatic residents may not be tested, the period of isolation is at the discretion of the MHO. Once clinical criteria for the end of isolation are established, this guidance will be updated.

B. Infection Prevention and Control Practices for COVID-19

In order to prevent or control the transmission of COVID-19 in long-term care and assisted living facilities, the following items must be addressed:

1. Screening for symptoms
2. Hand Hygiene
3. Respiratory Hygiene (also known as Respiratory/ Cough Etiquette)
4. Point of Care Risk Assessment (PCRA)
5. Droplet/Contact Precautions/ Respiratory Protection (i.e. use of Personal Protective Equipment (PPE))
6. Source Control
7. Accommodation
8. Laboratory Testing
9. Contact Tracing
10. Resident Transfer
11. Cleaning and Disinfection of Equipment
12. Visitors
13. Social Activities and Outside Appointments
14. Reporting

1. Screening for symptoms

Screening families, visitors, service providers with direct resident as well as residents (returning from family visits, day trips, appointments and those entering the facility for respite care) for respiratory symptoms will enable staff to implement infection control precautions to prevent transmission within the facility. Individuals with respiratory symptoms should not enter the facility unless under special circumstances and with the knowledge and pre-approval of the facility Director. This includes visitors, family members, adult day-care program clients, and all staff and service providers.

Families/ Visitors - To prevent introduction of COVID-19 into the facility. At a minimum,

- Passive screening of families and visitors should occur by way of signage (in multiple languages) posted at all entrances to the LTC facility reminding persons entering the facility to **NOT** enter if they have symptoms such as fever, cough, difficulty breathing, chills, sore throat, runny nose, sneezing or pink eye, (see the BCCDC Healthcare Professionals Page for signage). Signage should provide clear instructions on how to perform respiratory and hand hygiene. In addition, there must be signage that advises anyone entering the facility with symptoms to perform respiratory and hand hygiene and report to reception (see the BCCDC Healthcare Professionals page). Reception must have all visitors sign-in when entering the facility **(Appendix A)**.
- Active screening measures should be considered which can include phone screening and in-person questions to families and visitors about symptoms and exposure risk (i.e. travel to a place or contact with an infected person) in anticipation of COVID-19 transmission in the community.

Residents - Enhanced screening of residents for respiratory symptoms should be conducted; all residents should be monitored for fever, new cough, difficulty breathing/shortness of breath, at least once per day. In the event of an identified case of COVID-19, formal monitoring should be increased to twice daily in addition to PCRA. Implement Droplet and Contact Precautions and place in a single room if possible and consider testing all residents in the facility for COVID-19.

Healthcare professionals must ask all residents, families and visitors the following when entering the facility (e.g. new admission, returning from appointment/family outing, etc.):

A. *Does the person report?*:

- □ Fever
- □ Cough (new onset or worsening of chronic cough)
- □ Difficulty breathing or shortness of breath

If they answer **YES** to any of these questions: Provide patient and any accompanying individual(s) a surgical/ procedure mask to wear and ask them to perform hand hygiene. If they are unable to tolerate a mask or contact with the patient or their belongings is required, HCW must wear gown, gloves, mask and eye protection (goggles/ face shield).

Follow the instructions provided in this document.

Staff - Staff should perform self-assessment for respiratory symptoms and should not work if they are experiencing them or if they have been potentially exposed to COVID-19. Staff should be reminded of the importance of reporting their illness to those responsible for Occupational Health if they develop respiratory symptoms while on duty, and should be reminded to inform supervisor to arrange for replacement as soon as possible and go home if they develop symptoms. Wear a surgical/procedure mask and clean hands before contact with another individual while waiting for ability to leave.

2. Hand Hygiene

Diligent hand hygiene is essential for all persons entering the facility. Signage with clear instructions for residents, HCWs, other staff, volunteers, visitors, contractors, etc. to perform hand hygiene should be posted (see the BCCDC Health Professionals Page for poster). Alcohol-based hand rub (ABHR) should be available at the entrances to and exits from the facility, residential units, and at point-of-care in the resident's room. Hand hygiene is important for everyone:

- Before preparing, handling, serving or eating food
- After personal body functions
- Before donning (putting on) any PPE including gown, gloves, facial and eye protection, and after doffing (taking off) PPE
- Before and after engaging in group activities

In addition to the above moments for hand hygiene all HCWs are also required to clean their hands:

- Before contact with the resident or their environment

- Before doing an aseptic procedure
- After contact with body fluids
- After contact with the resident or their environment

All residents should be taught to perform hand hygiene, if physically/ cognitively feasible. If residents are unable to perform hand hygiene, they should be assisted with hand hygiene.

