COVID-19 Binder: Response Guidance for Long-Term Care, Assisted Living and Independent Living Facilities

Original: April 9, 2020

Updated: May 28, 2020

This binder is a compilation of documents from various sources and, as they are updated, the binder will be revised and re-released. Additional materials created, for the purpose of the binder, are also included here.

The primary audience for the binder is LTC, AL and IL sites.

All contents approved by LTC-AL-IL Coordination Committee.

This binder will be updated regularly as the response to, and evidence regarding, COVID-19 evolves. Please check regularly for updated versions. Notification of updates will be sent via email.

A number of restrictions are already in place to prevent a potential outbreak. This Binder focuses primarily on outbreak management. We encourage all sites to be proactive with prevention.

Contents

1.0 Introduction

The purpose of the binder is to provide facilities and Fraser Health personnel working in Long Term Care (LTC), Assisted Living (AL) and seniors Independent Living (IL) facilities with a common framework to guide response to outbreaks of COVID-19, facilities with high risk population groups, and to limit transmission to clients and staff within the facility. Guidance in this binder is based on the expectation that all facilities have implemented all foundational elements of COVID-19 prevention measures *applicable to their facility* as described in LTC Prevention-Preparedness Self-Assessment Tracker.

The guidance is meant to provide a set of interventions for COVID-19 outbreaks that builds upon existing approaches to FH respiratory outbreak protocols, available evidence on COVID-19, and current regional experience with COVID-19 control in this setting. The guidance is not prescriptive, and should be applied in the context of a specific outbreak scenario as directed by Public Health and/or the Medical Health Officer and/or Fraser Health designated site EOC lead.

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

This document builds on guidance previously prepared by Fraser Health and other Public Health organizations. Further details can be found through the following organizations:

- World Health Organization: https://apps.who.int/iris/bitstream/handle/10665/331508/WHO-2019-nCoV-IPC_long_term_care-2020.1-eng.pdf
- BCCDC http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/clinical-care/long-term-care-facilities-assisted-living.
- Public Health Ontario: http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_long_term_care_guidance.pdf
- US CDC https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html
- Fraser Health: https://www.fraserhealth.ca/health-topics-a-to-z/coronavirus#.Xo9Qr7qotPY

1.1 Medical Health Officer (MHO) Orders

MHO orders can be found here: https://www.fraserhealth.ca/health-topics-a-to-z/coronavirus/mho#.XrGI4Muou8w

Guidance and general updates from the MHO can be found here: https://www.fraserhealth.ca/employees/medical-health-officer-updates#.XrGI48uou8w

1.2 How to Use This Binder

This document has been structured into the following sections:

Have symptomatic clients and/or staff, not confirmed as COVID positive? Checklist – Suspect Case

Have a laboratory confirmed COVID positive case in your site? Go to one of these sections:

Checklist – ONE Client Positive COVID-19 test result (COVID Outbreak)

Checklist – ONE Staff member Positive COVID-19 test result

Checklist – TWO (or more) Positive COVID-19 test results (client and/or staff)

Need information about process or policy, logistics or general operations? Operations (processes, admissions), Logistics

Need a poster, tool or other resource? Resources (tools, algorithms, forms, posters), Posters

Need guidance on a clinical procedure? Clinical Practice Resources

A refresher on prevention activities that all sites should have implemented and be an ongoing part of COVID precautions can be found here: LTC Prevention-Preparedness Self-Assessment Tracker

1.3 Incubation and Transmission

At this time, the evidence suggests that the incubation period for COVID-19 is 5-9 days but may be as long as 14 days. The length of the infectious period of COVID-19 has not been established. Currently, the transmissible period for individuals infected with COVID-19 is considered to begin at symptom onset; the transmissible period is considered to end 10 days following symptomatic onset or upon resolution of symptoms, whichever is longer. A dry cough may persist for several weeks so a dry cough alone as a symptom does not indicate transmissibility or warrant continuation of self-isolation.

1.4 Key Contacts

This document is updated frequently with the most current direction, guidance and resources regarding COVID-19. Additional resources and FAQs can be found at https://www.fraserhealth.ca/health-topics-a-to-z/coronavirus#.Xo-SDbgotPZ.

If your specific questions are not covered in either of those places, email covid.ltc.al@fraserhealth.ca

☑ KEY CONTACT TO NOTIFY of 1+ Suspected (swabbed) Cases:

Public Health Hotline: Phone 604-507-5471 | Fax 604-507-5439

For suspected cases, please complete the appropriate Public Health Tool 27: Resident Illness Report and Tracking Form or Public Health Tool 28: Staff Illness Report and Tracking Form and fax to Public Health.

1.5 Who should be tested for COVID-19?

Medical Health Office Update

April 08, 2020

Change in testing guidance for suspect cases of novel coronavirus (COVID-19). Please follow the testing guidance below

Summary of updates:

- Changes to testing guidelines based on an increase in testing capacity in BC
- Any physician can order a test for COVID-19 for symptomatic individuals based on their clinical judgement, with new groups of people recommended and prioritized for testing if symptomatic
- New labelling categories for specimens
- New criteria for tests of clearance of positive COVID-19 cases requiring hospitalization
- Clarification of previous MHO update (March 23) in regard to HCW testing and return-to-work

COVID-19 testing is recommended and prioritized for the following groups with NEW ONSET respiratory or gastrointestinal symptoms (includes fever, cough, shortness of breath, sore throat, rhinorrhea, nasal congestion, loss of sense of smell, loss of appetite, chills, vomiting, diarrhea, headache, fatigue, and myalgia):

- Clients and staff of Long Term Care Facilities
- Patients requiring or likely requiring admission to hospital, and patients needing to enter hospital for ongoing treatment, including pregnant women in their 3rd trimester and people receiving chemotherapy, radiation, or hemodialysis
- Health care workers, including community pharmacists
- Residents of remote, isolated or Indigenous communities
- People who are homeless or have unstable housing
- People living and working in congregate settings such as shelters, work-camps, correctional facilities, group homes, assisted living facilities and seniors' residences
- Essential services providers, including first responders (police, firefighters, paramedics)
- Returning travelers identified at a point of entry to Canada
- Individuals part of an investigation of a cluster or outbreak (based on the direction from Public Health)

Please see below for **new labelling instructions** for some of the above categories.

DO NOT test for COVID-19 in asymptomatic individuals. Please see below the tests of clearance update for the only exception to this recommendation.

Any physician can order a test for COVID-19 based on their clinical judgement. For **symptomatic** individuals that do not fall in the above listed categories, physicians can order a test for COVID-19 based on clinical judgement. Note that most patients with lab-confirmed disease have mild to moderate symptoms and recover at home with limited medical intervention.

False negative results can occur early in the course of infection and in severely infected patients. Over the past two months, we have come to better understand the accuracy of the COVID-19 test. We have found that false negative results can occur early in the course of the infection, implying that a negative RNA test does not definitively rule out COVID-19 infection.

Advise patients with COVID-19 to seek medical care if symptoms do not improve 5-7 days following symptom onset
In retrospective studies of critically ill patients, onset of dyspnea occurred at a median time of 6.5 days after symptom onset, and progression to respiratory distress occurred quickly thereafter (median 2.5 days after onset of dyspnea).

Specimen Labelling
If applicable, please indicate one of the following codes on the specimen label to assist with processing:

- **HCW1** – Health Care Worker – Direct Care
- **HCW2** – Health Care Worker – Non Direct Care
- **UPC** – Urgent and Primary Care Centre
- **LTC** – Long Term Care Facility
- **OBK** – Outbreak - **including homeless populations**
- **HOS** – Hospital (Inpatient)
- **CMM** – Community (Outpatient)

Tests of clearance of positive COVID-19 cases requiring hospitalization

- For **cases who require hospitalization**, two negative tests at least 24 hours apart are required before being considered cleared from self-isolation. These tests are to be taken at least 10 days after the onset of symptoms and once symptoms are resolved. These patients can be discharged prior to the end of their 10 day infectious period, if they are deemed appropriate by their MRP to self-isolate and recover at home. The clearance tests do not need to be collected prior to discharge, and can be done at a GP's office or at an assessment centre.
- For all mild COVID-19 cases and health care workers **who do not require hospitalization**, negative tests of clearance are not required to determine discontinuation of self-isolation. Patients in this category are considered cleared 10 days after the onset of symptoms and once symptoms are resolved, whichever is longer. Note that a residual dry cough may persist for weeks; therefore, if this is the only symptom at the end of the isolation period, these patients may come off self-isolation.

Clarification of previous MHO update (March 23) in regard to HCW testing and return-to-work:

- Health care workers who have respiratory symptoms **and** are tested for COVID-19 **must self-isolate while awaiting test results**.
- If the test is **negative**, health care workers may return to work once their symptoms have resolved. Note that a residual dry cough may persist for weeks; therefore, if this is the only symptom remaining, health care workers may return to work.
- If the test is **positive**, health care workers must self-isolate for 10 days after the onset of symptoms, and may return to work after the 10th day provided they are asymptomatic. A residual dry cough is acceptable.
- A negative test of clearance **for health care workers who have tested positive** and did not require hospitalization is **not required** before returning to work.
- Asymptomatic health care workers who are returning from travel outside Canada may return to work but should otherwise self-isolate for 14 days

1.6 Definitions

Client will be used throughout the document in reference to clients, tenants and residents.

Most Responsible Provider (MRP) throughout refers to GP or NP.

1.6.1 COVID-19 Outbreak

One or more client or staff of a facility has a new lab-confirmed COVID-19 diagnosis. Outbreaks can also be declared at the discretion of Public Health.

1.6.2 Outbreak Stages

1. **Declared Outbreak:** Public Health declares the outbreak in a facility.
2. **Concluded Outbreak:** Public Health declares when an outbreak is concluded. 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 date the outbreak was declared, whichever is later. This uses the conservative two incubation periods of 14 days each.

1.6.3 Presentation (Symptoms)

1. **Respiratory symptoms**:
   - Includes new/acute onset of any of the following symptoms:
     - Fever: Screen staff 2 x shift and Residents 2 x day.
     - Sore throat
     - Arthralgia (joint pain)
     - Myalgia (muscle pain)
     - Headache
     - Prostration (physical or/and mental exhaustion)
     - Cough* (or worsening cough: that is not due to seasonal allergies or known pre-existing conditions)
     - Shortness of breath
     - Rhinorrhea (runny nose)
   - Does not include ongoing, chronic respiratory symptoms that are expected for a client unless the symptom is worsening for unknown reasons
   - Does not include seasonal allergies
2. **Atypical symptoms possibly due to COVID-19:**
   - Includes, but not limited to:
     - New Gastrointestinal Symptoms
     - Nausea/vomiting
     - Diarrhea
     - Increased fatigue
     - Acute functional decline

2.0 Outbreak Management

2.1 *REVISED - Contact Tracing

Public Health, working with the facility, will identify client(s) who share a room or have had close contact with a confirmed COVID-19 positive client (e.g. taking meals together, face-to-face conversations and other close contact).

All clients who have had close contact with the case will be considered to be exposed, and should be isolated for fourteen days. Exposed clients should not be transferred to any other room for fourteen days after the last exposure. Fourteen days is used for asymptomatic individuals to cover the probable incubation period.

Public Health, working with the facility, will identify contacts of staff cases who test positive for COVID-19. Close contacts may include clients receiving care from the staff case, as well as staff and household/community contacts.

All staff who test positive for COVID-19 will be contacted by Public Health and a detailed risk assessment will be performed to identify contacts occurring **while the case was symptomatic and 48 hours prior**. Public Health will contact any individual deemed a close contact of the confirmed case and ask individuals deemed as close contacts to isolate and self-monitor for symptoms for fourteen days. Clients who are close contacts of a staff case must be isolated in their rooms, and receive care with contact and droplet precautions.

Staff contacts of a confirmed COVID-19 case may continue to work as long as they remain asymptomatic, unless otherwise directed by Public Health.

What does Public Health do?

- When Public Health receives notification of a positive lab result for COVID-19, Public Health nurses follow up directly with the site. Public Health collects information about the case in order to determine their infectious period, and identifying if others may have been exposed to the case during this time. This includes soliciting information about individual contacts or settings where the case may have gone to while infectious.
- Public health staff continue to follow-up with these cases throughout their illness, which may involve (dependent on setting) daily monitoring of symptoms and providing advice about when to seek further care.
- Public Health will notify the case (or site) as to when they can be discharged from self-isolation.

How does contact tracing work?

- To identify contacts, Public Health determines where the case went during their infectious period, who they interacted with, and the degree of exposure each person had. Information about contacts can be collected directly from the case, or from site/program managers and Infection Prevention and Control.
- Public Health considers several factors in determining which identified contacts were at risk of exposure and require formal notification and follow up.

- Risk of exposure is influenced by factors such as duration of exposure, clinical presentations (cough and severe illness can increase risk), type of interaction, whether the client was wearing a mask, whether the HCW was following proper infection control practices, and other individual and context-based factors.
- Based on the type of exposure, contacts will be directed to self-isolate, self-monitor for symptoms, and/or continue physical distancing. Health care workers should be tested for COVID 19 if they become symptomatic

Q & A

Q: What is the infectious period that is used to determine contact tracing?

A: For people who do have symptoms of COVID-19 and test positive, Public Health will trace contacts from 48 hours before the start of symptoms until 10 days after symptom onset.

Q: I worked on a shift with someone who is COVID-19 positive (whether a client or co-worker) and have not been contacted. Have I been missed?

A: When Public Health performs contact tracing, they determine the level of risk to the contact, which may depend on the factors relevant to the COVID-19 case, such as symptom severity, as well as on the contact's factors, such as the duration of exposure and the use of PPE. Public Health asks managers to provide lists of staff who worked on a given unit/site at a specific time so that they can follow-up on potential exposures. If the risk is deemed to be low, you will not be contacted.

If you have not been contacted by Public Health and you do feel that you have had a high-risk exposure at work, such as providing direct care to a COVID+ patient without appropriate PPE or a breach in use of PPE, please contact your manager about your concerns.

Q: How long does the contact tracing process take, from when the case is tested?

A: Swabs are usually processed within 24-48 hours. Once public health receives the lab notification of a positive result, public health begins case investigation within 1 day, and contact identification and notification begins as soon as information is available. Public Health is working 7 days a week from 0830-1930 to support this follow up work.

Q: What are the Public Health guidelines for staff who were deemed as being exposed to COVID?

A: Public Health will assess each staff individually to provide appropriate guidance.

Q: Where can symptomatic staff go test tested for COVID-19?

A: Testing is recommended for symptomatic HCW staff. Information about testing sites is available here: https://www.fraserhealth.ca/employees/clinical-resources/coronavirus-information/testing#.XrXD27gotPY

Q: How long do staff need to remain off work and on home isolation if they are a confirmed case?

A: Generally, HCWs who are positive for COVID are required to remain on home isolation for a **minimum** of 10 days from the start of their symptoms. Public Health will monitor them and once their symptoms have resolved, they will be cleared to return to work.

2.2 Cohorting Clients and/or Staff

Clients

Cohorting options for clients are currently being considered by Fraser Health. Sites experiencing an outbreak will be supported to identify all options and should begin developing plans for cohorting in the event of multiple cases presenting.

Staff

Cohorting staff for COVID-19 positive clients means staff working with COVID-19 clients do not work with any other clients. For the purpose of cohorting staff, clients should be categorized into the following groups:

- Group A – COVID-19 positive
- Group B – Symptomatic clients awaiting swab results
- Group C – Clients exposed to COVID-19 staff or clients and not yet symptomatic (14 day isolation)
- Group D – Well clients

2.3 Monitoring and initial response for possible COVID-19 cases

(i.e. client or staff is symptomatic, prior to completion of lab testing)

Staff should actively monitor clients twice daily for compatible symptoms/presentations (see MHO order on Who Should be Tested?). Clients who meet the case definitions are considered possible cases and should be tested for COVID-19 via a nasopharyngeal swab (NP) swab.

Staff should swab clients experiencing mild ILI, respiratory, or gastrointestinal symptoms, as well as fever without known cause and clients experiencing atypical symptoms possibly due to COVID-19.

Rationale: COVID-19 cases in this population are known to occur in clients with mild or atypical presentations.

DO NOT test for COVID-19 in asymptomatic individuals.

2.4 Checklist – Suspect Case

2.4.1 For symptomatic client(s)

1. **Follow** droplet precautions and use appropriate personal protective equipment (which includes a gown, surgical/procedural mask, eye protection, and gloves) to deliver care to the respective client, including the collection of the NP swab for testing.
    a. **Post** Droplet signage outside the client's room (see Droplet Precautions Poster)
    b. **Provide** personal protective equipment (gowns, gloves, surgical/procedural masks, eye protection) and hand hygiene station outside the room for staff use prior to entering the room.
    c. **Dedicate** equipment (e.g thermometer, BP cuff, stethoscope, and commode) as much as possible. Equipment that cannot be dedicated must be cleaned and disinfected

(using Accel intervention wipes, Cavi wipes or Sani Cloth) before subsequent reuse. Provide disinfectant wipes. Refer to Health Canada COVID-19 Approved Disinfectants: Health Canada COVID-19 Approved Disinfectant.

d. **Isolate** the client within their room, to minimize exposure risk to other clients and staff. If client is taken out of their room, provide a surgical/procedural mask to the client if tolerated and assist in cleaning their hands if required

e. **Initiate** droplet precautions:

- Only essential Aerosol Generating Procedures (AGP) should be performed and will require donning a N95 respirator. This is in addition to eye protection, gown and gloves. Follow Aerosol Generating Procedures (AGP) regarding appropriate PPE. N95 respirator is not required for droplet precautions only

2. Nursing staff (LTC only) **Obtains** a nasopharyngeal (NP) swab specimen:
   a. For Instructions on how to collect a nasopharyngeal swab see Collecting a Nasopharyngeal Specimen for Culture below
      - The swab should be obtained as soon as possible and sent to BCCDC
      - Label requisition "LTC" to ensure prioritized testing

2.4.2 Additional steps facility should initiate

3. **Notify** leaders for the facility (Director of Care/AL Site Manager and/or Facility Medical Director)
4. **Admissions:** Hold all admissions to entire facility until swab results are known. Notify FH Access, Care & Transitions (ACT). At the time of matching, a discussion will occur to either halt the move or break the match.
5. **Cleaning**: Inform housekeeping of the need for enhanced cleaning for the affected facility (see section 'cleaning' of BCCDC LTCF COVID-19 document for details)
   a. 2x/day cleaning throughout the facility including high-touch surfaces (door knobs, faucets in bathrooms, common areas, dining rooms, gyms, recreational therapy rooms, shared equipment).
   b. Use 0.5% accelerated hydrogen peroxide wipes or bleach wipes
6. **Food service**: Meals for client awaiting test results should be provided in their room during isolation. Food delivery is done by cohorted staff and not by food services staff. The number of residents eating at a table must be controlled to allow enough distance apart to meet the required physical distance (minimum 2 metres). Practice one or more of the following to meet physical distancing requirements:
   a. Assign residents in small groups to the shared dining room,
   b. Space seating to allow a two metre separation between residents,
   c. Stagger the meal times,
   d. Distribute groups into other available rooms.
7. **Notify** client's primary care provider to determine if further assessment and treatment is indicated.
8. **Notify** client's family / substitute decision-maker / next-of-kin regarding the situation.
9. **Notify** (as relevant) BC Ambulance, and other similar transportation suppliers, oxygen services, laboratory services and other service providers of any outbreak control measures that may affect their provision of services
10. **Document goals of care**: Ensure proactive goals of care conversations are occurring, documented on the advance care planning record and client's MOST is current & up to date. Ensure facility Medical Director, delegate or Most Responsible Provider are involved and aware of client's goals of care.

11. **Cohort staff:** Cohort staff assignment as much as possible. Staff working with symptomatic clients should avoid working with clients who are well. As much as possible, staff providing

care/treatment to multiple clients within the facility should begin with unaffected units/clients and progress to affected units/clients. The same principle will also apply to housekeeping staff.

12. **Staff personal protective equipment (PPE)**: Staff to follow extended surgical/procedural mask and eye-protection protocol in all client areas. Staff entering the rooms of affected clients should follow Droplet Precautions including surgical/procedural mask, eye-protection, gloves and gown
13. **Hand Hygiene**: Staff should follow meticulous hand hygiene practices following the 4 moments of hand hygiene and when doffing PPE. Instruct, educate and enable all clients to clean their hands before eating, after toileting and before coming out of their room
14. **Client symptom monitoring**: facility should continue twice daily screening of all clients

2.4.3 For symptomatic staff member

15. **Ensure** staff notify supervisor/manager
16. **Exclude** staff from work
    - Staff with respiratory or new gastrointestinal symptoms should be excluded from the facility and present to an assessment centre for testing. This includes support staff (e.g. food services, housekeeping, maintenance) working in any site.
17. **Arrange** for testing
18. **Notify** Facility Medical Director

2.4.4 For either symptomatic client and/or staff

19. **Maintain** separate report and tracking lists of symptomatic staff and/or clients (see Public Health Tool 27: Resident Illness Report and Tracking Form or Public Health Tool 28: Staff Illness Report and Tracking Form), submit daily via Fax: 604-507-5439
20. **Staff monitoring**: All staff need to be actively screened for symptoms – before shift starts and end of shift, and also self-monitor at all times
21. **Prepare** for Public Health Risk Assessment:
    - Description of the facility: how many clients? Any shared rooms? How many levels of the facility? How many buildings? Common spaces? Independent Living / Assisted Living or Long Term Care Facilities? Are there other levels of service sharing the same 'campus'?
    - Prepare plans for isolation in the event many clients became ill. Is there a recreation room or other space that could be repurposed to cohort COVID positive clients?
    - Layout of the facility: a plan, building drawings or map of the facility if available. Identify where any suspect or confirmed clients are currently.
    - Staffing: staff that have interacted with the symptomatic client, etc.

2.5 Checklist – ONE Client Positive COVID-19 test result (COVID Outbreak)

Public Health is notified of all new lab-positive COVID-19 cases by the BCCDC, and will investigate all positive cases. Public Health will automatically contact the affected facility to conduct a risk assessment and provide outbreak measures. If a facility hears about a case through a source that is not Public Health, the facility should implement the following outbreak measures and await further instructions from Public Health.

A single lab-confirmed COVID-19 case **IS** considered an outbreak in the facility unless otherwise directed by the Medical Health Officer (MHO). An outbreak may also be declared by Public Health based on multiple suspect cases. For an outbreak which is declared due to a single client case or multiple suspect cases, the facility should begin the following measures.

2.5.1 Symptomatic clients or confirmed case

1) **Ensure** droplet precautions are undertaken and signage posted for symptomatic and/or confirmed COVID-19 positive client (see Droplet Precautions Poster)
2) **Isolate** client inside their room. If client comes out of their room for essential purposes, provide a surgical/procedural mask to the client if tolerated and clean their hands. If wearing an incontinent pad, ensure it is dry and secure
3) **Place** a PPE and hand hygiene station outside the symptomatic clients' rooms for the use of staff entering the room. Provide a container of disinfectant wipes.
4) **Serve** meals last for the confirmed positive COVID-19 client only. Food delivery is done by cohorted staff and not by food services staff.
5) **Provide** care last to the confirmed positive COVID-19 client only
6) **Dedicate** equipment (e.g. thermometer, BP cuff, stethoscope) as much as possible. Equipment that cannot be dedicated must be cleaned and disinfected before subsequent reuse on another client
7) **Implement** COVID care plan (refer to clinical practice resources)
8) **Continue and ensure** proactive goals of care conversations are occurring and client MOST is up to date. Ensure facility (and Medical Director, their delegate, or Most Responsible Provider) is aware and involved in ongoing conversations related to client's goals of care
9) **Perform** only essential Aerosol Generating Procedures (AGP), which will require donning a N95 respirator. This is in addition to eye protection, gown and gloves. Follow Droplet Precautions Poster and Aerosol Generating Procedures (AGP) regarding appropriate PPE
    - N95 respirator is not required for droplet precautions only
10) **Ensure** that ongoing serious illness conversations are occurring as appropriate with Substitute Decision Maker, and goals of care are aligning with management

2.5.2 All clients

11) **Continue** symptom checks for all clients twice daily
12) **Obtain** a nasopharyngeal (NP) swab specimen for any symptomatic clients
    - The swab should be obtained as soon as possible and sent to the BC-CDC
    - Ensure facility labels requisition "LTC" to ensure prioritized testing
13) **Continue** with extended surgical/procedural mask and eye-protection when on client units. Additionally, wear gloves and gowns when providing care for clients on Droplet precaution or when indicated by routine practices
14) **Minimize** contact between clients on affected floors/units/wards with unaffected areas through isolation.
15) **Limit** congregating of clients for recreation and dining unless able to maintain strict 2 metre physical distance and no sharing of high touch areas or objects.
16) **Remind** clients of hand hygiene and respiratory etiquette
17) **Close** the affected floor/unit/ward from other areas to limit traffic
18) **Discontinue** group activities
19) **Cancel** or reschedule all non-urgent appointments that do not risk the health or well-being of clients. Refer to LTC - Transfers for Medical Care or AL - Transfers for Medical Care process.
20) **Serve** meals to all clients in-room via tray service
    - If in-room meal service not possible, serve asymptomatic group first in common dining area AND clean dining area particularly high touch areas when finished THEN serve symptomatic/confirmed clients. Maintain physical distancing as much as possible

2.5.3 Facility

21) **Activate** site Emergency Operations Centre (EOC) with *at a minimum* the Director of Care, the Facility Medical Director (if applicable) and the FH assigned site EOC lead.
22) **Post** outbreak notification signs at facility entrance and floor/unit/ward
23) **Close** entire facility to admissions and transfers
24) **Continue** enhanced cleaning for unit/floor
    - 2x/day cleaning throughout the facility including high-touch surfaces (door knobs, faucets in bathrooms, common areas, dining rooms, gyms, recreational therapy rooms, shared equipment).
    - Use 0.5% accelerated hydrogen peroxide wipes or bleach wipes
25) **Continue** to ensure adequate supply of PPE, swabs, cleaning/disinfection and hand hygiene materials
26) **Continue** to **restrict** to 1 essential, adult visitor for actively dying residents only - visitor must be screened negative for symptoms
27) **Ensure** delivery staff (e.g. linens, food and nutrition, supply management) deliver first to the unaffected units before progressing to affected unit
28) **Dedicate** housekeeping cart to the outbreak unit. Cohort housekeeping staff to affected or unaffected units where possible. Otherwise, ensure housekeeping visits start with the unaffected units first before progressing to affected unit.
29) **Avoid** garbage and soiled linens traversing from the affected unit through other units; take directly to holding areas/loading dock
30) **Confirm** facility staff are not actively working at another site
    - If staff are dually employed, staff should be asked to only work at one facility throughout the duration of the outbreak

2.5.4 Communicate

31) **Public Health will provide** communication to facility staff, clients, and families using standardized letters. These letters cannot be altered, but can be attached to a separate letter from the facility. They will be provided to you by Public Health.
32) **Notify** non-facility staff, professionals, and service providers of the outbreak and restrictions to visit the facility to provide essential services only
33) **Discuss** outbreak with Public Health daily to implement additional outbreak control measures as directed
34) **Maintain** separate report and tracking lists of symptomatic staff and/or clients (see Public Health Tool 27: Resident Illness Report and Tracking Form or Public Health Tool 28: Staff Illness Report and Tracking Form), submit daily via Fax: 604-507-5439

2.6 Checklist – ONE Staff member Positive COVID-19 test result

Public Health is notified of all new lab-positive COVID-19 cases by the lab performing the test, and will investigate all positive cases. Public Health will automatically contact the affected facility to conduct a risk assessment and provide outbreak measures. If a facility hears about a case through a source that is not Public Health, the facility should implement the following outbreak measures and await further instructions from Public Health.

2.6.1 Outbreak Measures

1) **Exclusion** from work duties

2) **Home isolation** of the staff member for 10 days from the onset of symptoms or until symptom resolution, whichever is longer. A dry cough may persist for several weeks, so a dry cough alone does not warrant continuation of self-isolation
3) **Maintain** separate report and tracking lists of symptomatic staff and/or clients (see Public Health Tool 27: Resident Illness Report and Tracking Form or Public Health Tool 28: Staff Illness Report and Tracking Form), submit daily via Fax: 604-507-5439
4) **Public Health will provide** standardized letters for facility to distribute to staff.
5) **Confirm** facility staff are not actively working at another site
    - If staff are dually employed, staff should be asked to only work at one facility throughout the duration of the outbreak

2.6.2 Medical Measures

Encourage staff who are confirmed positive COVID-19 cases to engage with their usual primary care physician regarding medical care if needed – for example supportive care.

2.6.3 Return to Work

Staff infected with COVID-19 can return to work 10 days after the onset of symptoms or until symptom resolution. A dry cough may persist for several weeks, so a dry cough alone does not warrant continuation of self-isolation. Public Health will provide this information during routine follow-up. Encourage supervisors to follow-up with individual staff members 10 days after a positive test for psychosocial supports.

2.7 Checklist – TWO (or more) Positive COVID-19 test results (client and/or staff)

Public Health is notified of all new lab-positive COVID-19 cases by the lab performing the test, and will investigate all positive cases. Public Health will automatically contact the affected facility to conduct a risk assessment and provide outbreak measures. If a facility hears about a case through a source that is not Public Health, the facility should implement the following outbreak measures and await further instructions from Public Health.

A COVID-19 outbreak in a facility may be declared when there are one or more community members with confirmed COVID-19. The following are measures for the purpose of an outbreak with 2 or more confirmed cases (2 clients OR 2 staff OR 1 client AND 1 staff).

Upon the declaration of an outbreak, the facility begins the following measures:

2.7.1 Outbreak detection and confirmation

1) **Notify** Public Health when there are 2 or more clients (and/or staff) with respiratory or gastrointestinal symptoms (Phone 604-507-5471)
2) **Maintain** separate report and tracking lists of symptomatic staff and/or clients (see Public Health Tool 27: Resident Illness Report and Tracking Form or Public Health Tool 28: Staff Illness Report and Tracking Form), submit daily via Fax: 604-507-5439

2.7.2 Symptomatic clients or confirmed case

3) **Post** Droplet signage at the door of the affected clients (see Droplet Precautions Poster)
4) **Isolate** the client in their room
5) **Obtain** a nasopharyngeal (NP) swab specimen for any symptomatic clients. The swab should be obtained as soon as possible and sent to a lab for COVID-19 testing
6) **Ensure** labelling of all requisitions with “LTC” to ensure prioritized testing
7) **Place** a PPE, hand hygiene and disinfectant wipes station outside the symptomatic clients’ rooms for the use of staff entering and leaving the room. Place disinfectant wipes outside the room
8) **Continue** with extended surgical/procedural mask and eye-protection when on client units. Additionally, wear gloves and gowns when providing care for clients on Droplet precaution or when indicated by routine practices
9) **Provide** care last to the confirmed positive COVID-19 client
10) **Ask** the client to wear a surgical/procedural mask if anyone will be entering their room
11) **Implement** COVID care plan
12) **Continue and ensure** proactive goals of care conversations are occurring and client MOST is up to date. Ensure facility (and Medical Director, their delegate, or Most Responsible Provider) is aware and involved in ongoing conversations related to client’s goals of care
13) **Ensure** that ongoing serious illness conversations are occurring as appropriate with Substitute Decision Maker, and goals of care are aligning with management
14) **Consider** cohorting COVID-19 positive clients (see Cohorting section)

2.7.3 All clients

15) **Implement** droplet precautions throughout floor/unit/neighbourhood where clients are located or staff and client are epidemiologically linked or interact
16) **Isolate** all clients on the same floor or neighbourhood as the confirmed positive COVID-19 clients (or where staff worked), to the extent possible
17) **Serve** meals to all clients in-room via tray service (serve confirmed clients last)

- If in-room meal service not possible, serve asymptomatic group first in common dining area AND clean dining area particularly high touch areas when finished THEN serve symptomatic/confirmed clients. Maintain physical distancing as much as possible

18) **Continue** symptom checks for all clients twice daily
19) **Isolate and implement** droplet for any symptomatic clients
20) **Obtain** a nasopharyngeal (NP) swab specimen for any symptomatic clients
    - The swab should be obtained as soon as possible and sent to a lab conducted testing for COVID-19
    - Ensure to label requisition with "LTC" to ensure prioritized testing
21) **Continue** with extended surgical/procedural mask and eye-protection when on client units. Additionally, wear gloves and gowns when providing care for clients on Droplet precaution or when indicated by routine practices
22) **Minimize** contact between clients on affected floors/units/wards with unaffected areas through isolation, restricting group activities, physical distancing measures
23) **Remind** clients of hand hygiene and respiratory etiquette
24) **Close** the affected floor/unit/ward from other areas as possible
25) **Ensure** ongoing discontinuation of group activities and cancel all client gatherings
26) **Continue** physical distancing and avoid clients gathering in common areas
27) **Ensure** ongoing cancellation or rescheduling of all non-urgent appointments that do not risk the health or well-being of clients
28) **Consider** COVID-19 testing for other clients of the floor, regardless of reported symptoms
    - Note mild symptoms in client or atypical/unusual symptoms for assessment and/or testing

2.7.4 Staff

29) **Cohort** staff assignment. Staff working with symptomatic clients avoid working with clients who are well
30) **Restrict** staff throughout facility (no staff coverage between units/floors)
31) **Screen** all staff actively for new onset respiratory or gastrointestinal symptoms – before shift starts and end of shift, and also self-monitor at all times. Exclude any symptomatic staff
32) **Confirm** facility staff are not actively working at another site
    - If staff are dually employed, staff should be asked to only work at one facility throughout the duration of the outbreak

2.7.5 Facility

33) **Activate** site Emergency Operations Centre (EOC) with *at a minimum* the Director of Care, the Facility Medical Director (if applicable) and the FH assigned site EOC lead.
34) **Post** COVID-19 outbreak signage throughout the facility on doors, desk, boards, etc.
35) **Close** entire facility to admissions
36) **Continue** enhanced cleaning of floor and/or neighbourhood (consider facility)
    - 2x/day cleaning throughout the facility including high-touch surfaces (door knobs, faucets in bathrooms, common areas, dining rooms, gyms, recreational therapy rooms, shared equipment).
    - Use 0.5% accelerated hydrogen peroxide wipes or bleach wipes
37) **Continue** to ensure adequate supply of PPE, swabs, and hand hygiene materials
38) **Increase** restriction on visitors to No Visitors, unless by special exception by facility management. Visitor must be screened negative for symptoms.

39) **Alert** regular PPE supplier that additional hand hygiene products, gloves, gowns, eye protection, and surgical/procedural masks may be required
40) **Ensure** delivery staff (e.g. linens, food and nutrition, supply management) deliver first to the unaffected units before progressing to affected unit
41) **Dedicate** housekeeping cart to the outbreak unit
42) **Avoid** garbage and soiled linens traversing from the affected unit through other units; take directly to holding areas/loading dock

2.7.6 Communicate

43) **Provide** communication to facility staff, clients, and families using standardized letters that will be provided by Public Health. These letters cannot be altered, but can be attached to a separate letter from the facility. FH Patient Care Quality Office (PCQO) will attend to notify families by phone.
44) **Notify** non-facility staff, professionals, and service providers of the outbreak and the inability to visit the facility
45) **Discuss** outbreak with Public Health daily to implement additional outbreak control measures as directed
46) **Maintain** separate report and tracking lists of symptomatic staff and/or clients (see Public Health Tool 27: Resident Illness Report and Tracking Form or Public Health Tool 28: Staff Illness Report and Tracking Form), submit daily via Fax: 604-507-5439
47) **Encourage** diligence in hand washing and use of alcohol hand sanitizer for all visitors/clients/staff

2.8 Post-Outbreak Debrief

The tentative end date of an outbreak would be 28 days from implementation of outbreak control measures or symptom onset of the last lab-confirmed COVID-19 diagnosis at the facility, whichever is later. Guidelines are being updated as we learn more about the virus and are subject to change. Also, variables specific to each facility will be taken into consideration and may impact this timeline.

Consider a debrief meeting, led by Public Health, 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 staff and clients.

3.0 Operations (processes, admissions)

3.1 Site Emergency Operation Centre (EOC)

After the declaration of an outbreak, the site EOC Lead is activated by the Fraser Health LTC AL IL Coordination Centre. The facility receives the initial outbreak measures through the Respiratory Illness Outbreak Notification (RION) and is responsible for the implementation of the outbreak measures described therein. Public Health works with the facility on a daily basis to re-evaluate the outbreak. Public Health advises the site EOC Lead and facility of changes to outbreak measures throughout the outbreak. These are implemented and operationalized through the site EOC.

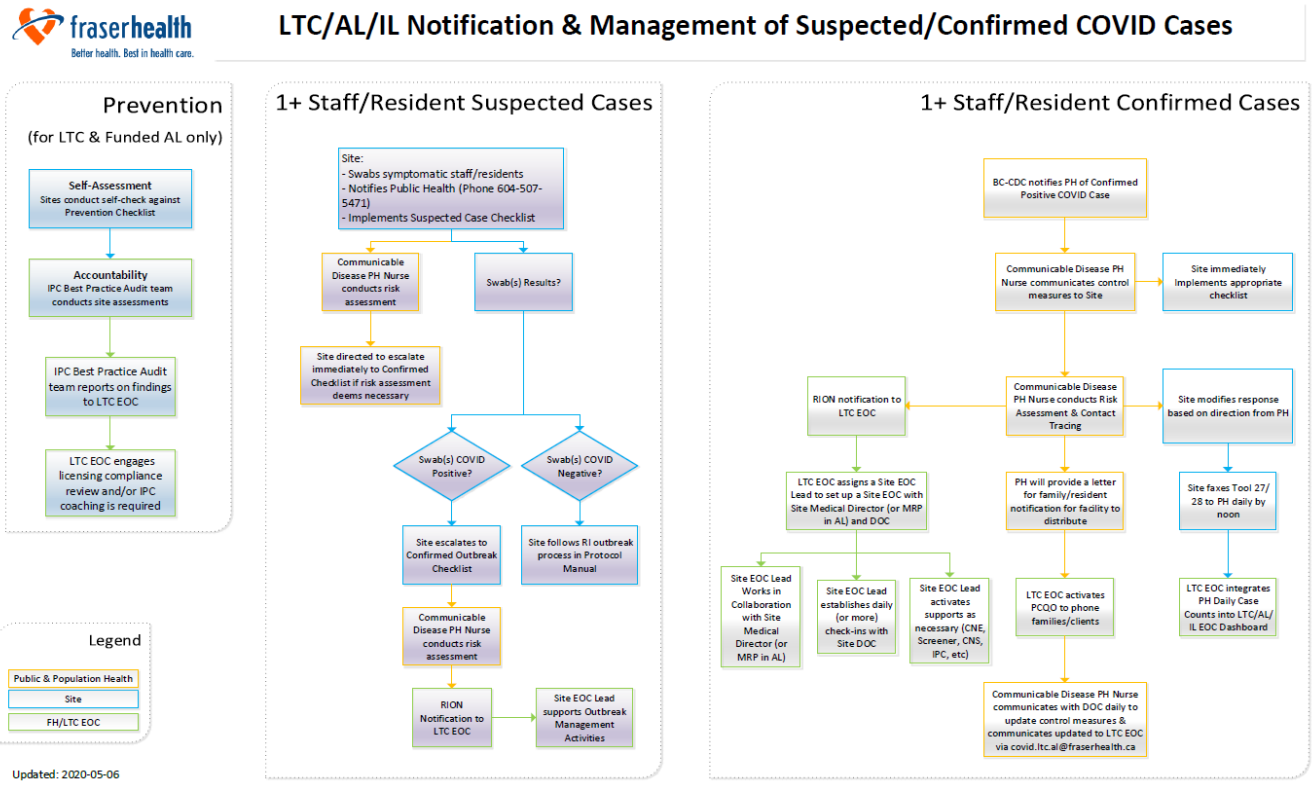
Site EOC Leads are automatically activated for all long term care, assisted living, and independent living facilities regardless of whether they are owned and operated by Fraser Health, or are private pay.

The site EOC lead is able to activate members of a regional resource team to meet the needs of the site during the outbreak if the needs exceed the site's capacity. The resource team consists of screeners, CNEs to support and coach the site re IPC and PPE, as well as what to expect with COVID-19 illness, access to IPC specialists for advanced education and problem-solving, PPE logistics, and access to staffing resources.

Upon declaration of an outbreak, sites are responsible to activate their site Emergency Operations Centre (EOC) with *at a minimum* the Director of Care, the Facility Medical Director (if applicable) and the FH assigned site EOC lead.

Roles and responsibilities (Prevention through Outbreak) are outlined in the Notification & Management Process for Suspected/Confirmed Cases algorithm below.

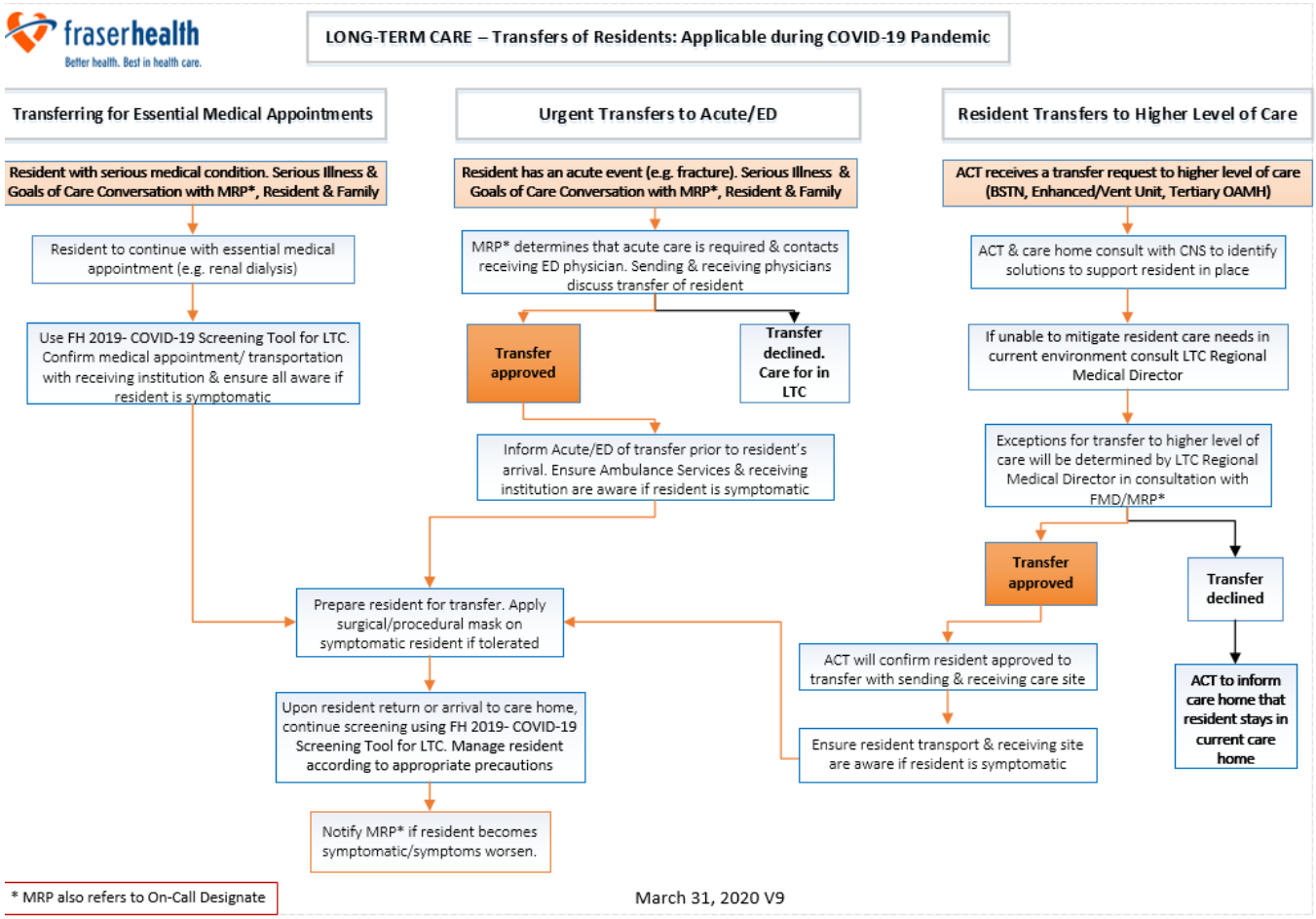
3.2 Notification & Management Process for Suspected/Confirmed Cases



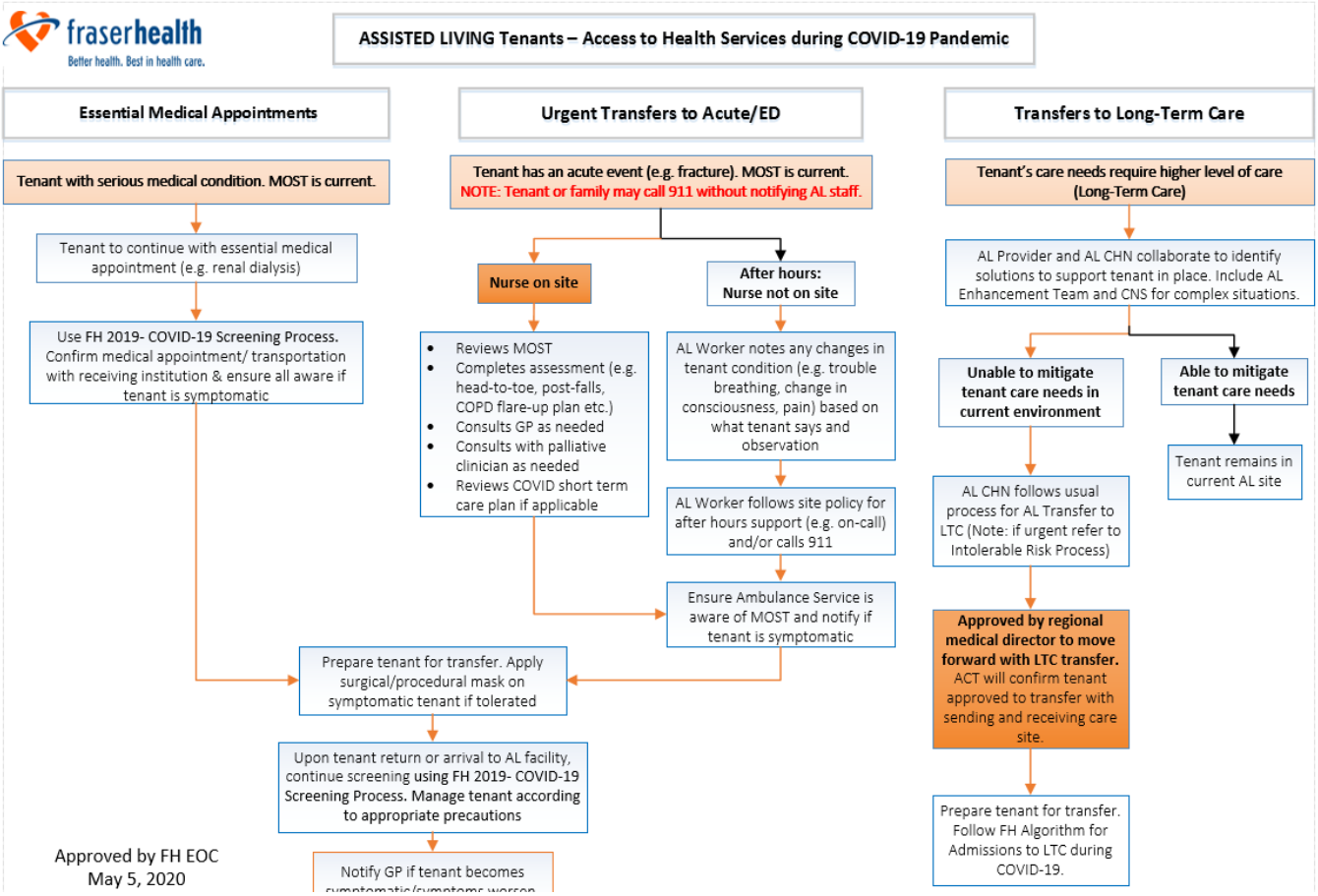
3.3 Essential Medical Appointments

Clients requiring transfer to essential medical appointments, a higher level of care, or to an acute setting during the COVID-19 pandemic will be transferred according to the algorithm below. Clients with confirmed COVID-19 infection who require urgent medical attention and transfer to an acute care facility should wear a surgical/procedural mask if tolerated. In addition to routine practices, Health Care Workers (HCWs) involved in transporting the client should wear a surgical/procedural mask, eye protection, gown and gloves as per droplet precautions.