3. Respiratory Hygiene (also known as Respiratory/ Cough Etiquette)

Residents should be taught how to perform respiratory hygiene practices (e.g. coughing into sleeve, using tissues, wearing a mask), if physically/ cognitively feasible. Residents with respiratory symptoms should wear a mask (if tolerated) when HCWs, or other staff or visitors are present.

4. Point of Care Risk Assessment (PCRA)

Prior to every patient interaction, health care providers have a responsibility to assess the infectious risk posed to themselves, colleagues, other patients, and visitors by a patient, situation or procedure. PCRA includes an assessment of the task/care to be performed, the patient's clinical presentation, physical state of the environment and the health care setting. This information is used to assess and analyze the potential for exposure to infectious agents and identify risks for transmission.

Appropriate measures to control the exposure such as use of PPE are then selected. Risk Assessments for any interaction includes:

- The patient's/resident's/client's symptoms and whether they may be consistent with an infectious illness (cough, fever, nausea/vomiting)
- The type of interaction that will occur (e.g. direct care vs. bringing something into the resident's room vs. providing nebulizing treatment or performing an aerosol generating medical procedure ((AGMP))
- The potential for contamination of themselves or any equipment used
- Identification of barriers (e.g. PPE) required to prevent transmission (i.e. gown, gloves, surgical/procedural mask, eye protection)
- Whether all secretion/excretions are contained (e.g. compliance with respiratory hygiene, wounds well covered)
- Whether the person is able to follow instructions (e.g. cognitive abilities, mental health condition)
- The setting in which the interaction will take place (e.g. single room vs. multi-bed room, vs. outpatient or common area)

In reality, HCWs do risk assessments many times a day for their safety and the safety of others in the health care environment. During a respiratory illness (RI) outbreak such as COVID-19 it is especially important that HCWs be vigilant in identifying risk of exposure to RI pathogens when assisting those who are acutely ill (e.g. fever, cough).

All health care settings should ensure they have the ability to identify cases of RI including COVID-19, and to detect clusters or outbreaks. Individuals being cared for in a health care setting who meet the case definition for COVID-19 (i.e. fever and new or worsening cough) should be asked to perform hand hygiene and wear a surgical/procedural mask, if tolerated. They should also be in a separate area or kept two meters away from other patients/residents who are not wearing facial protection

See Appendix B: Risk Assessment Matrix Tool for COVID-19

5. Droplet/Contact Precautions/ Respiratory Protection (i.e. use of Personal Protective Equipment (PPE))

In addition to routine practices, Droplet and Contact Precautions must be implemented for symptomatic residents (see the PICNet Resources Page for signage). This involves staff appropriately donning and doffing PPE (see the BCCDC Health Professionals Page for instructional poster).

Steps to donning (putting on) and doffing (taking off) PPE

Donning (putting on) PPE

1. Hand hygiene – Clean all surfaces of hands and wrists.
2. Gown – Cover torso and wrap around back, fasten in back of neck and waist.
3. Surgical/Procedural mask – Secure ties at middle of head and neck, fit nose band to your nose and pull bottom down to completely cover chin.
4. Eye protection (face shield or goggles) – Place goggles or face shield over face and eyes and adjust to fit.
5. Gloves – Extend to cover wrist of gown.

Doffing (taking off) PPE

1. Gloves – Remember, the outside of gloves are contaminated. Grasp palm area of one gloved hand and peel off first glove. Slide fingers of hand under other glove at wrist and peel off. Discard in regular waste.
2. Gown – Unfasten ties, pull gown away from neck and shoulders, touching ONLY the inside of the gown. Turn gown inside out and roll into a bundle. Discard in regular garbage.
3. Hand hygiene – Clean hands and use a paper towel to touch the doorknob to exit the room. If paper towel is not available then clean hands again after leaving room before removing gown.
4. Eye protection (face shield or goggles) – Do NOT touch the front of them. Discard in regular garbage or put in receptacle for reprocessing.
5. Surgical/Procedural mask – Grasp ties or elastics at back and remove WITHOUT touching the front. Discard in regular garbage.
6. Hand Hygiene – Clean all surfaces of hands and wrists.

IMPORTANT: If performing an aerosol generating medical procedure (e.g. nebulizing treatment), HCW must wear appropriate PPE including a gown, gloves, eye protection (face shield or goggles) and N95 Respirator.

6. Source Control

Source control includes engineering controls (e.g. use of partitions to establish 2 metre distance between residents with respiratory symptoms and others) and administrative controls (e.g. limiting access for visitors with respiratory symptoms). Applying administrative and engineering controls is the first strategy in protecting residents and HCWs from exposure to infectious agents in the LTC facility. LTC organizations should complete assessments of each area of all their LTC facilities including the physical plan (e.g. availability of single rooms, use of partitions, ability to establish 2 metre distance between residents with respiratory symptoms and others) and the types of resident care activities undertaken in residential areas. Based on these assessments, organizations need to determine what administrative and engineering controls are required.

7. Accommodation

Any resident who is identified with respiratory symptoms should be placed on additional (Droplet/Contact) precautions without delay and should be placed in a single bed room, if possible. If not possible, a separation of two metres must be maintained between the bed space of the ill resident and all roommates, and privacy curtains should be drawn. Appropriate signage (see the PICNet Resources Page for Signage) should be posted in the symptomatic resident's space/room indicating the precautions required. The resident should be restricted to his/ her room (bed space), including during meals and any other clinical or social activity.

8. Laboratory Testing

Please ensure that the latest BCCDC Public Health Laboratory COVID-19 Guidance has been reviewed prior to testing (see the BCCDC Health Professionals Page). The following guidance is subject to change and will be updated accordingly. Ensure that the correct swab and collection system is used. Obtain a nasopharyngeal (NP) swab (preferred) or an oropharyngeal (throat) swab from any symptomatic resident to send for laboratory confirmation. Use the Virology Requisition form and write COVID-19 testing is being requested, OR add a special label to the requisition indicating the need for COVID-19 testing.

See Appendix C: Instructions on how to collect a Nasopharyngeal swab (preferred specimen)

9. Contact Tracing

Contact tracing should be initiated if a patient tests positive for COVID-19 and all resident(s) who share a room with the ill resident should be considered as exposed and should be monitored for symptoms at least twice per day for fourteen days. Exposed roommates should not be transferred to any other room for fourteen days after the last exposure.

10. Resident Transfer

Residents with suspected or confirmed COVID-19 who require urgent medical attention and transfer to an acute care facility should wear a mask, if tolerated. Call an MHO or designate to review and discuss. In addition to Routine Practices, HCWs involved in transporting the resident should wear a surgical/procedure mask, eye protection, gown and gloves as per the above recommendations. Notify the BC Ambulance dispatch and receiving institution about a suspect/confirmed COVID-19 patient ahead of transport.

11. Cleaning and Disinfection of Equipment and the Environment

Equipment should be cleaned and disinfected after every use. High touch surfaces (e.g. door knobs, hand rails etc.) should be cleaned and disinfected with a health authority approved product as least twice daily. Any equipment that is shared between residents should be cleaned and disinfected before moving from one resident to another. Clean the entire room/bed space area, including all touch surfaces (e.g. overhead table, grab bars, hand rails) when someone who is suspected or confirmed for COVID-19 has moved. Pre-made solutions (no dilution needed) or ready-to-use wipes can be used. Always follow the manufacturer's instructions.