3.4 LTC - Transfers for Medical Care



3.5 AL - Transfers for Medical Care



3.6 Admissions/Transfers from Acute Care to Long-Term Care, Assisted Living & Independent Living

Fraser Health Guidelines for
Admissions to Long-Term Care/Convalescent Care/Assisted Living during COVID-19
New Admissions & Returning Residents/Tenants

Purpose

The purpose of this document is to provide guidance to Long-Term Care, Convalescent Care and Assisted Living providers (LTC, CV and AL) when accepting admissions. These guidelines are based on direction from the Fraser Health Emergency Operations Centre and Medical Health Officers; they may change in relation to new data, COVID-19 Pandemic changes, hospital surge increases and/or additional health orders.

April 27, 2020 Update:

As per the Ministry of Health (MOH) directives dated April 27, 2020, Fraser Health is resuming admissions from the community to Long-Term Care (LTC) and Assisted Living (AL). Previous policy and processes will be followed in relation to waitlists. Clients choosing not to move to their Preferred Care Home (PCH) or AL site will be placed on delay for the duration of COVID-19 pandemic in order to maintain their waitlist date.

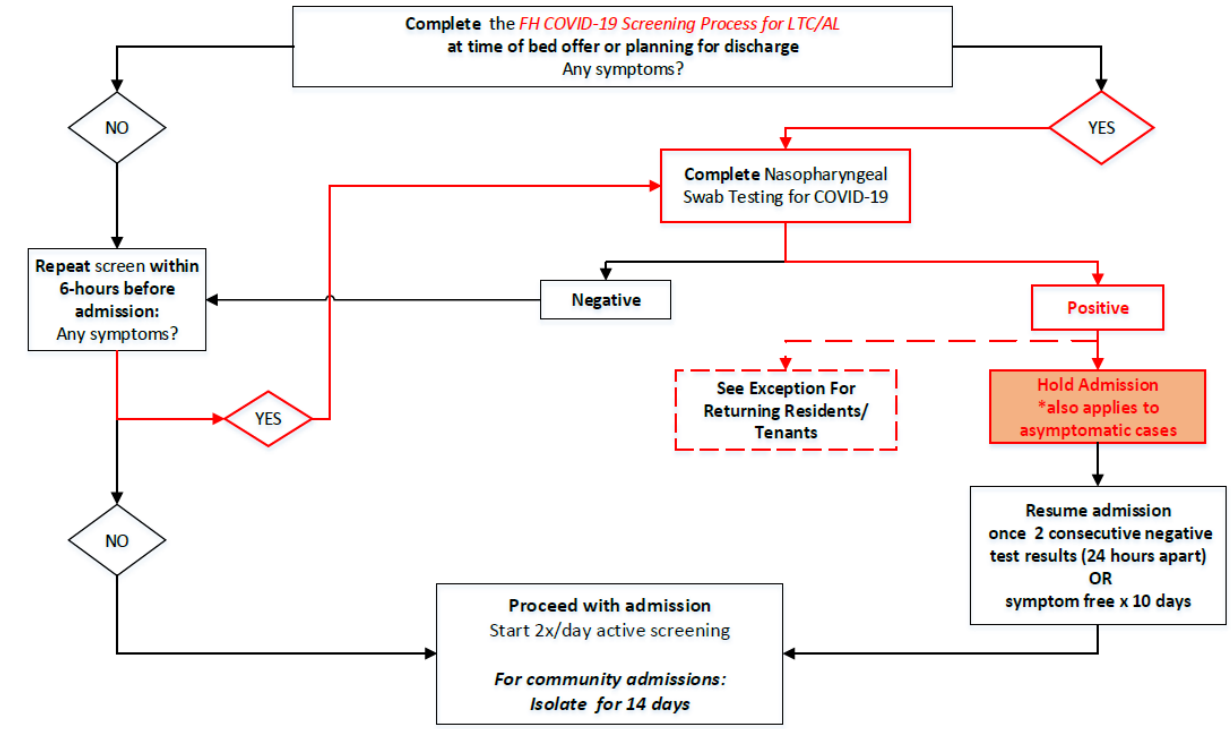
Important Notes

- Admissions from acute care will continue to be prioritized, as per MOH directives April 27, 2020
- Factors which are considered when accepting admissions include the outbreak status of facility and the COVID-19 status of patient/client/resident/tenant:
  - No new admissions to an outbreak facility/site
  - Returning residents/tenants who tested positive for COVID-19 cannot return to a neighbourhood/site with no other cases unless MHO approval is obtained
- Inter-facility transfers continue to be restricted under MOH directives March 18 & March 24, 2020
  - This restriction applies tor Short-term residential units where the beds are counted within the licensed LTC capacity
- The Ministry of Health advised on May 5, 2020 that admissions from the community require a 14 day isolation period and COVID-19 precautions for asymptomatic residents/tenants, preferentially in single (or semi-private) room. The Access, Care & Transition (ACT) Coordinators will collaborate with community clinicians and providers to:
  - Review the isolation plan
  - Ensure a fulsome plan to support the physical and psychological well being of the resident/tenant

The *FH COVID-19 Screening Process for LTC/AL* can be found: FH COVID-19 Screening Process for LTC/MHSU/AL

ALGORITHM FOR ADMISSIONS TO LONG-TERM CARE, CONVALESCENT CARE & ASSISTED LIVING DURING COVID-19 PANDEMIC

New Admissions & Returning Residents/Tenants



Approved by the FH EOC April 30, 2020
Minor revision May 6, 2020

3.7 *REVISED - Client Access to Essential Services

COVID-19

May 1, 2020 Revised

Resident/Tenant Access to Essential Clinical Services

What's Happening?

Residents/tenants may require access to essential clinical services provided by private or Fraser Health professionals such as foot care nurses, podiatrists and Fraser Health professionals (e.g. Community Health Nurse (CHN), Physiotherapist, Occupational Therapist, Social Worker etc.).

Access to these clinical services is permissible when the goals of care discussions between health care team members (e.g. MRP, resident/tenant & family/substitute decision-maker and care staff) confirm they are essential.

On-Site Visits

- Site staff will:
  - meet essential clinical services personnel at the door
  - advise if the site is under COVID-19 outbreak precautions
  - maintain a list of essential clinical services personnel visiting the site, including name of individual, date and time on site, location worked (e.g. third floor) and contact information
  - screen at the beginning and end of the visit as per FH staff screening guidelines
  - monitor the essential clinical services personnel donning and doffing of Personal Protective Equipment (PPE) to ensure technique and Infection Prevention and Control Guidelines properly followed
  - clean work area and common touch surfaces before and after each essential clinical services personnel visit

- All essential clinical services personnel will:
  - plan to visit outbreak facility/site last if attending multiple sites in a day
  - wear surgical/procedure masks and eye protection when in resident/tenant areas
  - as per point of care risk assessment when coming within 2 metres of a symptomatic client on Droplet Precautions *wear full PPE (e.g. wear surgical/procedure face mask, eye protection, gown and gloves)
  - perform hand hygiene as per 4 moments of hand hygiene

- Foot care nurse/Podiatrist and others as applicable will:
  - clean and disinfect surfaces used for the appointment with hospital grade disinfectant
  - follow sterilization of shared instruments as per reprocessing guideline

*To help conserve PPE, only change a surgical/procedure mask when leaving the resident/tenant area unless it's wet, damaged or visibly dirty. If mask is touched, clean hands immediately. Eye protection can be reused. Clean eye protection when leaving resident/tenant area or when visibly soiled. If eye protection touched, clean hands immediately.

Approved by the LTC-AL-IL Coordination Centre, May 1, 2020
Approved by the FH EOC May 4, 2020

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4.0 Logistics

4.1 Swabs

To order swabs, please contact the BCCDC.

An order form can be found here: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Forms/Labs/PHLOrderForm.pdf

4.2 Testing Process for Funded & Private Pay Tenants for Assisted Living Sites (attached to Long Term Care Home- LTC & AL Campus Process)

For clients who are able, arrange an appointment at one of the Community Assessment Sites.

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COVID-19 Testing Process for Funded & Private Pay Tenants for (attached to Long Term Care Home- LTC & AL Campus Process) Assisted Living Sites

Tenant Has Positive COVID-19 Screen

1.	☐ **AL nurse: isolate tenant with positive screen of COVID 19 symptoms, implements infection control practice for droplets precautions , and monitors tenant** ☐ AL nurse requests LTC nurse (RN/RPN/LPN) to complete COVID-19 swabbing by email or phone: Urgent – Covid-19 Testing Request See AL Swabbing Request Template below
2.	☐ LTC LPN uses Physician's Order for COVID-19 swabbing from the LTC site Medical Director. LTC RN/RPN does not require order.
3.	☐ LTC nurse swabs tenant at AL site. AL nurse supports as 2nd nurse. LTC nurse utilizes required supplies (swabs, PPE) from LTC Site. LTC Nurse sends swab for testing. LTC ensures adequate supplies are also ordered for AL.
4.	☐ Swab is stored in refrigerator at AL site. AL arranges for pick-up (e.g. LTC courier to pick up swab from AL etc.)
5.	☐ AL nurse continues implementing infection control practice for droplets precautions and monitoring of tenant
6.	☐ AL nurse informs AL CHN or responsible HH professional by email using standard template of funded & private pay tenants who were swabbed. ○ Subject line: Urgent – Covid-19 Testing Completed
7.	**For private pay tenants known to HH/HS:** ☐ AL CHN or responsible HH professional obtains results from UCI and communicates care plan changes to AL nurse and HS Supervisor ☐ HH CHN updates Paris Client Site Risk Assessment for COVID & completes case note using case note reason – *Viral Resp Illness*
8.	**For funded AL tenants:** ☐ AL CHN obtains results from UCI and communicates care plan changes to AL nurse ☐ AL CHN updates Paris Client Site Risk Assessment for COVID & completes case note using case note reason - *Viral Resp Illness*
9.	☐ AL site documents in their Electronic Medical Record (e.g. Senior Care)

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27 March 2020

4.3 Testing Process for Funded & Private Pay Tenants for Assisted Living Sites (Standalone)

For clients who are able, arrange an appointment at one of the Community Assessment Sites.

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COVID-19 Testing Process for Funded & Private Pay Tenants for Stand Alone Assisted Living Sites

Tenant Has Positive COVID-19 Screen

1.	☐ **AL nurse: isolate tenant with positive screen for COVID 19 symptoms, implements infection control practice for droplets precautions , and monitors tenant** ☐ AL nurse contacts AL CHN by email or cell phone • Subject line: Urgent – Covid-19 Testing Request Please refer to AL Swabbing Request Template below
2.	☐ AL CHN collects tenant information and arranges to have requisition, swabs, and PPE (community-specific) ☐ AL CHN completes blank requisition with regional MHO, Dr Alexandra Choi's billing information: CPSID 34576 MSP #62673
3.	☐ AL CHN swabs tenant at AL site. AL nurse supports as 2nd nurse.
4.	☐ AL nurse continues implementing infection control practice for droplets precautions and monitoring tenant
5.	**Transport Options (Site-Specific):** ☐ AL site arranges mobile lab pick-up ☐ AL site arranges same-day or overnight delivery of specimen, or if not available, by courier ➢ Outside the Lower Mainland: DHL (1-800-225-5345) ➢ Lower Mainland: T-Force (1 877 345 8801) ☐ AL CHN transports swab to community assessment centre
6.	**For private pay tenants known to HH/HS:** ☐ AL CHN informs responsible HH professional about tenants who have been swabbed. ☐ AL CHN or responsible HH professional obtains results from UCI and communicates care plan changes to AL nurse and HS Supervisor ☐ responsible HH professional updates Paris Client Site Risk Assessment for COVID & completes case note using case note reason – *Viral Resp Illness*
7.	**For funded AL tenants:** ☐ AL CHN obtains results from UCI and communicates care plan changes to AL nurse ☐ AL CHN updates Paris Client Site Risk Assessment for COVID & completes case note using case note reason – *Viral Resp Illness*
8.	☐ AL site documents in their Electronic Medical Record (e.g. Senior Care)

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27 March 2020

AL CHN completes online modules:

a) Transportation of Dangerous Goods https://worksitesafety.ca/product/training/online/tdg-online-training/

b) Training for COVID-19 swabbing https://point-of-care.elsevierperformancemanager.com/skills/434/notes?skillId=GN_43_7

c) Completes practical Swab specimen collection training at Community Testing site – AL CHN to arrange at their local site & communicate to AL CNE upon completion of training

4.4 AL Swabbing Request Template

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Subject line: Urgent – Covid-19 Testing-Swabbing Request

Hi,

I have a tenant with COVID -19 positive screening test.

Please come to _____ **as soon as possible.**
(name of your site)

Please bring PPE and the swab.

Neighbourhood:

Room number:

Tenant's Name:

Can you confirm when you will be able to visit our site?

AL Swabbing Request Template
FH AL Services
27 March 2020

4.5 *REVISED - Process for Staff Testing

Staff who have ***symptoms*** (fever; new or worsening cough; new or worsening shortness of breath; new or worsening sneezing; or sore throat; new gastrointestinal symptoms) ***as per*** the BC CDC identify themselves to their supervisor.

1. 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).
2. Staff member contacts the assessment centre directly to book an appointment and identifies themselves as a health care worker.

4.6 How to Access PPE Supplies

- **Effective May 5, 2020**, Long-Term Care and Assisted Living providers are to use the **Shopping Cart System** to order required PPE supplies. The previous ordering form/process is no longer in use.
- Sites must continue to order no more than 3 days worth of supplies.
- **The link to the PPE Shopping Cart is:** https://fraserhealth.illum.ca *(Google Chrome recommended)*
- An account has been created for your site. **Your login will be the email address you provided**. f you are unsure, please contact the PPE Community Support Desk for your email that has been used to create your online account: PPECommunitySupport@fraserhealth.ca
    - The first time you log on please click 'new user' to create your password
- Please **watch the video linked below** for information on how to log in for the first time.
    - https://drive.google.com/file/d/1-YUlNP7Ytgixcsnr9ODVPbwRHLhY-m2C/view
- If you have any questions, contact PPECommunitySupport@fraserhealth.ca

4.7 *NEW – Food and Essential Care Items Brought in For Patients

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Fraser Health COVID-19 Guidance for Food and Essential Care Items Brought in for Patients

Purpose

This guidance document provides Infection Prevention and Control (IPC) best practice recommendations on outside food and other essential care items brought in by families for patients in Fraser Health Acute Care sites and within Long Term Care and Assisted Living facilities.

Scope

This document applies to all Fraser Health Acute Care sites and Fraser Health Operated and Contracted Long-Term Care and Assisted Living facilities.

Definitions

Patients: In addition to patients in Acute Care Settings, in this document, the term also refers to all residents, client, and tenants in Long Term Care and Assisted Living facilities.

Process

Fraser Health recommends that the following measures are adhered to if food items and other personal belongings are being brought in by relatives for patients after agreement and arrangements are made with unit or facility staff:

- Food items that are prepared at home should be packaged in single-use food containers that can be discarded
  - Staff may reheat food using the designated microwave on site
- In Long Term Care facilities, it is preferred that any food item that is brought in should have a longer shelf life, do not require refrigeration, and are non-perishable
- Food and other essential items may be left with the staff at the nursing stations, or if the patient is in a Long Term Care facility, the items brought into the facility should be handed over to the staff at the entrance of the facility
- All essential care items (e.g., food, soaps, lotions, etc...) must be new products
- Any item brought in a disposable bag should be labelled with the patient's name, room number and date
- Leftover food must be disposed of as per the protocols at the facility
- Food items must not be shared with other patients
- Any clothing that is brought in for patients should be brought in a disposable bag
  - In Long Term Care facilities, clothing should be laundered onsite before issuing to patients
- Potted plants, flowers, vases are allowed; however, the exterior surface must be cleaned and disinfected using a hospital-grade disinfectant (e.g. Accel or Cavi wipes)
- Staff must perform hand hygiene after completing the cleaning task

Fraser Health Infection Prevention and Control
Updated May 8, 2020

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5.0 Resources (tools, algorithms, forms, posters)

5.1 Personal Protective Equipment (PPE) Framework

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COVID-19 Response Personal Protective Equipment (PPE) Framework:
Interim Guidance for Long-Term Care, Assisted Living and Mental Health and Substance Use Facilities

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Background

The following guidance is being provided to augment the KYI memo March 26, 2020 *Personal Protective Equipment in Operated and Contracted Long-Term Care, Assisted Living, and Mental Health and Substance Use Facilities*.

To protect staff and physicians against COVID-19 and preserve PPE supplies, the Ministry of Health now requires that all physicians, care staff and contracted staff working in resident care units must wear a surgical/procedure mask and eye protection (i.e. face-shield, goggles or safety glasses). In addition, gloves and gowns must be worn when providing care to any resident on Droplet Precautions or as indicated per routine practices.

This directive is applicable to but is not limited to physicians, healthcare aides, nursing staff, housekeeping staff, allied health staff, and any other staff that will be working or accessing resident care units within the facility. Generally, staff or contracted workers who will not be entering resident care units are exempt (e.g. kitchen staff, and administration staff).

Resident care units: includes residents' living spaces on the same campus, where staff or providers would interact with the residents in the course of their work (resident rooms, nursing station, dining areas, resident lounges, recreational spaces, rehab spaces, corridors, hallways, resident outdoor patios)

Reference: The framework below has been adapted from BC Ministry of Health and BCCDC COVID-19: *Emergency prioritization in a pandemic Personal Protective Equipment (PPE) Allocation Framework* March 25, 2020. The framework has been developed to assist LTC/AL/MHSU facilities in meeting the above requirements of PPE during the COVID-19 pandemic.

IMPORTANT: It is important to be meticulous when wearing the PPE as described below, including the mask and eye protection; **do not** dangle the mask and eye protection around your neck or other areas, as you will contaminate yourself.

Please note: This PPE framework is being provided as interim-guidance for a period of two months only.

Fraser Health Infection Prevention and Control
EOC Approval April 8, 2020
Updated April 8, 2020
Reference: Provincial COVID-19 Task Force. *PPE Allocation Framework* [March 25]

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Type of Healthcare Worker/Personnel	Location	Type of PPE	Putting on PPE	Taking off PPE
Physicians Nurses Healthcare Aides/Assistants	Resident care units	Surgical/procedure mask	▪ Put on surgical/procedure mask at beginning of shift ▪ Put on a new mask after coffee and lunch breaks and return to the unit ▪ Change mask if it becomes damp, damaged, visibly soiled, or difficult to breathe through ▪ Wear continuously as much as possible ▪ Avoid touching the mask ▪ Immediately clean hands if mask is adjusted or touched during shift	▪ Remove surgical/procedure mask when it becomes damp/damaged/visibly soiled, difficult to breathe through, before going for breaks or at the end of shift ▪ Remove and dispose of surgical/procedure mask in regular garbage outside of the resident rooms or care unit ▪ Clean hands after removing mask
		Eye protection (e.g. goggles, face-shield, or safety glasses)	▪ Put on eye protection at beginning of shift ▪ Put on cleaned eye protection after coffee, lunch breaks and return to the unit ▪ Clean eye protection if it becomes damp, damaged,	▪ Remove and clean eye protection when it becomes damp, visibly soiled, difficult to see through, before going for breaks or at the end of shift ▪ Clean hands after touching or removing eye protection

Type of Healthcare Worker/Personnel	Location	Type of PPE	Putting on PPE	Taking off PPE
			visibly soiled or difficult to see through ▪ Wear continuously as much as possible ▪ Avoid touching the eye protection ▪ Immediately clean hands if eye protection is adjusted or touched during shift	
		Gloves	▪ Wear gloves when providing care for residents on Droplet Precautions or as indicated by routine practices (e.g. touching mucous membranes, contact with blood and body fluids)	▪ Remove gloves and clean hands between each resident encounter and when leaving the resident room/bed-space
		Gowns	▪ Wear a gown when providing care for residents on Droplet Precautions or as indicated by routine practices when soiling of	▪ Remove gown and clean hands between each resident encounter and when leaving resident room/bed space

Type of Healthcare Worker/Personnel	Location	Type of PPE	Putting on PPE	Taking off PPE
			uniform/clothing is anticipated	
Housekeeping Staff	Resident care units	Surgical/procedure mask	▪ Put on surgical/procedure mask at beginning of shift ▪ Put on a new mask after coffee and lunch breaks and return to the unit ▪ Change mask if it becomes damp, damaged, visibly soiled, or difficult to breathe through ▪ It is not necessary to change mask when going from room to room or from unit to unit ▪ Avoid touching the mask ▪ Immediately clean hands if mask is adjusted or touched during shift	▪ Remove surgical/procedure mask when it becomes damp, damaged, visibly soiled, difficult to breathe through, before going for breaks or at the end of shift ▪ Remove mask outside resident rooms or care unit ▪ Clean hands after mask removal ▪ Put on a new mask when returning to the unit
		Eye protection (e.g. goggles, face-shield, or safety glasses)	▪ Put on eye protection at beginning of shift ▪ Put on cleaned eye protection after coffee,	▪ Remove and clean eye protection when it becomes damp, visibly soiled, difficult to

COVID-19 Response Personal Protective Equipment (PPE) Framework:
Interim Guidance for Long-Term Care, Assisted Living and Mental Health and Substance Use Facilities

Type of Healthcare Worker/Personnel	Location	Type of PPE	Putting on PPE	Taking off PPE
			lunch breaks and return to the unit ▪ Clean eye protection if it becomes damp, damaged, visibly soiled or difficult to see through ▪ It is not necessary to change eye protection when going from room to room or from unit to unit ▪ Avoid touching the eye protection ▪ Immediately clean hands if eye protection is adjusted or touched during shift	see through, before going for breaks or at the end of shift ▪ Clean hands after touching or removing eye protection
		Gloves	▪ Wear gloves when indicated by routine practices and when going into rooms with residents on Droplet Precautions	▪ Remove gloves and clean hands between bed-spaces, after leaving resident room and after completion of tasks requiring gloves
		Gown	▪ Wear gowns when indicated by routine practices and when going	▪ Remove gown and clean hands after cleaning completed in resident room/bed spaces and