Important Notes:

- Ensure the disinfectant product has a Drug Identification Number (DIN) on its label and that it is effective against enveloped viruses (e.g. influenza)
- Follow product instructions for dilution and wet contact time
- Ensure safe use including the use of PPE (gloves and gown), good ventilation, etc. or as otherwise advised by the manufacture's instructions, etc.
- Clean visibly soiled surfaces before disinfecting (unless otherwise stated on the product instructions)

12. Visitors

Post signs instructing persons **NOT** to enter if they have symptoms such as fever, cough, difficulty breathing (see the BCCDC Health Professionals Page for signage). Families and visitors have COVID-19 positive should be told to stay away until 14 days after their illness began or once they no longer have symptoms and have had 2 negative tests taken 24 hours apart, whichever is shorter. If an ill visitor is allowed to visit for compassionate reasons, the visitor must wear a mask at all times, and practice fastidious hand hygiene when in the facility. It may be necessary to post a staff member at the entrance to ensure of the facility to ensure compliance.

13. Social Activities and Outside Appointments

It a resident has respiratory symptoms, all social activities and outside appointments should be postponed unless medically necessary (See Resident Transfer, #10). Symptomatic residents should remain in their room and NOT participate in group activities.

14. Reporting

Notify the person responsible for infection prevention and control at the long-term care or assisted living facility of residents with symptoms of COVID-19. The person responsible for infection prevention and control leadership at your facility will notify Public Health of suspected or confirmed cases of COVID-19. If there is no designated infection prevention and control leadership call the Communicable Disease Unit at your local public health unit. **See Appendix D: Outbreak Protocol**

Appendix A – Visitor Sign-in Sheet

Visitor Name	Resident Name	Phone number	Email	Date

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

Prior to any patient interaction, all health care workers (HCWs) have a responsibility to always assess the infectious risk posed to themselves and to other patients, visitors, and HCWs. This risk assessment is based on professional judgement about the clinical situation and up-to-date information on how the specific healthcare organization has designed and implemented engineering and administrative controls, along with the availability and use of Personal Protective Equipment (PPE).

Point of Care Risk Assessment (PCRA) is an activity performed by the HCW before every patient interaction, to:

1. Evaluate the likelihood of exposure to COVID-19,
   - from a specific interaction (e.g., performing/ assisting with aerosol-generating medical procedures (AGMPs), other clinical procedures/ interaction, non-clinical interaction (i.e., admitting, teaching patient/ family), transporting patients, direct face-to-face interaction with patients, etc.),
   - with a specific patient (e.g., infants/ young children, patients not capable of self care/ hand hygiene, have poor-compliance with respiratory hygiene, copious respiratory secretions, frequent cough/ sneeze, early stage of illness, etc.),
   - in a specific environment (e.g., single rooms, shared rooms/ washrooms, hallway, assessment areas, emergency departments, public areas, therapeutic departments, diagnostic imaging departments, housekeeping, etc.),

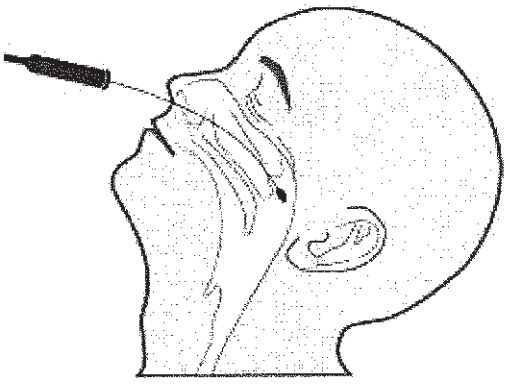
AND

2. Choose the appropriate actions/ PPE needed to minimize the risk of patient, HCW/other staff, visitor, contractor, etc. exposure to COVID-19.

PCRA is not a new concept, but one that is already performed regularly by professional HCWs many times a day for their safety and the safety of patients and others in the healthcare environment. For example, when a HCW evaluates a patient and situation to determine the possibility of blood or body fluid exposure or chooses appropriate PPE to care for a patient with an infectious disease, these actions are both activities of a PCRA.

Appendix C – Instructions on how to collect a Nasopharyngeal swab (preferred specimen)

- Review the latest BCCDC PHL COVID-19 Guidance for Testing (see the BCCDC Health Professionals Page).
- Assemble supplies;
    - USE the recommended collection devices that are routinely used for NP swabs for Influenza or other respiratory virus testing
    - Requisition and label, biohazard bag.
- Wash hands
- Put on PPE (gown, gloves, surgical/procedural mask with eye protection (face shield or goggles) to protect yourself if the patient/resident coughs or sneezes while you are collecting the specimen.
- Explain procedure to resident/patient.
- 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 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.
- Seat resident in a high-fowler's (70^0) position in bed with the back of the head supported. It may be necessary to have a second person available to assist with collection.
- Use the same collection devices that are routinely used for NP swabs for influenza or other respiratory virus testing and 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 patient/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.