Type of Healthcare Worker/Personnel	Location	Type of PPE	Putting on PPE	Taking off PPE
			into rooms with residents on Droplet Precautions	after completion of tasks requiring gowns ▪ Clean hands after gown removal
Pharmacy Rehab Therapist Recreational Therapist Lab Phlebotomist	Resident care units	Surgical/procedure mask	▪ Put on surgical/procedure mask when on resident unit ▪ Put on a new mask after coffee and lunch breaks and return to the unit ▪ Change mask if it becomes damp, damaged, visibly soiled, or difficult to breathe through ▪ It is not necessary to change mask when going from room to room or from unit to unit ▪ Avoid touching the mask ▪ Immediately clean hands if mask is adjusted or touched during shift	▪ Remove surgical/procedure mask when it becomes damp/damaged/visibly soiled, difficult to breathe through, before going for breaks or at the end of shift ▪ Remove and dispose of surgical/procedure mask in regular garbage outside of the resident rooms or care unit ▪ Clean hands after removing mask
		Eye protection (e.g. goggles, face-	▪ Put on eye protection when on resident unit	▪ Remove and clean eye protection when it becomes

COVID-19 Response Personal Protective Equipment (PPE) Framework:
Interim Guidance for Long-Term Care, Assisted Living and Mental Health and Substance Use Facilities

Type of Healthcare Worker/Personnel	Location	Type of PPE	Putting on PPE	Taking off PPE
		shield, or safety glasses)	▪ Put on cleaned eye protection after coffee, lunch breaks and return to the unit ▪ Clean eye protection if it becomes damp, damaged, visibly soiled or difficult to see through ▪ It is not necessary to change eye protection when going from room to room or from unit to unit ▪ Avoid touching the eye protection ▪ Immediately clean hands if eye protection is adjusted or touched during shift	damp, visibly soiled, difficult to see through, before going for breaks or at the end of shift ▪ Clean hands after touching or removing eye protection
		Gloves	▪ Wear gloves when going into a resident room/bed space on Droplet Precautions or when indicated by routine practices	▪ Remove gloves and clean hands after leaving resident room/bed space

Type of Healthcare Worker/Personnel	Location	Type of PPE	Putting on PPE	Taking off PPE
		Gown	▪ Wear gowns before going into a resident room/bed space on Droplet Precautions or when indicated by routine practices	▪ Remove gowns and clean hands after leaving resident room/bed space
Food and Nutrition Delivery Staff	Resident care units	Surgical/procedure mask	▪ Put on surgical/procedure mask when on resident unit ▪ Put on a new mask after coffee and lunch breaks and return to the unit ▪ Change mask if it becomes damp, damaged, visibly soiled, or difficult to breathe through ▪ It is not necessary to change mask when going from room to room or from unit to unit ▪ Avoid touching the mask ▪ Immediately clean hands if mask is adjusted or touched during shift	▪ Remove surgical/procedure mask when it becomes damp/damaged/visibly soiled, difficult to breathe through, before going for breaks or at the end of shift ▪ Remove and dispose of surgical/procedure mask in regular garbage outside of the resident rooms or care unit ▪ Clean hands after removing mask

COVID-19 Response Personal Protective Equipment (PPE) Framework:
Interim Guidance for Long-Term Care, Assisted Living and Mental Health and Substance Use Facilities

Type of Healthcare Worker/Personnel	Location	Type of PPE	Putting on PPE	Taking off PPE
		Eye protection (e.g. goggles, face-shield, or safety glasses)	▪ Put on eye protection when on resident unit ▪ Put on cleaned eye protection after coffee, lunch breaks and return to the unit ▪ Clean eye protection if it becomes damp, damaged, visibly soiled or difficult to see through ▪ It is not necessary to change eye protection when going from room to room or from unit to unit ▪ Avoid touching the eye protection ▪ Immediately clean hands if eye protection is adjusted or touched during shift	▪ Remove and clean eye protection when it becomes damp, visibly soiled, difficult to see through, before going for breaks or at the end of shift ▪ Clean hands after touching or removing eye protection
		Gloves	▪ Wear gloves when indicated by routine and safe food practices	▪ Clean hands after glove removal and at completion of tasks

Type of Healthcare Worker/Personnel	Location	Type of PPE	Putting on PPE	Taking off PPE
Facilities Maintenance Staff	Resident care units	Surgical/procedure mask	▪ Put on surgical/procedure mask when on resident unit ▪ Put on a new mask after coffee and lunch breaks and return to the unit ▪ Change mask if it becomes damp, damaged, visibly soiled, or difficult to breathe through ▪ It is not necessary to change mask when going from room to room or from unit to unit ▪ Avoid touching the mask ▪ Immediately clean hands if mask is adjusted or touched during shift	▪ Remove surgical/procedure mask when it becomes damp/damaged/visibly soiled, difficult to breathe through, before going for breaks or at the end of shift ▪ Remove and dispose of surgical/procedure mask in regular garbage outside of the resident rooms or care unit ▪ Clean hands after removing mask
		Eye protection (e.g. goggles, face-shield, or safety glasses)	▪ Put on eye protection when on resident unit ▪ Put on cleaned eye protection after coffee, lunch breaks and return to the unit	▪ Remove and clean eye protection when it becomes damp, visibly soiled, difficult to see through, before going for breaks or at the end of shift

COVID-19 Response Personal Protective Equipment (PPE) Framework:
Interim Guidance for Long-Term Care, Assisted Living and Mental Health and Substance Use Facilities

Type of Healthcare Worker/Personnel	Location	Type of PPE	Putting on PPE	Taking off PPE
			▪ Clean eye protection if it becomes damp, damaged, visibly soiled or difficult to see through ▪ It is not necessary to change eye protection when going from room to room or from unit to unit ▪ Avoid touching the eye protection ▪ Immediately clean hands if eye protection is adjusted or touched during shift	▪ Clean hands after touching or removing eye protection
		Gloves	▪ Wear gloves when going into a resident room/bed space on Droplet Precautions or when indicated by routine practices	▪ Remove gloves and clean hands after leaving resident room/bed space
		Gown	▪ Wear gown when going into a resident room/bed space on Droplet Precautions worn or when	▪ Remove gowns and clean hands when leaving resident room

Type of Healthcare Worker/Personnel	Location	Type of PPE	Putting on PPE	Taking off PPE
			indicated by routine practices	
Kitchen Staff (that will not be entering resident units)	Kitchen		▪ Wear routine personal protective equipment as per normal safe food handling practices ▪ Maintain physical/social distancing and hand hygiene practices	
Administrative Staff	Administrative areas/offices where there are no residents	None	▪ PPE is not necessary in areas where there are no residents ▪ Maintain physical/social distancing and hand hygiene practices	

5.2 Equipment and Enhanced Cleaning Guidelines

- Health Canada Link in this document: https://www.canada.ca/en/health-canada/services/drugs-health-products/disinfectants/covid-19/list.html
- Links in Reference section were used as reference only for content in this document

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COVID-19 Equipment and Enhanced Cleaning Guidelines
Long-Term Care, Assisted Living, and Mental Health and Substance Use

Purpose

The purpose of this document is to provide cleaning and disinfection guidelines to help prevent transmission of COVID-19 infections from shared medical equipment and environmental surfaces. The SARS-CoV-2 virus that causes COVID-19 has the potential to survive for several hours to days on surfaces. Therefore, there is risk of spreading the virus from potentially contaminated inanimate objects and surfaces to susceptible individuals. Cleaning and disinfection of shared equipment and increasing the frequency of environmental cleaning and disinfection, particularly of high-touched surfaces, can prevent infections. Enhanced cleaning (minimum twice daily cleaning) is an effective control strategy during increased community transmission and outbreaks.

Scope

This document was developed to assist long-term care facilities, assisted living, MHSU, and other congregate community settings with IPC cleaning and disinfection best practices. While this document is directed at this specific patient population, the guidelines apply across all health care settings.

Definitions

- **Cleaning**. The physical removal of foreign material (e.g., dust, soil and organic material such as blood) from a surface or object
- **Disinfection.** A process that reduces the number of microorganisms to a level at which they do not present a risk to patients/residents. In order for disinfection to be effective, surfaces and equipment must be thoroughly cleaned prior to disinfection
- **Manufacturer's Instructions for Use (MIFU).** Check the MIFU to determine if the same wipe can be used as a cleaner and a disinfectant, otherwise another product must be used for cleaning surfaces prior to disinfection (e.g., a detergent and water)
- **Disinfectants.** Must have a Drug Identification Number (DIN) from Health Canada
- **MIFU and Safety Data Sheet (SDS).** Follow the product MIFU and the SDS for use of cleaners and disinfectants (e.g., storage, contact time, safe use and disposal, etc.)

Equipment Cleaning/Disinfection

- As much as possible, dedicate reusable medical equipment to a resident on droplet precautions (e.g. thermometer, BP cuff, commode)
- As per routine practices, reusable medical equipment used on a resident must be cleaned and disinfected before using on another resident. Any resident-specific equipment (e.g., mobility aids) that are brought into the facility with the resident upon admission or transfer should be cleaned and disinfected.
- Use Health Canada approved hospital-grade cleaning/disinfectant wipes that are effective against COVID-19 virus (SARS-CoV-2): https://www.canada.ca/en/health-canada/services/drugs-health-products/disinfectants/covid-19/list.html. Some examples of cleaning/disinfectant wipes include:
  - 0.5 % Accelerated Hydrogen Peroxide (AHP) wipes; e.g., Accel Intervention wipes and Oxivir TB wipes (1-minute contact time)
  - Quaternary ammonium compound (QUATs) based disinfectant; e.g., Caviwipes (3-minute contact time)
- Clean and disinfect using a two-step process. Use one wipe to clean the surface. Use a second wipe to disinfect the surface. Multiple wipes maybe needed depending on the amount of soil present and the surface area to be disinfected. If the disinfectant is validated by MIFU to be a disinfectant with a cleaning agents, the same product can be used for cleaning and disinfection. However, a two-step process, using a

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minimum of two wipes must still be followed. Otherwise, use a pH-neutral cleaner followed by a disinfectant wipe

- Ensure the type of disinfectant used on the equipment is validated by the equipment MIFU to ensure compatibility
- Wear Personal Protective Equipment (PPE) as determined by disinfectant product SDS and additional precautions
- Ensure the equipment remains wet for the disinfectant contact time for enveloped viruses (e.g., influenza) as specified by MIFU

Enhanced Daily Environmental Cleaning/Disinfection

- Minimum twice daily cleaning of the affected unit or facility. The first routine clean/disinfection of the day is undertaken followed by a second environmental clean/disinfection, approximately 6-8 hours after the first clean. The second cleaning/disinfection focuses on frequently touched surfaces and areas on the unit and in the affected resident rooms on droplet precautions
- To facilitate effective environmental enhanced cleaning, unit staff and environmental services should ensure:
  - All horizontal surfaces are clear for cleaning
  - Hallways are free from equipment and clutter
  - Clean linen and supplies are protected in a clean room, closet or enclosed cart
  - Surfaces or furniture that are damaged, cracked or torn cannot be cleaned must be removed from use and replaced (e.g., torn mattresses, cushions or chairs)
- Use Health Canada approved hospital-grade disinfectants that are effective against COVID-19 virus (SARS-CoV-2): https://www.canada.ca/en/health-canada/services/drugs-health-products/disinfectants/covid-19/list.html. Some types of cleaning/disinfectants include:
  - 0.5 % Accelerated Hydrogen Peroxide (AHP). Examples include Accel Intervention and Oxivir TB
  - ≥ 1,000 ppm Sodium hypochlorite/bleach. Examples include Clorox Bleach or PCS 10000 wipes
- Follow cleaning and disinfection best practices:
  - Wear appropriate personal protective equipment (PPE) based on disinfectant SDS and when entering/cleaning the rooms of residents on additional Droplet/Contact precautions
  - Work from clean to dirty; high to low areas. Clean rooms of unaffected rooms followed by rooms on Droplet/Contact Precautions
  - Ensure there is a dedicated housekeeping cart for affected unit, which is not taken to other units/areas
  - Follow MIFU on how to prepare, store and use cleaning and disinfection products
  - Use a two-step process: first pass to clean the surface, followed by a second pass to disinfect the surface. If the disinfectant is validated by MIFU to be a disinfectant with cleaning agents, the same product can be used for both cleaning and disinfection, however, a two-step process must still be followed. Otherwise, use a pH-neutral cleaner followed by a disinfectant wipe
  - Apply adequate friction to remove visible soil (cleaning) prior to disinfection of surfaces
  - Ensure the surface remains wet for the disinfectant MIFU contact time
  - If a bucket of cleaning/disinfection solution is used, use fresh cloths for each resident space. Do not double dip the cloth in disinfectant solution

- Frequently touched surfaces in a resident's rooms include but is not limited to:
  - ☐ Door knobs/handles
  - ☐ Telephone/remote control
  - ☐ Bed rails and bed controls
  - ☐ Bed-side table
  - ☐ Over-bed table
  - ☐ Light switches
  - ☐ Alcohol based hand rub dispensers
  - ☐ Ceiling lift handles/controls
  - ☐ Resident mobility aid handles
  - ☐ Mobile medical equipment (e.g. IV pump)
  - ☐ Resident bathroom (toilet area, sink handles/faucet, soap dispenser, counter, grab bars)
- Frequently touched surfaces on a facility unit includes but is not limited to:
  - ☐ Common areas still in use (lounges, table tops, chairs)
  - ☐ Nursing/Care Team Station
  - ☐ Door knobs/handles
  - ☐ Light switches
  - ☐ Hand rails
  - ☐ Elevator buttons
  - ☐ Soiled Utility Room
  - ☐ Alcohol based hand rub dispensers
  - ☐ Staff lounge and washrooms

Isolation Discharge (Terminal) Cleaning/Disinfection

A thorough cleaning and disinfection must occur in a resident room before Droplet/Contact precautions are discontinued on a resident or when a resident on Droplet/Contact precautions is discharged from the room. Remove and replace privacy curtains. Remove Droplet/Contact precaution signage after completion of cleaning.

References

Fraser Health Infection Prevention and Control. (2020). IPC Recommendations for Environmental Cleaning for COVID-19 in Community Healthcare Settings. Retrieved from: http://fhpulse/quality_and_patient_safety/infection_control/novel_coronavirus/FH%20COVID-19%20Cleaning%20and%20Disinfection%20for%20Community%20Settings%20[Mar%209].pdf

Provincial Infection Control Network of British Columbia. (2016). British Columbia Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Healthcare Settings and Programs. Retrieved from: 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

5.3 *REVISED - Donning and Doffing Personal Protective Equipment

FH Video: https://www.youtube.com/watch?v=_D0HtUCkUS4

FH Aerosol Generating Procedures Standard Operating Procedure Link: Aerosol Generating Procedures (AGP)

5.4 Aerosol Generating Procedures (AGP)

Note: The procedures below may or may not be routine in your site.

Aerosol Generating Procedures (AGP) in Acute Care
Standard Operating Procedure

An aerosol generating procedure is any procedure that can generate aerosols as a result of artificial manipulation of a person's airway.

Whereas there are many procedures that result in the generation of aerosols, only a limited number of them have a documented increased risk for infection transmission. Examples of such high-risk AGPs are endotracheal tube intubation, tracheotomy, diagnostic bronchoscopy and sputum induction. Table 1 provides the list of high-risk AGPs and PPE requirements for healthcare providers when performing them.

Table 1. AGPs Requiring Respiratory Protection for all patients (High Risk)

Procedure	Required Personal Protective Equipment			
	Gloves	Gown	*N95 respirator	Eye protection
Tracheotomy	X	X	X	X
Sputum Induction	X	X	X	X
Autopsy	X	X	X**	X
Bag Valve (manual) Ventilation (without expiratory filter)	X	X	X	X
Endotracheal Tube Intubation and Extubation (and related procedures – manual ventilation, open suctioning)	X	X	X	X
Bronchoscopy and bronchoalveolar lavage (diagnostic & therapeutic^)	X	X	X	X
CPR (with manual ventilation and open suctioning)	X	X	X	X

*There are exceptions for N95 respirator use. Refer to the N95 Respirator Clinical Protocol (Section 5.3) for details. Use a procedure mask instead if exceptions apply.

**Use of an elastomeric half-face respirator with combination P100 and formaldehyde cartridges is recommended for Autopsy.

^Therapeutic bronchoscopies are recognized as being lower risk than diagnostic, however in order to ensure consistency of precautions, respiratory protection is recommended for ALL bronchoscopies.

Another group of AGPs have inconclusive evidence for the increased risk of transmission. Examples of such low-risk AGPs are nebulized therapies, aerosolized high flow O2 and non-invasive positive pressure ventilation. Respiratory protection (e.g. N95 respirator) is required when such AGPs are performed in patients on Droplet Precautions. Table 2 provides the list of low-risk AGPs and PPE requirements for healthcare providers when performing them on patients on Droplet Precautions.

Table 2. AGPs Requiring Respiratory Protection for Patients on Droplet Precautions (Low Risk)

Procedure	Required Personal Protective Equipment			
	Gloves	Gown	N95 respirator	Eye protection
Nebulized therapies	X	X	X	X
Humidified high-flow O2 (yellow or green top nebulizer with attached water bottle, wide bore tubing and aerosol mask or "star wars" mask) Note: Low-flow O2 (1–6 lpm on nasal prongs, or up to 15 lpm on a non-rebreather mask) is not considered an AGP	X	X	X	X

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Non-invasive Positive Pressure Ventilation (BiPAP, CPAP, heated high flow - Optiflow)	X	X	X	X
Breaking the integrity of the ventilator circuit while in operation (open suctioning, circuit changes, Heat and Moisture Exchanger – Filter changes, open suctioning in tracheostomy care)	X	X	X	X
Nasopharyngeal aspirates, washes, and scoping	X	X	X	X

Patients on Droplet Precautions should not share the room with high-risk patients such as immunocompromised patients, children with chronic cardiac or lung disease, elderly, patients with other respiratory illnesses etc. Best practice guidelines recommend the use of negative pressure rooms for AGPs. It is recognized that there are competing needs for negative pressure and single occupancy rooms and they are not always available for AGPs. The guidelines below identify best practice recommendations and are to be followed when possible. Consult with Infection Prevention and Control if you have questions.

In addition, the following is required for AGPs performed in patients on Droplet Precautions:

	Requirements
Patient Placement	▪ A patient requiring frequent AGPs is to be placed in a negative pressure room whenever possible ▪ For a patient receiving infrequent AGPs a single occupancy room should be used whenever possible. Keep the door closed during and for 60 minutes* after AGP complete ▪ If a single occupancy room is not available and a multi-bed room is used, draw all curtains during and for one hour (60 minutes)^ after AGP is complete
Signage	▪ Post an AGP sign when AGP is performed on a patient on Droplet Precautions ▪ The AGP sign must remain posted on entry to room/bed space during and for one hour (60 minutes)* after the AGP is complete
Visitors	▪ Visitors should be instructed to check with the unit staff before entering the room while AGP is in progress

* This time may be shorter depending on air changes per hour (ACH) in that room/area. Contact your FMO for information on ACH. Refer to Table 3 to determine the length of time the room must be vacated to remove at least 99% of airborne particles.

Table 3. Air changes per hour (ACH) and time (minutes) required for airborne-contaminant removal efficiencies of 99% and 99.9% (CDC, 2005)

ACH*	99% efficiency (minutes)	99.9% efficiency (minutes)
2	138	207
4	69	104
6	46	69
8	35	52
10	28	41
12	23	35
15	18	28
20	14	21
50	6	8

*Values apply to an empty room with no aerosol-generating source. With a person present and generating aerosol, this table would not apply.

5.5 Eye/Facial Protection Cleaning and Disinfection Instructions

Link in this document: Health Canada COVID-19 Approved Disinfectant

LTC / AL / MHSU Facilities

Eye/Facial Protection Cleaning and Disinfection Instructions

The following cleaning and disinfection of eye/facial protection instructions are for **LTC, AL and MHSU Facilities**

Cleaning and disinfection: Health Canada COVID-19 Approved Disinfectant wipes (e.g. Accel Intervention™ wipes, Caviwipes™, or Sani-cloth wipes™)

PPE required: Exam gloves

More information on hydrogen peroxide based disinfectant - see the Health Hazard Information Sheet

A. Reusable Eye Protection

Goggles | Safety glasses | Face shields without foam

If reusable eye protection is visibly contaminated/soiled:

- Don a new pair of exam gloves
- Clean with soap and water to remove visible soil
- Do not use handwashing sinks to clean visibly soiled reusable eye protection
- Proceed to step 1 below
- If eye protection is extremely soiled, discard

Cleaning and Disinfecting Reusable Eye Protection

1. Put on a pair of exam gloves
2. Using a new disinfectant, clean the item thoroughly from the inside to the outside
3. Use another new disinfectant wipe, disinfect the interior followed by the exterior of the facial protection
4. Ensure items remain wet with disinfectant for at least 1 minute (or applicable disinfectant wipe contact time).
5. Repeat above steps if visible soil remains
6. Allow to dry (air dry or use absorbent towel)
7. If necessary, use an absorbent towel to remove any residue
8. Remove gloves and perform hand hygiene
9. Store equipment in a clean container or area

B. Face Shield with Visor & Foam Forehead

To be used by a single healthcare provider over the same shift

If the foam forehead piece is visibly soiled or appears damaged and/or compromised: DO NOT REUSE

If the visor is visibly contaminated or soiled, please use the directions on the left **"If reusable eye protection is visibly contaminated/soiled"**

Cleaning and Disinfecting Face Shields with Visor & Foam Forehead

1. Put on a pair of exam gloves
2. Using a new disinfectant, clean the item thoroughly from the inside to the outside
3. Use another new disinfectant wipe, disinfect the interior, followed by the foam band, strap, and then the exterior of the visor.
4. Ensure items remain wet with disinfectant for at least 1 minute (or applicable disinfectant wipe contact time).
5. Repeat above steps if visible soil remains
6. Allow to dry (air dry or use absorbent towel)
7. If necessary, use an absorbent towel to remove any residue
8. Remove gloves and perform hand hygiene
9. Store equipment in a clean container or area
10. Discard at the end of shift

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5.6 *REVISED - Screening Tool

- MHO Alert Link in this document can be found here: Who should be tested for COVID-19?
- FH Signs of Cold or Flu and COVID-19; FH No Signs of Cold or Flu and COVID-19 links in this document refer here: Presentation

Fraser Health COVID-19 Screening Process for Long-Term Care, MHSU, Assisted Living and other Residential Settings

Purpose: This document provides direction to Fraser Health Operated and Contracted Long-Term Care, including Mental Health and Substance Use (MHSU) and Assisted Living long-term care facilities to determine Residents' risks for exposure to the novel coronavirus. The screening pertains to signs and symptoms of respiratory and gastrointestinal (GI) illness with the goal of keeping Residents and health care providers safe from COVID-19 infection.

Scope: This document is applicable to all Fraser Health Operated and Contracted Long-Term Care, including MHSU, Assisted Living, Residents in Respite Care and Adult Day Care programs in long-term care facilities. This document does not apply to Acute Care facilities, Emergency Departments, or Community clinics and settings.