- Place in the tube of transport medium (check with 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 is being requested, OR add a special label to the requisition indicating the need for COVID-19 testing.
- Ensure that the patient identifiers and ordering physician are correct.

Place the specimen container in a biohazard transport bag, and insert the requisition in the side pouch. Submit samples as you usually do through your local diagnostic Microbiology Laboratories.

Appendix D – Outbreak Protocol for COVID-19

Early detection and prompt reporting of influenza-like illness to the MHO will help us recognize the outbreak and implement effective control measures. Early detection and immediate implementation of control measures can be two of the most important factors in determining the size and length of the outbreak.

- Using COVID-19 outbreak surveillance forms (**Appendix E and Appendix F**) maintain ongoing surveillance for influenza-like illness (ILI). This means monitoring all residents for fever and cough or sore throat. For COVID-19, difficulty breathing is another common symptom.
- In the event of a suspected outbreak of influenza-like-illness, immediately report and discuss the suspected outbreak with an MHO or public health delegate at your local health authority.
- Take viral specimens (nasopharyngeal or nasal swab) for lab testing as soon as possible. See "Influenza-Like-Illness outbreak Specimen Collection" attached.
- Isolate all symptomatic individuals promptly.

Outbreak Detection and Confirmation

Definition: If two or more cases of ILI are detected in residents and/or staff within a 12-day period, with at least one case identified as a resident, or if any staff or resident is diagnosed with COVID-19.

- Immediately report and discuss the suspected outbreak with a MHO or designate [i.e. Public Health Nurse, Adult Care Licensing Officer (ALO)] at your local health authority.
- Isolate all symptomatic patients and use routine, droplet and contact precautions when providing care or collecting specimens.
- Obtain viral specimens as soon as possible and forward to BCCDC laboratory for testing (See the BCCDC Health Professionals Page for latest instructions for specimen collection).

Outbreak Management Infection Control & Cleaning and Disinfection Procedures During an Outbreak

All outbreak control measures take priority over routine operations until the outbreak is declared over. Restrictions will be in place until the outbreak is declared over by the MHO.

1. **Facility**

a. Post outbreak notification sign(s) at facility entrance and/or floor/unit/ward advising visitors about the outbreak. (see the BCCDC Healthcare Professionals Page for signage).

b. Maintain an outbreak **line list** of cases in residents and a line list of cases in staff (nursing, food handlers, housekeeping, etc.). **(Appendix E)**

   i. Record the details as required on the attached Influenza-Like-Illness Line List for Residents and/or the Influenza-Like-Illness Line List for Staff.

   ii. Forward the line list(s) when requested to the MHO or designate.

iii. Once an outbreak is declared, residents no longer need testing. All residents with symptoms should be assumed to have COVIS-19 and be cared for accordingly.

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. Enhanced housekeeping and cleaning should include more frequent disinfection of commonly touched surfaces/items, safe disposal of contaminated items and laundry within resident rooms, availability of alcohol-based hand-sanitizers in each resident's room, and disinfection of equipment between use for different residents/areas.
d. Close the affected floor/unit/ward or facility to new admissions, readmissions, or transfers unless medically necessary.
e. If an admission or transfer is deemed medically necessary, call the MHO or designate to review and discuss. Notify the receiving hospital or clinic to ensure that care can be provided safely.
f. If a resident is transferred to an acute care facility for treatment of COVID-19 or its complications, they may return to the facility when they are medically stable.
g. Residents transferred to an acute care facility who do not have COVID-19 should not generally be re-admitted to the facility until the outbreak is declared over.
h. Notify other service providers such as volunteers, clergy, Handy DART, oxygen service, BC Ambulance, paid companions, students, and others of any outbreak control measures that may affect their provision of services. Suspend non-essential services for the duration of the outbreak.
i. Notify any facility that would have admitted a resident from you within the past 14 days that the facility has a COVID-19 outbreak.
j. Cancel all in-person organized social activities and community social activities for that unit/ward/floor.
k. Notify and consult with infection prevention and control.