Attachments: FH COVID-19 Signs of Illness – No Need for COVID-19 Testing
FH COVID-19 No Signs of Illness – No Need for COVID-19 Testing

References: MHO Alert COVID-19 – Updated COVID-19 Testing Guidelines [Apr 24]

Visitors: Visitors are restricted to essential visits only at all of our sites through controlled access points.

Guiding Principles:

- COVID-19 screening outlined in this document must occur for anyone entering the Care facility, including family members, staff, services providers and visitors who interact directly with Residents (dentistry, estheticians, foot care nurses, rehab specialists, and other therapists, etc.)
- Active screening and isolation will occur for any Resident after returning from an absence longer than 12 hours and those entering the facility for respite care or adult day-care programs
- Persons cannot enter the facility if they are ill with respiratory and GI symptoms unless by special exemption provided by the Director of Care; this includes all staff, service providers, family members, Respite care residents and adult day-care program clients
- All staff should perform frequent self-assessments for symptoms of respiratory illness and should not work if they are ill or if Public Health has asked them to self-isolate. They must report any new respiratory symptoms prior to their return to work to their manager.
- Staff must monitor Residents two times per day for respiratory symptoms. If they become ill, they must immediately be isolated under Droplet Precautions (in a single room if possible) and have samples collected for Influenza and for COVID-19.

COVID-19 Screening Update:

- COVID-19 testing is recommended and prioritized for all individuals with new respiratory or systemic symptoms compatible with COVID-19, however mild
  - Symptoms may include fever, chills, cough, shortness of breath, sore throat, odynophagia, rhinorrhea, nasal congestion, loss of sense of smell, headache, muscle aches, fatigue, or loss of appetite
- COVID-19 testing is not recommended for individuals without symptoms
- Health care providers can order a COVID-19 test for any patient based on their clinical judgment

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Updated May 7, 2020
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Note: THIS FORM MUST REMAIN ON THE PATIENT/CLIENT/RESIDENT'S CHART

Resident name: _____ID# _____Date: _____

Section 1: COVID-19 screening for the Resident Intake Process (at the time of bed offer), including Residents for Respite-Care:

1. **The Health Care Professional will ask the patient/client/Resident (or the family member/substitute decision maker to corroborate) the following questions during the intake process for a new admission by phone; check all that apply:**

	Yes	No
Do you have a fever?		
Do you have a new or worsening cough?		
Do you have new or worsening shortness of breath?		
Do you have new onset of GI symptoms (e.g., diarrhea or vomiting)?		

If NO to all questions, follow routine protocols.

If YES to any of these questions, the Health Care Professional will assist the family member to make arrangements for the patient/client/Resident to have a follow-up COVID-19 assessment with their Health Care Professional.

Section 2: Resident Screening – Move-In Day

2. **The Health Care Professional will ask the patient/client/Resident (or the family member/substitute decision-maker to corroborate) the following screening questions at the time of move-in, when returning from family visits, travel, outings and medical appointments (longer than 12 hours absence); check all that apply:**

	Yes	No
Do you have a fever?		
Do you have a new or worsening cough?		
Do you have new or worsening shortness of breath?		
Do you have new onset of GI symptoms (e.g., diarrhea or vomiting)?		

If NO to all questions, follow routine protocols.

If YES to any of these questions, isolate the Resident in a private room immediately on Droplet Precautions and arrange for a Health Care Professional to conduct a more in-depth COVID-19 assessment.

3. The Health Care Professional must don personal protective equipment for Droplet Precautions (gown, procedure mask, protective eyewear/face shield and gloves) and assess the Resident in a private area for history, a respiratory examination, exposure risk and possible COVID-19 specimen collection.

Section 3: Visitor and Family Screening

Visitors are restricted to essential visits only at all of Fraser Health sites through controlled access points. Essential visitors cannot visit if they have any respiratory symptoms, including fever, cough, difficulty breathing, sneezing, sore throat, etc. If the Director of Care allows a symptomatic visitor to enter the facility for compassionate reasons, appropriate IPC measures must be in place prior to the visit. Essential visitors will be actively screened for respiratory and GI symptoms at the entrance to the facility each time they visit.

4. **A Receptionist/or designate will ask family members or visitors the following questions immediately upon entry to the facility:**

	Yes	No
Do you have a fever?		
Do you have a new or worsening cough?		
Do you have new or worsening shortness of breath?		
Do you have new onset of GI symptoms (e.g., diarrhea or vomiting)?		

If NO to all questions, follow routine visit protocols.

If YES to any of these questions, ask the family member or visitor to resume visits when their symptoms resolve; they can call HealthLinkBC at 8-1-1 for further questions or concerns.

Section 4: Regular Assessment of Residents

5. **At a minimum of two times per day, the Resident will be assessed for respiratory and/or GI illness; check all that apply:**

	Yes	No
Do you have a fever?		
Do you have a new or worsening cough?		
Do you have new or worsening shortness of breath?		
Do you have new onset of GI symptoms (e.g., diarrhea or vomiting)?		

If NO to all questions, follow routine practices.

If YES to any of the questions, inform the Nurse; they will:

- Isolate the Resident in a single room (if possible room) on Droplet Precautions
  - Collect a NP swab and specify Influenza and COVID-19 testing
  - Nasopharyngeal (NP)swabs can be performed using Droplet Precautions with a surgical mask and eye protection; NP swabs do not require the use of an N95 respirator
- An N95 respirator and eye protection (i.e., goggles or face shield) should be donned when performing aerosol-generating procedures (AGP)

5.7 Public Health Tool 27: Resident Illness Report and Tracking Form

Tool 27: Resident Illness Report and Tracking Form

RESIDENT RESPIRATORY ILLNESS REPORT

Update Daily for all viral Respiratory Illness Outbreaks

For new outbreaks or confirmed Influenza and COVID-19 Outbreaks FAX Daily to 604-507-5439 to Public Health

FACILITY NAME:		NEIGHBOURHOOD, FLOOR OR OTHER AREA AFFECTED: Name: Total # of residents:		DATE PUBLIC HEALTH CONTACT NOTIFIED:
TELEPHONE (DIRECT TO CONTACT PERSON):		AFTER HOURS TELEPHONE NUMBER (DIRECT TO CONTACT PERSON):		TIME PUBLIC HEALTH CONTACT NOTIFIED:
FACILITY FAX NUMBER		EMAIL OF FACILITY CONTACT PERSON:		DATE ANTIVIRAL PROPHYLAXIS INTIATED:
FORM COMPLETED BY:	DATE OF FIRST REPORT:	DATE OF UPDATE 4:	DATE OF UPDATE 8:	DATE OUTBREAK DECLARED:
	DATE OF UPDATE 1:	DATE OF UPDATE 5:	DATE OF UPDATE 9:	
ROLE:	DATE OF UPDATE 2:	DATE OF UPDATE 6:	DATE OF UPDATE 10:	DATE OUTBREAK DECLARED OVER:
	DATE OF UPDATE 3:	DATE OF UPDATE 7:	DATE OF UPDATE 11:	

Name of Resident (Last Name, First Name)	Care Card Number (PHN)	Sex (M/F)	Age	New or Worse Cough (Y/N)	Fever (Y/N)	Sore Throat, Joint Pain, OR Muscle Ache, Extreme Fatigue (Y/N)	Diarrhea (Y/N)	Other gastro-intestinal (e.g., nausea, vomiting) (Y/N)	Date Onset of First Symptom MM	Date Onset of First Symptom DD	Date Swab Test Taken MM	Date Swab Test Taken DD	Swab Test Result: Negative or Name of Virus Found	Date of Last Influenza Vacc'n MM	Date of Last Influenza Vacc'n DD	Date Influenza Antiviral for Treatment Started MM	Date Influenza Antiviral for Treatment Started DD	FOR COVID ONLY: Recovered (see definition below*) (Y/N)	If applicable: Date Resident Admitted to Hospital MM	Date Resident Admitted to Hospital DD	Date of Resident's Death MM	Date of Resident's Death DD	Place of Resident's Death: Facility (F) or Hospital (H) F/H	Date of Transfer from Acute Care during Outbreak or Date of New Admission to Facility MM	Date of Transfer from Acute Care during Outbreak or Date of New Admission to Facility DD

* Recovered is defined as 10 days from symptom onset or until symptoms are resolved, which ever takes longer

5.8 Public Health Tool 28: Staff Illness Report and Tracking Form

Tool 28: *Staff Illness Report and Tracking Form*

STAFF RESPIRATORY ILLNESS REPORT

Update Daily for all viral Respiratory Illness Outbreaks

For new outbreaks or confirmed Influenza and COVID-19 Outbreaks FAX DAILY to 604-507-5439 to Public Health

FACILITY NAME:		NEIGHBOURHOOD, FLOOR OR OTHER AREA AFFECTED: Name: / Total # of staff:		DATE PUBLIC HEALTH CONTACT NOTIFIED:
TELEPHONE (DIRECT TO CONTACT PERSON):		AFTER HOURS TELEPHONE NUMBER (DIRECT TO CONTACT PERSON):		TIME PUBLIC HEALTH CONTACT NOTIFIED:
FACILITY FAX NUMBER		EMAIL OF FACILITY CONTACT PERSON:		
FORM COMPLETED BY: ROLE:	DATE OF FIRST REPORT:	DATE OF UPDATE 4:	DATE OF UPDATE 8:	DATE OUTBREAK DECLARED:
	DATE OF UPDATE 1:	DATE OF UPDATE 5:	DATE OF UPDATE 9:	
	DATE OF UPDATE 2:	DATE OF UPDATE 6:	DATE OF UPDATE 10:	DATE OUTBREAK DECLARED OVER:
	DATE OF UPDATE 3:	DATE OF UPDATE 7:	DATE OF UPDATE 11:	

Name of Staff Member (Last Name, First Name)	Care Card Number (PHN)	Sex (M/F)	Age	New or Worse Cough (Y/N)	Fever (Y/N)	Sore Throat, Joint Pain, OR Muscle Ache, Extreme Fatigue (Y/N)	Diarrhea (Y/N)	Other gastro-intestinal (e.g. nausea, vomiting) (Y/N)	Date Onset of First Symptom MM	Date Onset of First Symptom DD	Date Swab Test Taken MM	Date Swab Test Taken DD	Swab Test Result: Negative OR Name of Virus Found	Date of Last Influenza Vacc'n MM	Date of Last Influenza Vacc'n DD	FOR COVID ONLY: Recovered (see definition below*) (Y/N)	Date Last Worked At Facility MM	Date Last Worked At Facility DD	Date Returned To Work At Facility MM	Date Returned To Work At Facility DD	Does Staff Member Work At Another Facility? (Y/N)

* Recovered is defined as 10 days from symptom onset or until symptoms are resolved, which ever takes longer

5.9 Tips for Completing Public Health Tools 27 & 28

Tips for Completing Tool 27: *Resident Illness Reporting and Tracking Form* and Tool 28: *Staff Illness and Reporting Tracking Form* for COVID-19 Outbreaks

Record symptomatic clients / staff and swabbed clients / staff on Tools 27 and 28

- For COVID-19 outbreaks, symptomatic clients / staff refers to clients / staff with new or worse symptoms of respiratory illness (e.g. cough, fever) OR gastrointestinal symptoms (e.g. diarrhea, nausea)
- If you are aware of any clients who are admitted to hospital due to unrelated health conditions (e.g. fall, fractures) but are swabbed in hospital for COVID-19, please record them on Tool 27
- Remember to update these tools every day, including weekends
- FAX the completed forms to Fraser Health Public Health at **604-507-5439** 7 days per week, by noon

1. Filling out the forms on the first day:
   a. Fill out as much as you can in the top section
   b. Most important information:
      i. facility name
      ii. the neighbourhood, floor or other area affected
      iii. total number of residents / staff
   c. If you have symptomatic clients or staff in different units, floors, or buildings of your facility, please start a separate Tool 27/28 for each area and fax each sheet to Fraser Health Public Health daily by noon

Update Daily for all viral Respiratory Illness Outbreaks
For new outbreaks or confirmed Influenza and COVID-19 Outbreaks FAX Daily to 604-507-5439 to Public Health

FACILITY NAME:	NEIGHBOURHOOD, FLOOR OR OTHER AREA AFFECTED:		DATE PUBLIC HEALTH CONTACT NOTIFIED:
	Name:	Total # of residents:	
TELEPHONE (DIRECT TO CONTACT PERSON):	AFTER HOURS TELEPHONE NUMBER (DIRECT TO CONTACT PERSON):		TIME PUBLIC HEALTH CONTACT NOTIFIED:
FACILITY FAX NUMBER	EMAIL OF FACILITY CONTACT PERSON:		DATE ANTIVIRAL PROPHYLAXIS INTIATED:

2. Enter information for any symptomatic or swabbed clients or staff:
   a. Date of the report
   b. Details of each client or staff who are symptomatic
      i. name, PHN, sex, age, symptoms, and date of onset of first symptoms. Note: For independent living facilities, please enter the date of birth for a client or staff in the PHN field if you are unable to obtain the PHN.
      ii. enter the date for the swab
      iii. remaining information for each client / staff may be unknown at this point so can be completed later

FORM COMPLETED BY:	DATE OF FIRST REPORT: 16-Apr-2020	DATE OF UPDATE 4:	DATE OF UPDATE 8:	DATE OUTBREAK DECLARED:
	DATE OF UPDATE 1:	DATE OF UPDATE 5:	DATE OF UPDATE 9:	
ROLE:	DATE OF UPDATE 2:	DATE OF UPDATE 6:	DATE OF UPDATE 10:	DATE OUTBREAK DECLARED OVER:
	DATE OF UPDATE 3:	DATE OF UPDATE 7:	DATE OF UPDATE 11:	

Name of Resident (Last Name, First Name)	Care Card Number (PHN)	Sex (M/F)	Age	New or Worse Cough (Y/N)	Fever (Y/N)	[illegible] (Y/N)	[illegible] (Y/N)	Other [illegible] (Y/N)	Date Onset of First Symptom (MM)	(DD)	Date Swab Test Taken (MM)	(DD)	Swab Test Result (Negative or Name of Virus Found)	Date of Last Influenza Vaccine (MM)	(DD)	Date Influenza Antiviral for Treatment Started (MM)	(DD)	FOR COVID ONLY: Recovered (see definition below) (Y/N)	Date Resident Admitted to Hospital (MM)	(DD)	Date of Resident's Death (MM)	(DD)	Place of Resident's Death: Facility (F) or Hospital (H) (F/H)	Date of Transfer from Acute Care during Outbreak or Date of New Admission to Facility (MM)	(DD)
Smith, Joe	9814 xxx xxx	M	78	N	Y	N	N	N	4/14		4/15														

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Prepared by the Long Term Care/Assisted Living Coordination Centre

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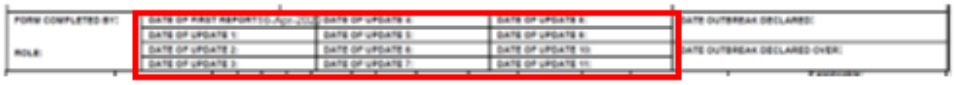
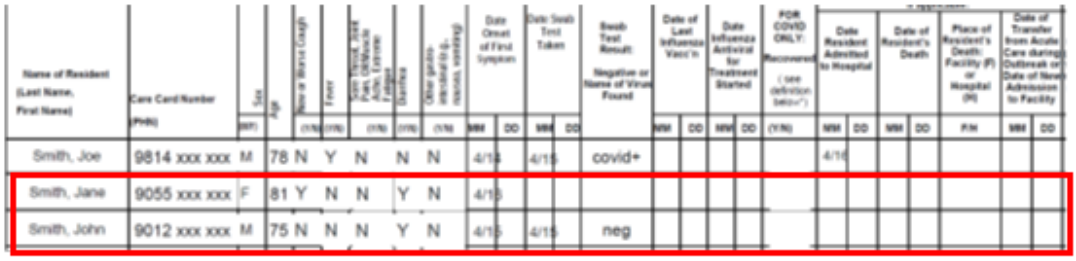
3. When doing daily updates after the first day, continue with the form(s) you have already started:
    a. Enter the date of report in "Date of Update" field at top of tool
    b. If you run out of space to add a date, write the date at the top of the form

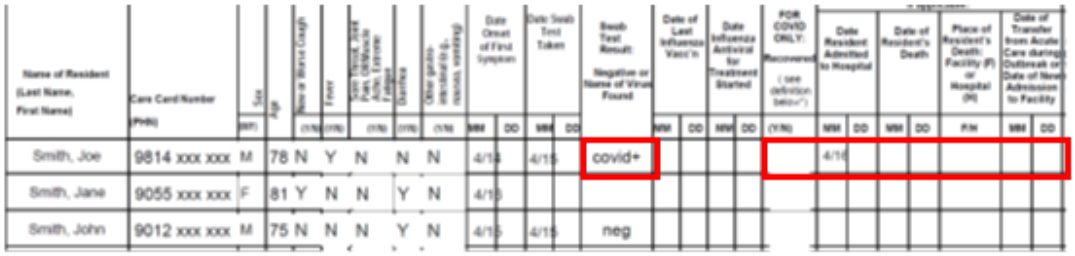


4. Add any new symptomatic or swabbed clients / staff to the forms and fill out as much information as you can.
    a. Add new pages as needed
    b. If you need to use multiple pages, include facility name, neighbourhood, floor / other area affected and total number of residents / staff at the top (refer to step 1).



Name of Resident (Last Name, First Name)	Care Card Number (PHN)	Sex (M/F)	Age	Shortness of Breath / Cough (Y/N)	Fever (Y/N)	Sore Throat, Joint Pain, Chills/Muscle Ache, Extreme Fatigue / Diarrhea (Y/N)	Other (Y/N)	Other (specify e.g. nausea, vomiting)	Date Onset of First Symptom MM	Date Onset of First Symptom DD	Date Swab Test Taken MM	Date Swab Test Taken DD	Swab Test Result: Negative or Name of Virus Found	Date of Last Influenza Vacc'n MM	Date of Last Influenza Vacc'n DD	Date Influenza Antiviral for Treatment Started MM	Date Influenza Antiviral for Treatment Started DD	FOR COVID ONLY: Recovered (Y/N)	Date Resident Admitted to Hospital MM	Date Resident Admitted to Hospital DD	Date of Resident's Death MM	Date of Resident's Death DD	Place of Resident's Death: Facility (F) or Hospital (H)	Date of Transfer from Acute Care during Outbreak or Date of New Admission to Facility MM	Date of Transfer from Acute Care during Outbreak or Date of New Admission to Facility DD
Smith, Joe	9814 xxx xxx	M	78	N	Y	N	N	N	4/13		4/15		covid+						4/16						
Smith, Jane	9055 xxx xxx	F	81	Y	N	N	Y	N	4/13																
Smith, John	9012 xxx xxx	M	75	N	N	N	Y	N	4/15		4/15		neg												

5. For any clients or staff added on previous days, update any additional information received:
    a. Update swab results as they come in
    b. Mark client or staff as recovered if they meeting the definition outlined on the form
    c. NOTE: Date of Last Influenza Vaccination and Date Influenza Antiviral for Treatment Started are not needed for COVID outbreaks



Name of Resident (Last Name, First Name)	Care Card Number (PHN)	Sex (M/F)	Age	Shortness of Breath / Cough (Y/N)	Fever (Y/N)	Sore Throat, Joint Pain, Chills/Muscle Ache, Extreme Fatigue / Diarrhea (Y/N)	Other (Y/N)	Other (specify e.g. nausea, vomiting)	Date Onset of First Symptom MM	Date Onset of First Symptom DD	Date Swab Test Taken MM	Date Swab Test Taken DD	Swab Test Result: Negative or Name of Virus Found	Date of Last Influenza Vacc'n MM	Date of Last Influenza Vacc'n DD	Date Influenza Antiviral for Treatment Started MM	Date Influenza Antiviral for Treatment Started DD	FOR COVID ONLY: Recovered (Y/N)	Date Resident Admitted to Hospital MM	Date Resident Admitted to Hospital DD	Date of Resident's Death MM	Date of Resident's Death DD	Place of Resident's Death: Facility (F) or Hospital (H)	Date of Transfer from Acute Care during Outbreak or Date of New Admission to Facility MM	Date of Transfer from Acute Care during Outbreak or Date of New Admission to Facility DD
Smith, Joe	9814 xxx xxx	M	78	N	Y	N	N	N	4/13		4/15		covid+						4/16						
Smith, Jane	9055 xxx xxx	F	81	Y	N	N	Y	N	4/13																
Smith, John	9012 xxx xxx	M	75	N	N	N	Y	N	4/15		4/15		neg												

6. Please keep one row of information for one client/staff.
    a. If someone you entered previously has new symptoms, please edit the information in the row you have already started (e.g. cross out N and write Y).
    b. If someone you entered previously no longer has a symptom, you do not have to make any changes (e.g. if you previously entered Y for fever and the client/staff no longer has a fever, please leave it as Y).

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7. The exception would be if one client/staff had multiple swabs, then you can enter the new swab on a new row.
    a. For example, Jane Client had a swab on Mar 24 that was indeterminate. She was swabbed again on Apr 8 and this time had a positive result. In this case you can enter the information on two different rows.

Name of Resident (Last Name, First Name)	Care Card Number (PHN)	Sex (M/F)	Age	New or Worse Cough (Y/N)	Fever (Y/N)	Sore throat, Joint Pain, Oft Muscle Ache, Extreme Fatigue (Y/N)	Diarrhea (Y/N)	Other gastro-intestinal (e.g. nausea, vomiting) (Y/N)	Date Onset of First Symptom MM	Date Onset of First Symptom DD	Date Swab Test Taken MM	Date Swab Test Taken DD	Swab Test Result: Negative or Name of Virus Found	Date of Last Influenza Vacc'n MM	Date of Last Influenza Vacc'n DD	Date Influenza Antiviral for Treatment Started MM	Date Influenza Antiviral for Treatment Started DD	FOR COVID ONLY: Recovered (see definition below*) (Y/N)	If applicable: Date Resident Admitted to Hospital MM	Date Resident Admitted to Hospital DD	Date of Resident's Death MM	Date of Resident's Death DD	Place of Resident's Death: Facility (F) or Hospital (H) F/H	Date of Transfer from Acute Care during Outbreak or Date of New Admission to Facility MM	Date of Transfer from Acute Care during Outbreak or Date of New Admission to Facility DD
Client, Jane	9714 xxx xxx	F	92	Y	N	N	N	N	3/23		3/24		covid indeterminate												
Test, Joe	9200 xxx xxx	M	88	N	Y	N	N	N	3/25		3/26		covid+					Y							
Client, Jane	9714 xxx xxx	F	92	Y	Y	N	N	N	4/7		4/8		covid+												

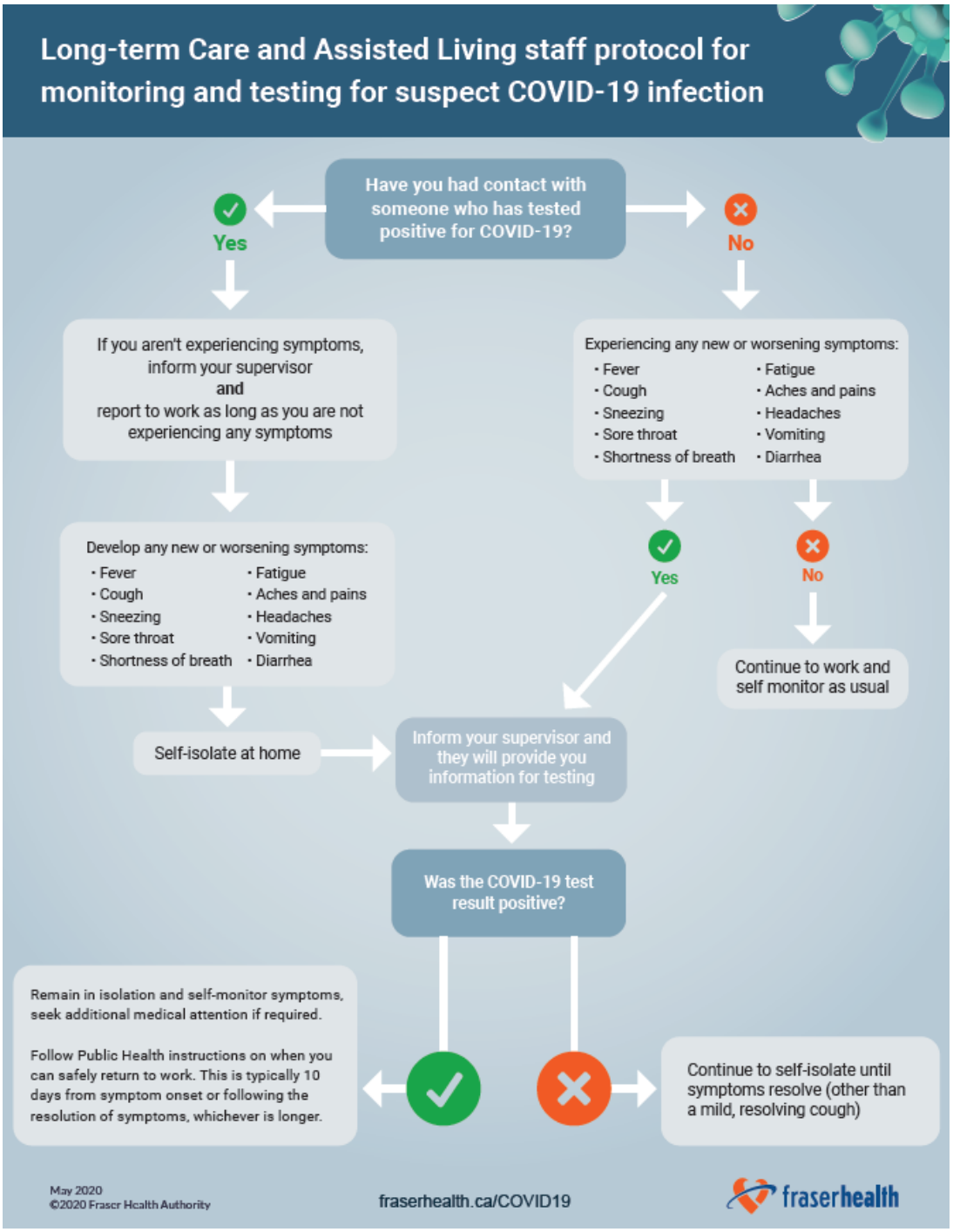
8. Do not enter "tests for clearance" on Tool 27 for residents. Note that as of May 5, 2020, residents who are positive for COVID-19 do not require two negative swabs to be removed from isolation.

9. If there are no updates for a day, please:
    a. Note the date and that there is no update (e.g. "Apr 17 – no change") on the existing pages of Tools 27/28
    b. Fax Tools 27/28 so Fraser Health Public Health is aware there is no update and do not have to follow-up with you regarding this reporting.

6.0 Posters

A library of FH posters can be accessed here: https://www.fraserhealth.ca/health-topics-a-to-z/coronavirus/resources#.XrSNjF5KiUk

6.1 *REVISED - Staff Protocol for Monitoring & Testing Poster



6.2 Droplet Precautions Poster

DROPLET PRECAUTIONS

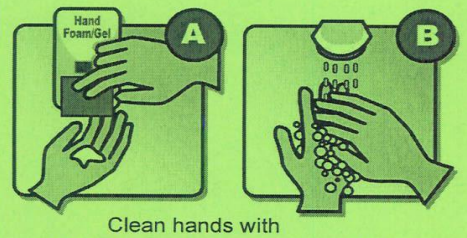
Families and Visitors:

STOP

Bed #

Please report to staff before entering

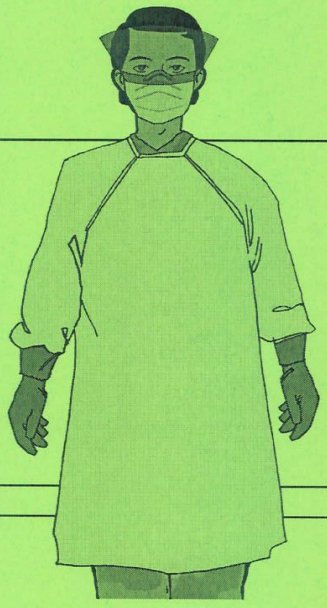
Clean hands before entering and when leaving room



Clean hands with
A) hand foam/gel or B) soap and water

Wear **mask and eye protection** when within **2 metres** of patient

If helping to care for the patient, put on **gown and gloves** before entering room, and remove them before leaving room.



Staff - Required:

- **Point of Care Risk Assessment**
- **Gown and gloves**
- Procedure mask with eye protection when within 2 metres of patient
- **Keep 2 metres between patients**

KEEP SIGN POSTED UNTIL ROOM CLEANED
HOUSEKEEPER will remove sign after Isolation Discharge cleaning

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Better health. Best in health care.

FH Infection Prevention & Control STORES #323289 August 2016

PICNet
PROVINCIAL INFECTION CONTROL NETWORK OF BRITISH COLUMBIA
A program of the Provincial Health Services Authority

6.3 Visitor Policy Poster

VISITORS TO THIS SITE

To keep our patients, families and staff safe and in keeping with the provincial health officer's recommendations for social distancing, we are limiting the number of visitors entering our buildings.

Do not visit if you are sick. If you are experiencing ANY cough, fever or other respiratory symptoms OR believe you may have been exposed to COVID-19 or any other respiratory illness, please do not enter our site for the protection of our patients and employees.

Until further notice, one essential visitor only.

ESSENTIAL
visits only

April 2020

fraserhealth.ca/COVID19

6.4 *REVISED - Visitor Screening Poster

6.5 *NEW – Outbreak Alert Facility Entrance Poster

STOP

ATTENTION

This site is in outbreak

The following infection control and prevention measures are in place

Do not visit if you are sick.

Only Essential Visitors are permitted at this time.

Everyone will be screened for symptoms before entering this site

Clean your hands when entering and exiting the facility and each room or unit.

Thank you for your cooperation.

Prepared by LTC/AL/IL Coordination Centre: May 13, 2020
Reviewed by: Infection Prevention and Control

6.6 *NEW – Outbreak Alert Facility Unit Poster

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STOP

ATTENTION

This area is in outbreak

The following infection control and prevention measures are in place

Do not visit if you are sick.

Only Essential Visitors are permitted at this time

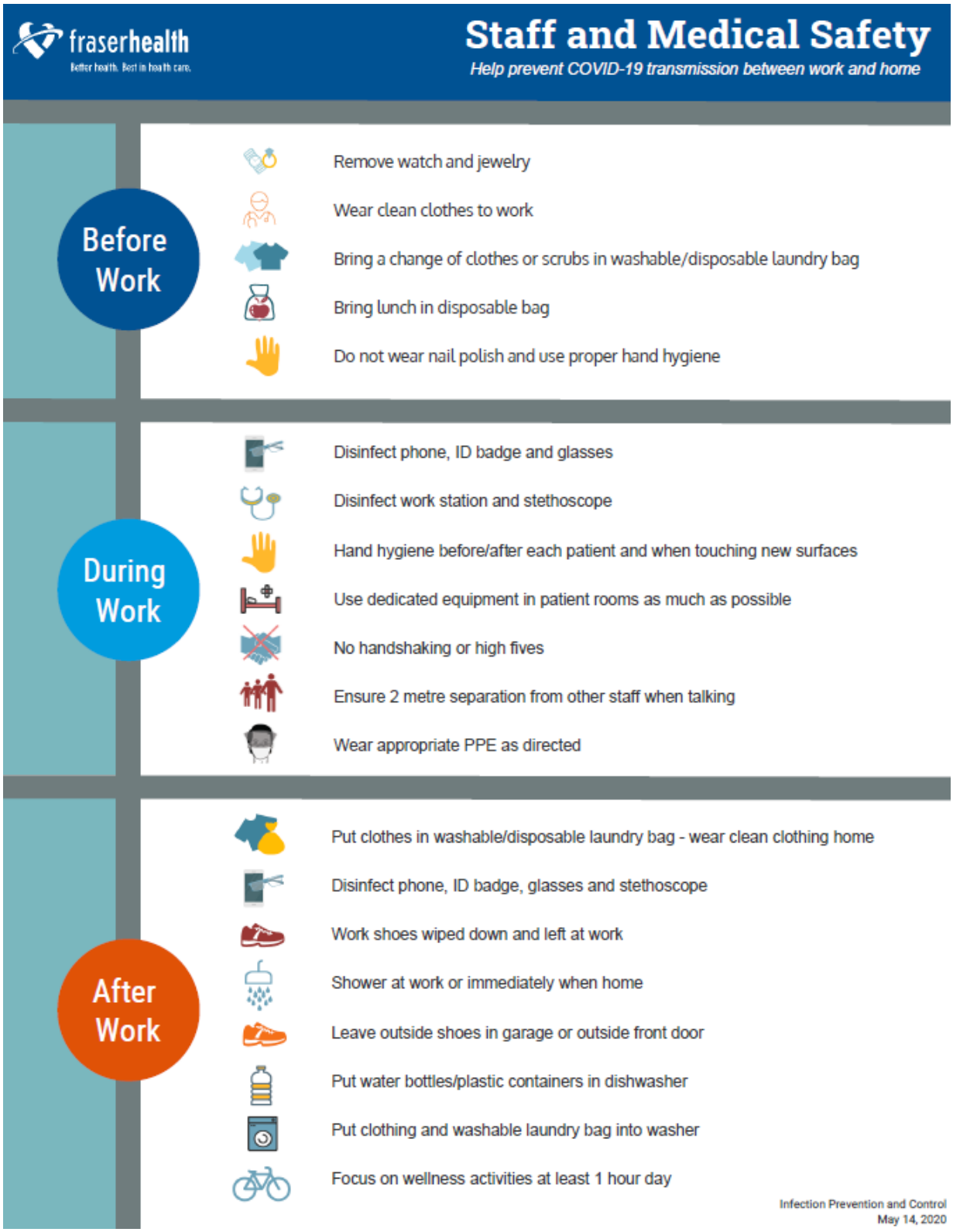
Everyone must wear proper personal protective equipment in this area

Clean your hands when entering and exiting any room or unit

Thank you for your cooperation.

Prepared by LTC/AL/IL Coordination Centre: May 13, 2020
Reviewed by: Infection Prevention and Control

6.7 *NEW - Staff and Medical Safety Poster



7.0 Clinical Practice Resources

7.1 Pharmaceutical Measures

Fraser Health currently does not recommend the use of unproven therapies for COVID-19 outside of a clinical trial. There are currently no clinical trials for unproven therapies for COVID-19 occurring at long term care, assisted living, or independent living facilities in the Fraser Health region.

For more information, please see http://www.bccdc.ca/Health-Professionals-Site/Documents/Guidelines_Unproven_Therapies_COVID-19.pdf

7.2 Skills Checklist - Nasopharyngeal Swab

Nasopharyngeal Swab Skills Checklist

S: Satisfactory U: Unsatisfactory NP: Not Performed

	Collecting and nasopharyngeal specimen for Culture: Swab Method	S	U	NP
1.	Reviewed the practitioner's orders.	☐	☐	☐
2.	Checked the expiry date and integrity of the swab packet before use.	☐	☐	☐
3.	Performed hand hygiene and donned gloves.	☐	☐	☐
4.	Had the nasopharyngeal swab (on flexible wire) and the culture tube ready for use. If using a prepackaged culture swab in a tube, loosened the top, so that the swab could be removed easily.	☐	☐	☐
5.	Donned personal protective equipment (PPE) (contact and droplet precautions) before taking swab, per Fraser Health Infection Control Manual.	☐	☐	☐
6.	Introduced self to patient.	☐	☐	☐
7.	Verified the correct patient using two identifiers.	☐	☐	☐
8.	Explained the procedure to the patient and ensured that he or she agreed to treatment.	☐	☐	☐
9.	Assessed the nasal mucosa and sinuses and observed for any drainage.	☐	☐	☐
10.	Determined if the patient experienced postnasal drip, sinus headache or tenderness, nasal congestion, or sore throat, or if he or she had been exposed to others with symptoms.	☐	☐	☐
11.	Assessed the condition of the posterior pharynx.	☐	☐	☐
12.	Patients with copious nasal discharge gently cleaned their nose by washing or using a tissue.	☐	☐	☐
13.	Assessed the patient for deviated septum, previous nasal surgery, and/or nasal polyps. Asked if the patient had a preferred side or nares to have their test taken on.	☐	☐	☐
14.	Instructed the patient to sit erect in bed or in a chair facing the nurse and inclined the head approximately 45 to 70°. If patient was acutely ill or a young child, instructed to lay back against the bed with the head of the bed raised.	☐	☐	☐
15.	Estimated the distance to the nasopharynx; prior to swab insertion, measured distance from corner of the nose to the front of the ear, and inserted the swab to approximately half this distance.	☐	☐	☐
16.	Gently inserted swab perpendicular to the face along the medial part of the septum, along the base of the nose, until it reached the posterior nasopharynx. Inserted swab straight back, perpendicular to the face, NOT upwards towards the eyes.	☐	☐	☐
17.	Did not force the swab, if resistance or obstruction was felt on the side, tried the other nostril.	☐	☐	☐
18.	Gently advanced the swab to the nasopharynx until resistance was met.	☐	☐	☐
19.	Rolled or rotated the swab gently several times (e.g. 5 to 10 seconds) around inside of the nasal passage and along the floor at the nasal cavity to collect respiratory cells. Gently removed the swab from the nose.	☐	☐	☐
20.	Inserted the swab into the vial of viral transport media and broke the swab at the scored line so it did not protrude above the rim of the transport media container.	☐	☐	☐
21.	Placed the top securely on the culture tube.	☐	☐	☐
22.	Offered the patient a facial tissue to blow his or her nose if needed.	☐	☐	☐
23.	Remove PPE equipment and perform hand hygiene.			
24.	In the presence of the patient, labelled the specimen per the organization's practice.	☐	☐	☐
25.	Prepared specimen for transport. a. Placed the labelled specimen in a biohazard bag. b. Recorded on the laboratory requisition if the patient was taking an antibiotic or if a specific organism was suspected.	☐	☐	☐
26.	Immediately transported the specimen to the laboratory.	☐	☐	☐
27.	Discarded supplies, removed gloves, and performed hand hygiene.	☐	☐	☐
28.	Documented procedure in the patient's record.	☐	☐	☐

Date: _____ Performed by: _____

Time: _____ Observed by: _____

7.3 Collecting a Nasopharyngeal Specimen for Culture

Quick Sheet: Collecting a Nasopharyngeal Specimen for Culture: Swab Method

Source: Clinical Skills - Elsevier Performance Manager

ALERT

Do not attempt to collect a throat specimen for culture if acute epiglottitis is suspected because trauma from the swab may cause increased edema resulting in airway occlusion.

Collect nasopharyngeal specimens within 3 days of symptom onset if possible but no later than 7 days of symptom onset and before the start of antimicrobial therapy.

Assessment:

1. Perform hand hygiene before patient contact.
2. Introduce yourself to the patient.
3. Verify the correct patient using two identifiers.
4. Assess the patient's understanding of the purpose of the procedure and his or her ability to cooperate.
5. Assess the nasal mucosa and sinuses and observe for any drainage.
6. Determine if the patient experiences postnasal drip, sinus headache or tenderness, nasal congestion, or sore throat or if he or she has been exposed to others with similar symptoms.
7. Assess the condition of the posterior pharynx.
8. Assess the patient for systemic signs of infection.
9. Review the practitioner's orders to determine if a nasal specimen, throat specimen, or both are needed.
10. Plan to collect the specimen before mealtime to avoid contamination.
11. Obtain assistance for collecting throat specimens from confused, combative, or unconscious patients.

Source: https://point-of-care.elsevierperformancemanager.com/skills/434/quick-sheet?skillId=GN_43_7
Clinical Skills Elsevier
Adapted for FH 23 Mar 2020

Page 1 of 4

Quick Sheet: Collecting a Nasopharyngeal Specimen for Culture: Swab Method

Source: Clinical Skills - Elsevier Performance Manager

Collecting a Nasopharyngeal Specimen for Culture: Swab Method

1. Perform hand hygiene and don gloves.
2. Introduce yourself to the patient.
3. Verify the correct patient using two identifiers.
4. Explain the procedure to the patient and ensure that he or she agrees to treatment.
5. Instruct the patient to sit erect in bed or in a chair facing the nurse. A patient who is acutely ill or a young child may lie back against the bed with the head of the bed raised.
6. Have the nasopharyngeal swab (on flexible wire) and the culture tube ready for use. If using a prepackaged culture swab in a tube, loosen the top so the swab can be removed easily.

7. Gently advance the swab to the nasopharynx until resistance is met.
8. Roll the swab and allow it to remain in place for several seconds.

Source: https://point-of-care.elsevierperformancemanager.com/skills/434/quick-sheet?skillId=GN_43_7
Clinical Skills Elsevier
Adapted for FH 23 Mar 2020

Page 2 of 4

Quick Sheet: Collecting a Nasopharyngeal Specimen for Culture: Swab Method

Source: Clinical Skills - Elsevier Performance Manager

9. Insert the swab into the culture tube and push the tip into the liquid medium at the bottom of the tube.
10. Place the top securely on the culture tube.
11. Offer the patient a facial tissue to blow his or her nose if needed.
12. In the presence of the patient, label the specimen per the organization's practice.
13. Prepare the specimen for transport.
    a. Place the labeled specimen in a biohazard bag.
    b. Record on the laboratory requisition if the patient is taking an antibiotic or if a specific organism is suspected.
14. Immediately transport the specimen to the laboratory.
15. Assess, treat, and reassess pain.
16. Discard supplies, remove gloves, and perform hand hygiene.
17. Document the procedure in the patient's record.

Source: https://point-of-care.elsevierperformancemanager.com/skills/434/quick-sheet?skillId=GN_43_7
Clinical Skills Elsevier
Adapted for FH 23 Mar 2020

Quick Sheet: Collecting a Nasopharyngeal Specimen for Culture: Swab Method

Source: Clinical Skills - Elsevier Performance Manager

Quiz Questions:

1. Which is the correct way to place the swab into a commercially prepared culture tube?

- ☐ Place the swab into the culture tube and add a special reagent to the tube.
- ☐ Place the swab into the tube, close it securely, and keep it warm until it is sent to the laboratory.
- ☐ Take the swab and mix it in the reagent to check for color changes.
- ☐ Push the tip of the swab into the liquid medium at the bottom of the tube.

2. When acute epiglottitis is suspected in a patient, what should a nurse do?

- ☐ Collect a throat specimen for culture.
- ☐ Refrain from collecting a specimen for culture.
- ☐ Collect a nose specimen for culture.
- ☐ Collect a nasopharyngeal specimen for culture.

3. Which statement describes a difference between collecting a specimen for a nasal culture and collecting a specimen for a nasopharyngeal culture?

- ☐ Specimen collection for a nasopharyngeal culture causes more bleeding than specimen collection for a nasal culture.
- ☐ A nasopharyngeal swab is flexed upward to reach the nasopharynx through the mouth, and the nasal swab goes through the nose.
- ☐ The nasopharyngeal specimen is placed on ice to preserve the organisms, and a nasal culture specimen is not.
- ☐ The specimen for a nasopharyngeal culture is obtained with a swab on a flexible wire, and a nasal swab does not contain a wire.

4. A patient comes into the emergency department complaining of nasopharyngeal symptoms for 3 days. Which action should the health care team take next?

- ☐ Tell the patient to go home and rest.
- ☐ Tell the patient it is too soon to collect a nasopharyngeal specimen.
- ☐ Collect a nasopharyngeal specimen.
- ☐ Tell the patient it is past the time when they can collect a nasopharyngeal specimen.

Source: https://point-of-care.elsevierperformancemanager.com/skills/434/quick-sheet?skillId=GN_43_7
Clinical Skills Elsevier
Adapted for FH 23 Mar 2020

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7.4 *UPDATED - Regional Pre-Printed Orders for COVID-19 Confirmed or Pending LTC

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Regional Pre-Printed Orders for
COVID-19 Confirmed or Presumed
Long-Term Care (LTC)

Form ID: DRDO107351B Rev: May 19, 2020 Page: 1 of 2

DRUG & FOOD ALLERGIES

• **Mandatory** ☐ **Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.**

- Review Advance Care Planning documents (ACP) Record, Advance Directive, Representation Agreements, Identification of Substitute Decision Maker (SDM) List
- Initiate or engage in conversations (utilize Serious Illness Conversation Guide (SICG SDM COVID-19)), document on ACP Record
- Update MOST with resident & SDM based on above
- If a transfer to acute care is recommended by the MRP, MRP to call receiving ER physician to discuss and accept transfer before calling EHS. Resident to wear a surgical/procedure mask during transportation.

INFECTION PREVENTION AND CONTROL:

- Cohort and isolate (with droplet precautions) all residents with suspected or confirmed COVID-19.
- Ensure staff have reviewed proper donning and doffing techniques
- Stop all Aerosol Generating Procedures (AGP) including nebulized medications, CPAP, nocturnal BiPAP and high flow oxygen for all residents in the facility unless deemed clinically essential.
- Start nocturnal oxygen instead of CPAP treatment. If nocturnal BiPAP use is essential, the resident should be in a private room, on airborne precautions.

MONITORING:

- Vital signs (BP, HR, RR, O_2, Temperature) once daily and as clinically required
- Monitor resident's clinical status, symptoms, and comfort twice per shift
- Use O_2 PRN up to 6 L/min via Nasal Prong to maintain an O_2 sat of 92% or greater
- If on O_2 6 L/min via Nasal Prong and resident unable to maintain an O_2 sat greater than 92%, continue O_2 at 6 L/min and start medications to support comfort with increasing respiratory distress

MEDICATIONS:

Avoid routine corticosteroids in COVID-19 residents unless evidence of COPD/asthma exacerbation. Supply of bronchodilator inhalers is limited; order selectively for appropriate clinical indications (e.g. wheezing)

ANALGESICS AND ANTIPYRETICS:

- Treat fever only if presenting with associated discomfort:
- **acetaminophen** 650 mg PO/rectal Q6H PRN for pain/fever

Select one of the following:

☐ Maximum **acetaminophen** from all sources 4000 mg per 24 hours
OR
☐ Maximum **acetaminophen** from all sources 2000 mg in 24 hours (advanced liver disease)

Date (dd/mm/yyyy)	Time	Prescriber Signature	Printed Name and College ID#

Print Shop # 263493

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Regional Pre-Printed Orders for
COVID-19 Confirmed or Presumed
Long-Term Care (LTC)

DRUG & FOOD ALLERGIES

• **Mandatory** ☐ **Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.**

SHORTNESS OF BREATH:

☐ **HYDROmorphone** 0.5 mg PO Q4H PRN

AND/OR

☐ **HYDROmorphone** 0.25 mg subcutaneous Q4H PRN

OR

☐ **HYDROmorphone** _____

- Adjust the opioid dose if resident is already receiving scheduled narcotics and/or if comfort needs are not met despite PRN opioid use. If persistent shortness of breath, consider addition of regularly scheduled opioid in addition to PRN
- Review goals of care if resident is unable to maintain O_2 sat and is experiencing increased respiratory distress. Initiate actively dying protocol if appropriate.