2. Residents

a. For symptomatic residents, restrict contact as much as possible until symptoms resolve. This includes, whenever possible:
    i. Placing symptomatic residents in private rooms, or if that is not possible, placing symptomatic residents with other symptomatic residents.
    ii. Serving meals in the resident's room, or floor/unit/ward.
    iii. Restricting participation in any group activities.
    iv. If tolerated, wear a mask when a health care worker or visitor is in the room.

b. For all residents
    i. Minimize contact between patients/residents on affected floors/units/wards with unaffected areas.
    ii. Remind patients/residents to wash hands thoroughly and report any symptoms.
    iii. In consultation with the MHO or designate decrease or discontinue group activities or outings. Well patients/residents should not be discouraged from outings with family members or other one-on-one activities.
    iv. Cancel or reschedule appointments that do not risk the health or well-being of the resident until the outbreak is declared over.
    v. Reinforce hand hygiene and respiratory hygiene practices

3. Staff

a. Symptomatic staff should isolate promptly and phone 8-1-1 or their health care provider. Staff should follow testing instructions for close contacts of COVID-19. At this time, the recommendation is to test all close-contacts of COVID-19. As the situation evolves in BC, these recommendations may change. Maintain a COVID-19 outbreak line list for staff **(Appendix F)**.
b. Symptomatic staff are excluded from working and will remain off work **with pay** until symptoms resolve or until they have had two negative COVID-19 tests 24 hours apart whichever is sooner.
c. Cohort staff as much as possible e.g. staff working with symptomatic residents should avoid working with residents who are well.
d. If dedicated staff for sick residents is not available, staff should first work with the well and then move on to care for the ill and avoid movement between floors and units where possible.
e. Practice strict hand hygiene between residents at all times.
f. Staff working between outbreak and non-outbreak facilities will be at the determination of the MHO. In general:
    i. Staff from outbreak facilities may not work in facilities with no COVID-19 outbreak and if not permited to work elsewhere, will be compensated for missed shifts.
    ii. In the event of critical staff shortages, and under the direction of the MHO, staff from outbreak facilities may work in non-outbreak facilities as long as they are able to confirm at the beginning of each shift that they are afebrile and asymptomatic, and are able to self-isolate as soon as symptoms develop.
    iii. Staff who have recovered from COVID-19 may work in all facilities and should be prioritized to work in outbreak facilities.

4. Visitors and Volunteers:

a. Symptomatic persons should not enter the facility until their symptoms resolve. If the visit is deemed necessary, they should wear a surgical mask during the visit and to visit only their immediate family member or friend, no others.
b. If possible, keep a 2 m distance from symptomatic residents during the visit.
c. Visitors to a patient/resident with ILI should be offered the same personal protective equipment as that worn by health care providers.
d. Restrict visitation of multiple residents/clients, including by privately employed non-care facility staff (e.g. paid companions). If visiting multiple residents is necessary, visit asymptomatic residents first.
e. Remind visitors about the importance of thorough hand hygiene and respiratory hygiene

Outbreak Termination

Control measures will be continued until the outbreak is declared over by the MHO. Once the outbreak is declared ver:

- Complete the "Influenza-Like-Illness Outbreak Report Form" and fax it to your local health authority.
- Order replacement viral specimen kits by emailing the updated Sample container order form to kitorders@hssbc.ca or by faxing a request to BCCDC at 604-707-2606.
- Consider a debrief with your facility to evaluate the management of the outbreak.
- Remain alert for possible new cases in staff and residents. Report any suspect outbreaks to the MHO or designate.

Appendix E: COVID-19 Outbreak Line List - Patients/Residents/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, **F**=Fever, **DB** = Difficulty Breathing, **ST**=sore throat, **NC**= nasal congestion (runny nose)

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, F=Fever, DB = Difficulty Breathing, ST=sore throat, NC= nasal congestion (runny nose)

ENCLOSURE

Medical Health Officer Dr. Althea Hayden Amended Class Order #2 Dated April 9, 2020