ANTIBIOTICS:

- Antibiotics not recommended for outpatients with COVID-19 who do not require supplemental oxygen.
- Consider antibiotics if suspected bacterial co-infection, rapidly increasing supplemental oxygen requirements, or evidence of sepsis.

☐ **azithromycin** 500 mg PO daily x 3 days (caution if prolonged QTc)

AND ONE OF:

☐ **amoxicillin-clavulanate** 500 mg-125 mg PO TID x 5 days if eGFR greater than or equal to 30 mL/min

☐ **amoxicillin-clavulanate** 500 mg-125 mg PO BID x 5 days if eGFR less than 30 mL/min

OR

IF SEVERE PENICILLIN ALLERGY:

☐ **MOXIfloxacin** 400 mg PO daily x 5 days (addition of azithromycin not necessary)

Date (dd/mm/yyyy)	Time	Prescriber Signature	Printed Name and College ID#

7.5 Supporting clients living with dementia

Clients who are unable to follow directions to isolate in their room, or who are on the move from room to room during a COVID-19 pandemic, will present a challenge to care providers. Efforts to contain the spreading of germs will require creative approaches and patience. It is paramount that we continue to adopt a least restrictive approach by using strategies that might mitigate risks to ensure the safety and well-being for all.

- Continue to use a behavioural tracking sheet, analyze what needs might be unmet, and find ways to meet those
- Use technology to help a client maintain contact with family members to help ease any anxiety
- Be mindful that care provider's anxiety/emotions might be mirrored by clients through a behavioural response (e.g. if you're anxious & tense it will rub off). Pause and self-evaluate what energy you're bringing into each interaction
- People living with dementia might also react to (e.g. be frightened and have responsive behaviours) familiar care providers that now look unfamiliar due to a face surgical/procedural mask, goggles & other PPE
- Take extra time to explain who you are, why you are there, and seek understanding/permission before proceeding with personal care/entering the client's personal space
- Monitor for environmental stimuli that can contribute to anxiety, fear and behaviours e.g. information about the pandemic via staff conversations & TV/radio broadcasting. Take measures to limit this exposure
- Avoid leaving contaminated PPE available for the client to manipulate
- Hand hygiene important for clients during this time should be attempted on a more regular basis. Ask if they want to wash their hands and provide a rationale. Try a joke or sing a song about hand washing as you guide in hand washing
- Encourage/assist client with hand washing after going to the toilet, before & after eating, after sneezing, coughing and touching their face. Try applying hand sanitizer by way of a hand massage
- Encourage client to cough or sneeze into their arm or into a tissue/cloth then discard & wash clients hands
- If client is coughing, try applying a surgical/procedural mask if tolerated especially if client goes into common areas and or is entering other client's rooms
- Consider closing client bedroom doors if preferred and/or tolerated
- 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/

References

British Geriatrics Society. March 25, 2020. Managing COVID-19 Pandemic in Care Homes. Good practice guide. Available @ 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 @ https://www.dementiability.com/resources/Hand-Hygiene-in-dementia-care.pdf

Fraser Health Authority (2019). Infection Prevention and Control Manual. Respiratory Outbreak.

7.6 LTC Short Term Care Plan

Caring for Resident with COVID-19 – Short Term Care Plan

Resident ID

Date:

April 1, 2020 V7 Page: 1 of 2

Focus of Care	Check all interventions that apply
Serious Illness Conversations (SIC)	☐ Ensure current Serious Illness Conversation, Goals of Care, Advanced Care Planning & MOST are updated on file after any discussion between MRP/& resident/family/decision-maker prior to & when COVID-19 diagnosis confirmed ☐ Align interventions based on SIC (including medication reconciliation) ☐ On-going Serious Illness Conversation (SIC) as condition changes
Actively dying	☐ Refer to Actively Dying Protocol & PPO
Infection Prevention & Control	☐ Isolation in single room ideal ☐ Ensure a 2-metre distance (6 feet) between infected person and non-infected residents e.g. curtain between residents in a shared room ☐ Personal Protection Equipment (PPE) must be worn by staff for close contact (e.g. surgical/face mask, eye protection, gown, gloves). Proper PPE donning & doffing is critical ☐ Equipment should be stored in resident's room & follow cleaning protocols for reusable equipment ☐ Ensure frequent resident and staff hand washing ☐ Monitor for signs & symptoms of pneumonia & sepsis ☐ Ensure mouth care maintained to prevent pneumonia
Vital signs	☐ Monitor temperature, respirations, O2 saturation, BP & pulse, auscultate lungs/chest as ordered or required
Hydration	☐ Encourage sufficient oral fluids to maintain hydration
Artificial hydration ordered - hypodermoclysis	☐ Follow MRP's order for hypodermoclysis if prescribed ☐ Ensure supplies available e.g. appropriate solution, tubing, pole, subcutaneous (sc) butterfly needles ☐ Change sc catheter insitu q24-48 hours, tubing q96 hours, solution q24 hour ☐ Monitor for complications due to artificial hydration e.g. sc site swelling, redness, leaking, bruising, burning/pain ☐ Record all forms of fluid on intake sheet including outputs
Dyspnea, Hypoxemia, Cough	☐ Follow MRP's orders for oxygen therapy via nasal prongs (e.g. <6 lpm) ☐ Follow MRP's medication orders if prescribed. Evaluate response & report to prescriber ☐ Use Metered Dose Inhaler (MDI) with spacer and or with spacer mask as ordered
Pain Management	☐ Administer opioids as prescribed & review PRN use to titrate dose ☐ Monitor pain behavior ☐ Evaluate response e.g. relief or excess sedation & report to prescriber
Mobility & Skin care	☐ Keep head of bed at 30 degrees and foot of bed at 15 degrees, unless instructed not to do so ☐ Establish a turning schedule
Behavioural change	☐ Observe for hyper/hypoactivity. fluctuations in cognition, function & behavior, or excessive sedation ☐ Track behavioral changes to determine underlying causes, risks & interventions ☐ Rule out/treat delirium ☐ Administer medications to manage behaviour if prescribed
Psychosocial needs	☐ Observe, listen & validate verbal & non-verbal communications re: worries, fears ☐ Use technology if appropriate to connect resident with family or spiritual care etc.

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Caring for Resident with COVID-19 – Short Term Care Plan Resident ID

Date: April 1, 2020 V7 Page: 2 of 2

Focus of Care	Check all interventions that apply
	☐ ☐ ☐ ☐
	☐ ☐ ☐ ☐
	☐ ☐ ☐ ☐
	☐ ☐ ☐ ☐
	☐ ☐ ☐ ☐
	☐ ☐ ☐ ☐

7.7 AL Short Term Care Plan

Care Plan for Tenants with COVID-19 in Assisted Living

Collaboration Between AL Clinician/CCP and AL Nurse When There is a Tenant with Positive COVID-19

Topic	Nurse Actions/Needs	Notes/Comments	Date/Initial
Review MOST	☐ Ensure MOST is up to date and on client's fridge ☐ Ask tenant/family to connect with Most Responsible Physician (MRP) to discuss their wishes		
End of Life	☐ Consult with AL CCP to make referral to Home Health palliative team ☐ Follow processes recommended by team		
Infection Prevention & Control	☐ **If screening is positive, Isolate tenant as soon as possible** ☐ Review AL Infection Control Toolkit (Respiratory Outbreak protocols sections) ☐ Review Fraser Health COVID-19 tools and resources: AL Screening Algorithm, Swabbing Processes, PPE Education, training NP swabs for nurses, FH AL COVID-19 updates ☐ Review supplies (PPE, swabs)		
Hydration	☐ Monitor fluid intake/output (e.g. check meal trays, asking tenant about voiding, checking continence products etc.) ☐ Use fluid intake/output sheet as indicated		
Medications	☐ Review tenant's supply of medication (e.g. expiration dates, supply etc.) ☐ Review best possible medication history		
Dyspnea, Hypoxemia, Cough	☐ Consult with Community Respiratory Services as required ☐ Ensure tenant has sufficient oxygen supplies (e.g. O2 tanks, nasal prongs) ☐ If tenant has an order for oxygen 1 to 6 L/min use nasal prongs. ☐ If tenant has an order for 5 to 10 L/min use O2 mask. 5 to 10 L/min produces aerosol. N 95 will be required. ☐ Ask MRP to change nebulizers to metered-dose inhaler to decrease aerosols		
Pain Management	☐ Review PRN medications and connect with MRP as needed (e.g. request PRN medications to be changed to regular doses when LPN not available) ☐ Use PAIN scale and monitor pain behaviors		

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Care Plan for Tenants with COVID-19 in Assisted Living

Collaboration Between AL Clinician/CCP and AL Nurse When There is a Tenant with Positive COVID-19

Mobility/Skin	☐ Encourage mobility and ensure mobility equipment is in place ☐ For bedbound tenants: obtaining hospital bed, establish a turning schedule ☐ Monitor skin changes (reddened/open areas, incontinence, dry skin etc.)		
Behavioral change	☐ Track behavioral changes to determine underlying causes, risks & interventions ☐ Rule out/treat delirium – Use Confusion Assessment Method (CAM) Tool ☐ Monitor signs and symptoms of infection (e.g. pneumonia, UTI, and sepsis)		
Psychosocial needs	☐ Observe, listen & validate verbal & non-verbal communications re: worries, fears ☐ Use technology to connect tenant with family or spiritual care etc. if requested		
Other	☐		

7.8 Serious Illness Conversations: Tool for Clinicians

SERIOUS ILLNESS CONVERSATION GUIDE

A CONVERSATION TOOL FOR CLINICIANS
Adaptation for COVID-19

The purpose of this scripted guide is to discuss potential outcomes of possible COVID-19 infection with at risk adults prior to a health crisis, including the elderly, those with chronic conditions (eg. heart/lung/renal disease, diabetes) or immunocompromised patients (eg. cancer, HIV/AIDS, transplant recipients). The intention is to open up dialogue and to introduce possible limitations to critical care interventions - eg. they may not be a candidate for ventilation, or for transfer to hospital. It is not intended to be a conversation to convince patients/clients to change their MOST status. This guide is to learn more about patients.

CONVERSATION FLOW	GUIDED SCRIPT
1. ***Set up the conversation*** • Introduce purpose • Prepare of future decisions • Ask permission	"I'd like to talk with you about COVID-19 and what may be ahead for you and your care. I would also like to hear from you about what is important to you so that we can make sure we provide you with the care you want if you get sick with COVID-19 - **is this okay?**"
Transition conversation to Step 2. Utilize paraphrasing and demonstrate empathy to let them know they've been heard.	
2. ***Assess COVID-19 understanding and preferences***	"What is your **understanding** about COVID-19 and how it is affecting at risk people?" "How much **information** would you like from me about COVID-19 and what is likely to be ahead if you get sick with it?" "How are you **coping** during this time of uncertainty?"
Transition conversation to Step 3. Utilize paraphrasing and demonstrate empathy to let them know they've been heard.	
3. ***Share prognosis*** • Share prognosis • <u>Caution:</u> *purpose is not to provide patient education* • Frame as a "wish...worry" "hope ... wonder" statement • Allow silence, explore emotion	"I want to share with you our current **understanding** of COVID-19 and how it affects people at risk, specifically those like you with _____ (specific health condition(s), eg. heart/lung/renal disease, cancer, diabetes, etc.)." "COVID-19 is a virus that spreads through contact with liquid droplets when someone coughs or sneezes, often entering through our eyes, nose or throat if you are in close contact. We know that it is particularly serious for vulnerable people, especially for those who have other health problems. It can also cause other very severe problems." "It can be difficult to predict what will happen if you get sick with COVID-19. I **hope** it would not be severe and that you will continue to live well at _____ (current place of residence: home, assisted living, long term care, etc.)." "But I'm **worried** that as an adult with other health problems, you could get sick quickly and that you are at risk of dying. I think it is important for us to prepare for that possibility."
Transition conversation to Step 4 by allowing for silence. Consider exploring emotion. Refer to SIC Clinicians Reference Guide for more scripted language on common difficult responses (Eg. tears, anger, denial). **March 26, 2020**	

Form ID: XXQI107338A; Rev: Mar 26, 2020

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SERIOUS ILLNESS CONVERSATION GUIDE

A CONVERSATION TOOL FOR CLINICIANS
Adaptation for COVID-19
Cont'd

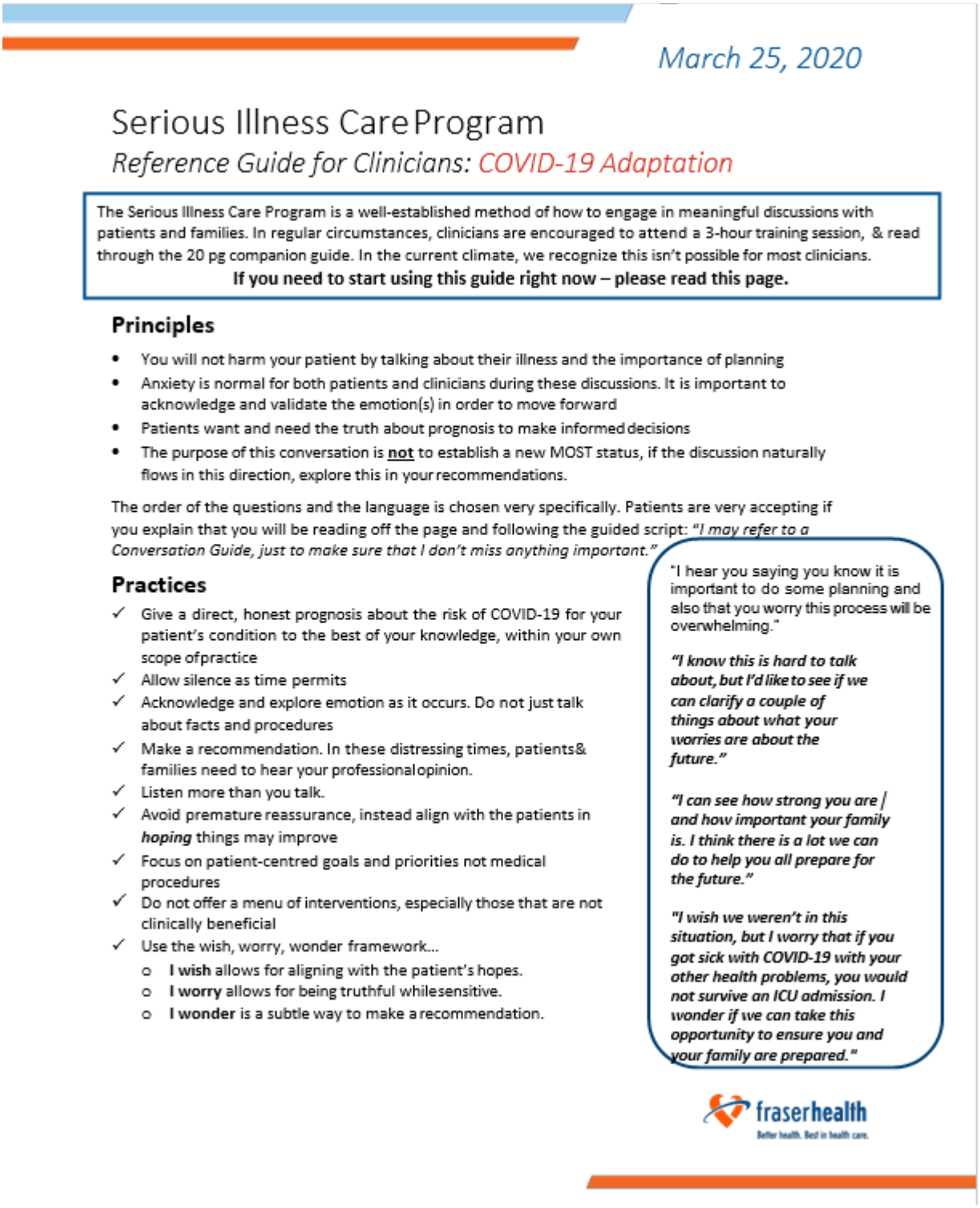
CONVERSATION FLOW	GUIDED SCRIPT
4. Explore key topics • Meaning • Fears and worries • Sources of strength • Family/People that matter • Best care	"What is **most important** to you right now? What means the most to you, and gives your life **meaning?"** "What are your biggest **fears and worries** about the future and your health?" "What gives you **strength** as you think about the future?" "How much does your **family/people that matter to you** know about your priorities and wishes?" "Is there anything else that we need to know about you so that we can give you the **best care possible?"**
Transition conversation to Step 5. Utilize paraphrasing and demonstrate empathy to let them know they've been heard.	
5. Reassurance	"We want you to know that **our priority is to ensure that you are cared for and comfortable** if you become sicker. Regardless of the medical treatments that you get or do not get, your health care team will always provide treatments to help make you feel better. So it is important to let us know if you get a new cough, fever, shortness of breath or other signs that your health is changing. We will continue to support you as best we can to get the right help for you."
Transition conversation to Step 6. Utilize paraphrasing and demonstrate empathy to let them know they've been heard.	
6. Close the conversation • Summarize what you've heard • Make a recommendation within your scope of practice • Check in with patient • Affirm commitment **Refer to Serious Illness Clinician Reference Guide for additional help with recommendations (page 18)**	"I've heard you say that_____is really important to you. Keeping that in mind, and what we know about COVID-19 and your current health, I **recommend*** that we....

Focus: **Wellbeing**	"Talk again in a few days, to reassess where you are at."
Focus: **Illness**	"Talk with your primary care providers." "Make plans for care at home."
Focus: **Support System**	"Talk to your family/those that matter to you/including your Substitute Decision Makers."
Focus: **Help**	"Get you more information about risks and benefits regarding specific critical care treatments (e.g. restarting your heart or using a breathing machine)."

"How does this seem to you?"
"I know this is a scary time for all of us. We will do everything we can to help you through this."

7. Document your conversation on the ACP Record and fax if non-acute setting. Communicate with primary care providers. Store in Greensleeve if paper charts are used in your setting.

8. Communicate with key clinicians.



March 25, 2020

Serious Illness Care Program

Reference Guide for Clinicians: COVID-19 Adaptation

The Serious Illness Care Program is a well-established method of how to engage in meaningful discussions with patients and families. In regular circumstances, clinicians are encouraged to attend a 3-hour training session, & read through the 20 pg companion guide. In the current climate, we recognize this isn't possible for most clinicians.

If you need to start using this guide right now – please read this page.

Principles

- You will not harm your patient by talking about their illness and the importance of planning
- Anxiety is normal for both patients and clinicians during these discussions. It is important to acknowledge and validate the emotion(s) in order to move forward
- Patients want and need the truth about prognosis to make informed decisions
- The purpose of this conversation is **not** to establish a new MOST status, if the discussion naturally flows in this direction, explore this in your recommendations.

The order of the questions and the language is chosen very specifically. Patients are very accepting if you explain that you will be reading off the page and following the guided script: *"I may refer to a Conversation Guide, just to make sure that I don't miss anything important."*

Practices

- ✓ Give a direct, honest prognosis about the risk of COVID-19 for your patient's condition to the best of your knowledge, within your own scope of practice
- ✓ Allow silence as time permits
- ✓ Acknowledge and explore emotion as it occurs. Do not just talk about facts and procedures
- ✓ Make a recommendation. In these distressing times, patients & families need to hear your professional opinion.
- ✓ Listen more than you talk.
- ✓ Avoid premature reassurance, instead align with the patients in ***hoping*** things may improve
- ✓ Focus on patient-centred goals and priorities not medical procedures
- ✓ Do not offer a menu of interventions, especially those that are not clinically beneficial
- ✓ Use the wish, worry, wonder framework...
  - **I wish** allows for aligning with the patient's hopes.
  - **I worry** allows for being truthful while sensitive.
  - **I wonder** is a subtle way to make a recommendation.

"I hear you saying you know it is important to do some planning and also that you worry this process will be overwhelming."

"I know this is hard to talk about, but I'd like to see if we can clarify a couple of things about what your worries are about the future."

"I can see how strong you are / and how important your family is. I think there is a lot we can do to help you all prepare for the future."

"I wish we weren't in this situation, but I worry that if you got sick with COVID-19 with your other health problems, you would not survive an ICU admission. I wonder if we can take this opportunity to ensure you and your family are prepared."

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Resources

- Healthcare Provider Serious Illness Resources
- Clinician Reference Guide: Strategies for Common Scenarios
- Public Advance Care Planning Resources

7.9 Serious Illness Conversation Guide for Substitute Decision Makers

SERIOUS ILLNESS CONVERSATION GUIDE
SUBSTITUTE DECISION MAKERS
A CONVERSATION TOOL FOR CLINICIANS
Adaptation for COVID-19

CONVERSATION FLOW	GUIDED SCRIPT
4. ***Explore key topics*** • Meaning • Fears and worries • Sources of strength • Family/People that matter • Best care	"What would your _____ say is **most important** to him/her right now? What means the most to your _____, and gives his/her life meaning?" "What would your _____ say are his/her biggest **fears and worries** about the future and his/her health?" "What gives your _____ and you **strength** as you think about the future?" "How much do your _____'s **other family/people that matter to him/her** know about his/her priorities and wishes?" "Is there anything else that we need to know about your _____ so that we can give him/her the **best care possible?**"
Transition conversation to Step 5. Utilize paraphrasing and demonstrate empathy to let them know they've been heard.	
5. ***Reassurance***	"We want you to know that **our priority is to ensure that your _____ is cared for and comfortable** if he/she becomes sicker. Regardless of the medical treatments that he/she gets or does not get, his/her health care team will always provide treatments to help make him/her feel better. So it is important to let us know if your _____ gets a new cough, fever, shortness of breath or other signs that his/her health is changing. We will continue to support you and your _____ as best we can to get the right help for him/her."
Transition conversation to Step 6. Utilize paraphrasing and demonstrate empathy to let them know they've been heard.	
6. ***Close the conversation*** • Summarize what you've heard • Make a recommendation within your scope of practice • Check in with patient • Affirm commitment **Refer to Serious Illness Clinician Reference Guide for additional help with recommendations (page 18)**	"I've heard you say that _____ is really important to your _____. Keeping that in mind, and what we know about COVID-19 and his/her current health, I **recommend*** that we.... Focus: **Wellbeing** — "Talk again in a few days, to reassess where your _____ is at." Focus: **Illness** — "Talk with your _____'s primary care providers." "Make plans for care at home." Focus: **Support System** — "Talk to your_____'s other family/those that matter to him/her." Focus: **Help** — "Get you and other family/people that matter more information about risks and benefits regarding specific critical care treatments (eg. restarting their heart or using a breathing machine)."
7. ***Document your conversation on the ACP Record and fax if non-acute setting. Communicate with primary care providers. Store in Greensleeve if paper charts are used in your setting.***	
8. ***Communicate with key clinicians.***	"How does this seem to you?" " I know this is a scary time for all of us. We will do everything we can to help you through this."

Form ID: XXQI107345A; Rev: April 06, 2020

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SERIOUS ILLNESS CONVERSATION GUIDE
SUBSTITUTE DECISION MAKERS
A CONVERSATION TOOL FOR CLINICIANS
Adaptation for COVID-19

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The purpose of this scripted guide is to discuss potential outcomes of possible COVID-19 infection with at risk adults and their Substitute Decision Makers prior to a health crisis, including the elderly, those with chronic conditions (eg. heart/lung/renal disease, diabetes) or immunocompromised patients (eg. cancer, HIV/AIDS, transplant recipients). The intention is to open up dialogue and to introduce possible limitations to critical care interventions - eg. they may not be a candidate for ventilation, or for transfer to hospital. It is not intended to be a conversation to convince patients/clients to change their MOST status. This guide is to learn more about patients.

CONVERSATION FLOW	GUIDED SCRIPT
1. ***Set up the conversation*** • Introduce purpose • Prepare of future decisions • Ask permission	"I'd like to talk with you about COVID-19 and what may be ahead for your _____ (eg. mother, brother, friend, etc.) and his/her care. I would also like to hear from you about what is important to your _____ so that we can make sure we provide him/her with the care he/she wants if he/she gets sick with COVID-19 - **is this okay?**"
Transition conversation to Step 2. Utilize paraphrasing and demonstrate empathy to let them know they've been heard.	
2. ***Assess COVID-19 understanding and preferences***	"What is your **understanding** about COVID-19 and how it is affecting at risk people?" "How much **information** would you like from me about COVID-19 and what is likely to be ahead if for your _____(eg. mother, brother, friend, etc) if they get sick with it?" "How are you **coping** during this time of uncertainty?"
Transition conversation to Step 3. Utilize paraphrasing and demonstrate empathy to let them know they've been heard.	
3. ***Share prognosis*** • Share prognosis • *Caution: purpose is not to provide education* • Frame as a "wish...worry" "hope ... wonder" statement • Allow silence, explore emotion	"I want to share with you our current **understanding** of COVID-19 and how it affects people at risk, specifically those like your _____ with _____ (specific health condition(s), eg. heart/lung/renal disease, cancer, diabetes, etc.). COVID-19 is a virus that spreads through contact with liquid droplets when someone coughs or sneezes, often entering through our eyes, nose or throat if you are in close contact. We know that it is particularly serious for vulnerable people, especially for those who have other health problems. It can also cause other very severe problems. It can be difficult to predict what will happen if your _____ gets sick with COVID-19. I **hope** it would not be severe and that he/she will continue to live well at _____ (current place of residence, eg. home, assisted living, long term care, etc.). But I'm **worried** that as an adult with other health problems, your _____ could get sick quickly and that he/she is at risk of dying. I think it is important for us to prepare for that possibility."
Transition conversation to Step 4 by allowing for silence. Consider exploring emotion. Refer to SIC Clinicians Reference Guide for more scripted language on common difficult responses (eg. tears, anger, denial). **April 06, 2020**	

Form ID: XXQI107345A; Rev: April 06, 2020

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7.10 Guidelines for CPR in Clients with COVID-19

Link to Aerosol Generating Procedures (AGP): Aerosol Generating Procedures (AGP)

COVID-19

April 22, 2020

Uncommon Practice: Cardio Pulmonary Resuscitation (CPR) in Long-Term Care (CPR – C2)

CPR is not attempted on a resident who has suffered an unwitnessed cardiac arrest. Please ensure families are aware that CPR will not be initiated for a non-witnessed arrest.

WITNESSED ARREST ONLY (The following applies to ALL cases of CPR administration for the duration of the COVID-19 pandemic due to risk of inadvertent COVID-19 transmission)

1. Call 911
2. Keep the resident in the same room. If required, clear space by moving room-mates out of the area.
3. If possible, move other residents in the hallway or lounge area. If not possible, apply surgical/procedure masks to room-mates.
4. Staff must wear the required PPE- eye protection (face shield/goggles), surgical/procedure mask, gown and gloves
5. Apply a surgical/procedural mask to the resident
6. Start COMPRESSIONS ONLY, NO ventilations (compressions without ventilations or oral suctioning is not considered an Aerosol Generating Procedure).

NB: If ventilations are initiated (via code team, BCAS), then all team members must wear a N95 respirator in addition to eye protection, gowns and gloves

For resources on Aerosol Generating Procedures (AGP) see:
http://fhpulse/quality_and_patient_safety/infection_control/novel_coronavirus/FH%20Aerosol%20Generating%20Procedures%20(AGP)%20SOP%20%5brev%20Mar%2024%5d.pdf

Note most residents are frail and vulnerable and M1-M3 DNR.

Preventative proactive conversations should occur to ensure all residents have updated goals of care documented and the Medical Orders Scope of Treatment reflecting the wishes and preferences of the resident. Included in the conversation are explanations of COVID-19 and possible outcomes of a COVID-19 positive diagnosis. This will ensure the residents goals of care are in alignment with that information.

Source Information: Acute Care AGP, Consultation with Emily Boorman CNS Critical Care, LTC Physician COVID-19 Task Force, FH Infection Prevention and Control

 Updated: April 22, 2020

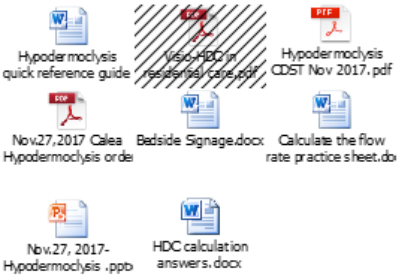
Prepared by Long Term Care/Assisted Living Coordination Centre

7.11 Hypodermoclysis in Long Term Care – Lesson Plan

Please contact CNE for education support as required and to access the files linked in this lesson plan.

fraserhealth Caring for a Resident with COVID-19 Lesson Plan: Hypodermoclysis April 9, 2020 V2

Title of Session: Hypodermoclysis for residents during COVID-19 pandemic	Who are the learners (target audience)? Long-term care nurses & healthcare assistants	Length of session: 40-45 mins
Goal: For LTC staff to have the knowledge and feel confident in caring for resident with hypodermoclysis		
Learning Intentions/Objectives: 1. Define hypodermoclysis 2. Describe the increased risk for dehydration in older adults 3. Describe indications for use of hypodermoclysis 4. Demonstrate good knowledge of related equipment 5. Recognize complications and interventions to take		
Required pre-workshop participant preparation: Nurses to refresh SC https://point-of-care.elsevierperformancemanager.com/skills/9100/quick-sheet?skillId=ZZ_0121 Med admin Intermittent and continuous https://point-of-care.elsevierperformancemanager.com/skills/379/quick-sheet?skillId=GN_21_9		

Time:	Learning Objective	Learning Activity	Materials/Resources/Key References
5 mins	Create a safe learning environment	Introductions. Discussion: Discussion with learners about their knowledge of HDC Check in: Acknowledge any reluctance, fears associated with new skill Provide reassurance	Sign in sheet. Handouts:  Equipment: Flip chart, markers, tubing set, solution, pole or hook on the wall to hang the set up, calculator
5 mins	Hook: Objectives 1 and 2	Lecture: What is hypodermoclysis and why use in LTC?	Slides 2 to 10 Emphasize quality of life and preventing hospitalization

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Lesson Plan Template Revised April 9, 2020

5mins	Pre-Assessment (What do learners already know about the topic?):	Discussion: Relate new skill to what learner already know and doing: S/C medication administration, tube feeding Check in with learner	Discussion Check in with learner about level of apprehension
5 mins	Objective 3: Inclusion and exclusion criteria	Lecture	Slides 11 to 16
5 mins	Objective 4: Equipment review	Lecture Demonstration with equipment. Learner to handle equipment. Lecture: Review particulars	Slides17 to 19 Need solution, tube set and hook/pole Slide 20
10 mins		Lecture: Rate calculation. Hands on: rate calculation practice Lecture: Monitoring and bed side signage.	Slide 21-22, review example handout and explain formula Have learner work through the Calculate the flow rate practice sheet. Use the flip chart to go through the calculations. Presenter can refer to the Answer sheet to the calculation examples. Slide 23-24
5 mins	Objective 5	Lecture: Complications and troubleshooting Documentation Resources available- review	Slides 25-29 Slides 30-32 Slides 33 Review HDC quick reference guide
	Post-Assessment (How will I know that learning has occurred?):	Discussion: -Questions -Check in with learner how they are feeling with new skill post education session. Do they feel confident to care for resident	Slide 34. Answer any questions. Discussion Slide 35

Important Concepts (i.e. related to topic, clinical program/service goals):	Important Context (related to this topic)
Polypharmacy	Quality of life/ improve health.
Preview ED	Early detection of change/ prompt assessment and treatment as needed
Palliative approach	Quality of life/ alignment with goals of care/ SIC

Developer(s): Ann Jamieson-Wright
Date Developed: November 7, 2017
Date Revised: April 3, 2020 by COVID Clinical Task Group

7.12 Post-mortem Care

General Recommendations (excerpt *from BC-CDC Safe Handling of Bodies of Deceased Persons with Suspected or Confirmed COVID-19: Interim Guidance,* Dated*:* April 2, 2020)

The recommended use of personal protective equipment (PPE) in this guidance document outline precautionary strategies to minimize the risk and spread of the disease.

- Perform a Point of Care Risk Assessment (PCRA) prior to all interactions with the deceased.
- Individuals not wearing PPE should avoid unnecessary contact with the deceased.
- Workers must follow Routine Practices, which includes the appropriate use of PPE, performing diligent hand hygiene with plain soap and water or alcohol-based hand sanitizer (70% alcohol content), appropriate cleaning and disinfecting of equipment, and appropriate environmental cleaning.
- For more information about Routine Practices, please see: https://www.canada.ca/en/public-health/services/publications/diseases-conditions/routine-practices-precautions-healthcare-associated-infections.html
- Workers should always wear disposable gloves and long-sleeved fluid-resistant gowns when handling the deceased.
- If the Point of Care Risk Assessment determines a risk for splashes from the patient's body fluids or secretions onto the worker's body or face, then a fluid-resistant surgical/procedural mask and eye protection should be worn as well.
- Post-mortem examinations may carry a higher risk for aerosol-generating medical procedures (AGMPs). Accordingly, an N95 respirator should be worn in addition to gloves, gown and eye protection. Diligent hand washing is essential.
- All single use PPE should be immediately disposed.

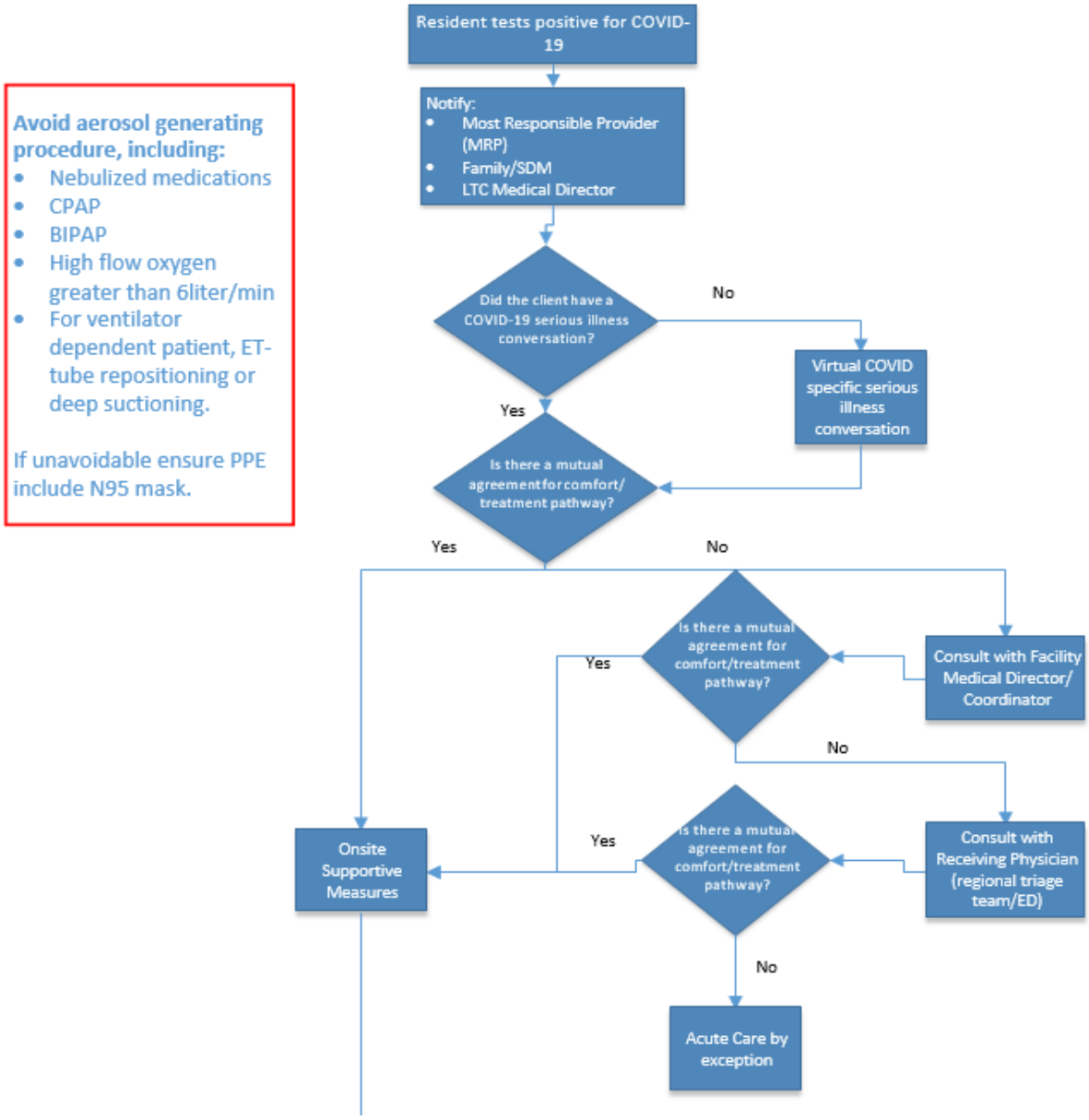
Reference the BC-CDC website for complete guidelines on the care of deceased persons (including Preparations, Transporting and Environmental Cleaning). http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/deceased-persons

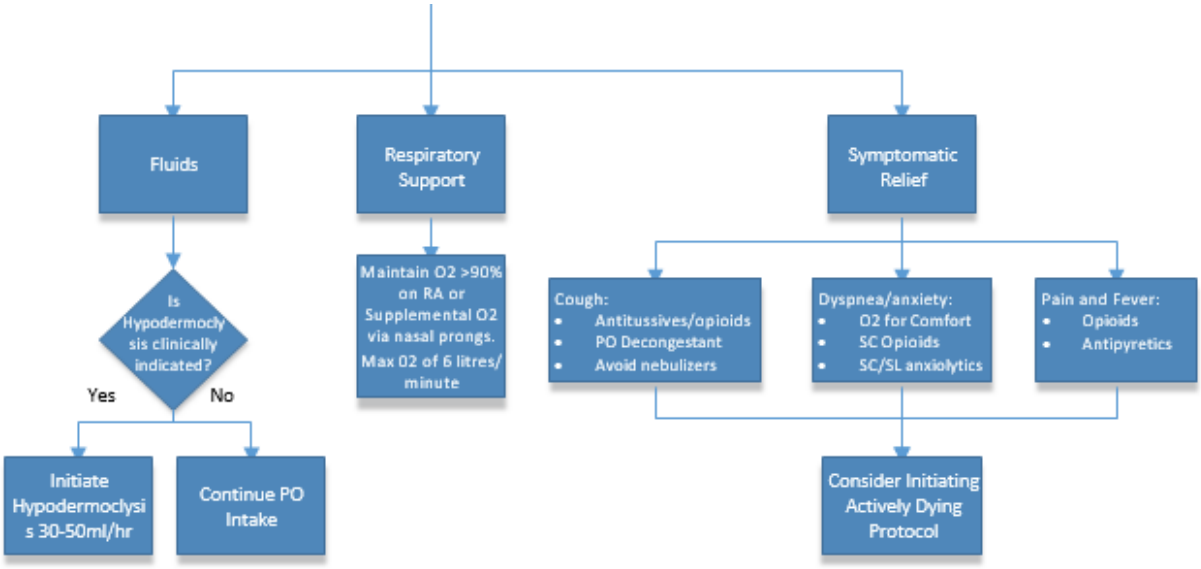
8.0 LTC Physician Resources

8.1 Physician Clinical Pathway

Clinical Decision Pathway COVID-19 in LTC Residents

This algorithm assumes Public Health Authorities are involved and are coordinating outbreak in facility, and is meant to aid clinicians to manage care of residents with COVID-19 LTC.





8.2 Physician Updates

8.2.1 Physician Resourcing

- All routine clinical care will be provided virtually by the client's MRP.
- Care homes have been asked to organize ALL meetings that typically occur at a care home virtually so that unnecessary on-site visitations can be minimized. This includes all clinical interdisciplinary meetings, family meetings, etc.
- Divisions of Family Practice will develop systems to ensure after hours and weekend coverage is available to meet on-call needs for their community. All Divisions have committed to have a backup on-call system and will develop contingency plans for coverage should the scheduled on-call physician be unable to take call.
- If necessary, Divisions may collaborate with neighbouring Divisions in exceptional circumstances where additional physician capacity is required both clinically and for after hours and weekend coverage.

8.2.2 Preventing Spread

- Non-essential physician visits should be avoided unless absolutely clinically necessary; the majority of care is to be provided virtually by physicians.
- Recommendation for physicians who provide in-patient care at a hospital or in a COVID-19 sensitive environment in the community to provide care to their LTC clients virtually; when clinically necessary care is required on-site, find a designate when possible. Facility Medical Directors are working with physician colleagues to implement this where possible.
- ALL care-related meetings that typically occur at a care home (ie. care conferences, medication reviews, etc.) should take place virtually unless absolutely clinically essential or if the physician is already on-site for a clinically essential visit.

8.2.3 Minimizing ER Transfers

- ER transfers will occur only when clinically essential based on the MRP's clinical judgement.

- Recommendation to MRPs to proactively have COVID-19-related goals of care discussions with families, starting with M3 or higher clients and with families who may already be anxious.
- Part of the development of a clinical decision pathway for management of COVID-19 in LTC which was approved by the MoH and is on the BCCDC website. This will be circulated to all LTC physicians and we are developing a PPO for management of COVID-19 in LTC which will complement the pathway.
- Providing a webinar to all LTC MRPs with training for difficult conversations through our Palliative Approach to Care physician consultants. Palliative Care Physicians and team also available for MRPs for difficult cases
- Development of an algorithm for client transfers; circulated to LTC and acute care leadership.

8.2.4 Technological Capacity and Capability

- Collaborated with FH Virtual Health and Innovation, Planning, and Transformation to determine technological gaps at LTC homes and address by providing sites with devices as needed.
- Collaborated with FH Home Health to ensure devices used for wound care consultations can be utilized for virtual clinical care and social visits.
- Coordination with Divisions to ensure that all sites have capacity for virtual physician clinical visits
- Collaborated with FH Virtual Health and Innovation, Planning, and Transformation to provide care homes with FH-approved software to conduct virtual visits.

9.0 LTC Prevention-Preparedness Self-Assessment Tracker

All sites are to review the Prevention & Preparedness activities below and immediately implement any that are not yet completed.

Care Home Name:	**Completed by (include title):**	**Date:**

Operational Details	Complete	Notes
Resident Protection Policies		
NEW RESIDENT SCREENING: All residents will be screened when bed offer is made and **again** 6 hrs before move-in. If the resident screens positive, no bed offer will be made. Acute care will screen before a bed offer is made and **again** before transfer.		
All RESIDENTS: Screened 2x per day following the existing resident screening algorithm. Swab any client with new or worsening respiratory or gastrointestinal symptoms.		
Stop group activities into the community; stop community organizations/groups from entering care home.		
Stop residents going into the community except for urgent medical needs (ie dialysis), refer to Transfer for Medical Care Algorithm		
If applicable: Day Programs for Older Adults co-located with Long-term Care facilities closed as of March 18th		
Social distancing for dining – additional meal times if possible, tray service as much as possible; maximize separation between residents as much as possible, within the confines of your environment; cancelling group activities – the standard is 2 metre (6 feet) distancing		
Isolate patients with new fever, respiratory, or gastrointestinal symptoms (as possible with multi-bed rooms)		
Provide continuous guidance to clients on hand hygiene and respiratory etiquette		
Ensure family contact lists and client information are up-to-date, including GP contacts		
Resident - Clinical		
Ongoing serious illness conversations as appropriate with Substitute Decision Maker; align goals of care with management		
Ensure every client has an updated MOST. Ensure goals of care are documented on the advance care plan and aligned with MOST. Ensure all documentation is easily accessible		
Ensure clients who have been temporarily removed from the facility to live elsewhere are aware they will not be permitted to return during a COVID-19 outbreak		
Complete an internal (preparatory) list of families who may potentially be able to provide care of their family member at home in the event of very low staffing levels.		
Prepare plans for isolation in the event many residents became ill. Is there a recreation room or other space that could be repurposed to cohort COVID positive residents?		
Visitor Policies		
Visitors: Restrict to 1 adult visitor at a time for actively dying residents only - visitor must be screened negative.		

	Visitors must access the facility through a single controlled entrance. Ensure signage is posted. Visitors who are symptomatic cannot visit * exemption only by DOC, consultation with IPC on appropriate precautions		
	Strategies Supporting Acute Care Capacity		
	Transfers between LTC care homes are suspended. Only exceptions considered will be for a higher level of LTC that can not be mitigated in existing home. Follow transfer algorithm.		
	Transfers between units should only occur based on client care needs (i.e. to/from a higher level of care like BSTN).		
	Suspend Access policy - Available LTC beds are being prioritized for ALC-LTC patients in Acute		
	Need for transfer to acute care determined by MRP/on-call designate & contacts receiving ED physician. Sending & receiving physicians discuss transfer of resident		
	Site Staffing Management		
	Care Home proactively communicate with staff that retired in past 3 years and request they relicense with professional bodies (where applicable) or indicate that they are willing to work if needed.		
	Sites that are part of a multi-site organization use staff from other sites		
	If shortage is <=24 hours, care home to repurpose non-clinical staff to support essential services.		
	Proactively prepare for staffing shortages and deployment potential		
	Enhanced Cleaning – Physical Environment		
	2x/day cleaning throughout the facility including high-touch surfaces (door knobs, faucets in bathrooms, common areas, dining rooms, gyms, recreational therapy rooms, shared equipment).		
	Facilities instructed to use 0.5% accelerated hydrogen peroxide wipes or bleach wipes		
	Enhanced Infection Prevention & Control		
	Ensure all staff (direct and support) receive a refresher on: a) Use of PPE, screening of staff, Hand hygiene audits on sites b) IPC best practices		
	Conduct Proactive Supply Inventory		
	Staff Symptom Monitoring		
	All staff need to be actively screened for symptoms – before shift starts and end of shift, and also self-monitor at all times		
	Screen all external services/contractors using screen as provided by MHO		
	All care staff that have travelled out of country are to come to work, as long as they are not experiencing any symptoms, and will continue to self-monitor		
	Staff exhibiting symptoms, regardless of severity, must immediately stop work and leave facility to self-isolate. All staff will be directed to a community testing site of their choice to be swabbed		
	Staff provided with protocol for self monitoring		
	Staff Education		

	Signage for staff/physicians about how to protect themselves at work placed in area visible to all staff/physicians (e.g. breakroom)		
	Physician Coverage		
	Physicians self-organizing by community to have back-up if one becomes symptomatic; doing phone visits primarily.		
	Any transfer to acute must be by physician approval ONLY		
	Ensure all residents have up to date MOST and support goals of care discussions with residents and families		
	Communication		
	Messaging to families, staff and signage		
	Ensure proper signage at entrance to facility and throughout facility highlighting visitor restrictions, hand washing and self-monitoring for symptoms		
	FH to support sites with communications material – messages; letters; etc		