Living Document – Updated July 16, 2020

Kiwanis Village Nanaimo: Novel Coronavirus Infection Prevention and Control and Exposure Control Plan for Healthcare Professionals in LTC-AL-IL-SL

Introduction

In response to the Covid-19 pandemic and the increased attention to infection and exposure control, Kiwanis Village Nanaimo has developed a Covid-19 Exposure Control Plan. Orders from the Provincial Health Authority and guidance to employers provided by the BC Centre for Disease Control represent the minimum standard the employer must meet to comply with worker health and safety. In order to address health and safety concerns within Kiwanis related to Covid-19, we asked ourselves the following questions that support the content of this plan:

- How do we connect with, educate and support workers about Covid-19?
- How can we use existing communication processes, including but not limited to JOSH-IPAC, incident reporting, staff huddles and shift reports, committee meetings etc to ensure workers have enough relevant and accurate information to protect themselves in the workplace and, with Covid-19, within our communities?
- How can we quickly identify potential hazards and develop mitigating measures to control exposure?
- How can we obtain accurate feedback from workers that validate the measures taken and learn more about our potential challenges?
- Have we clearly identified issues and developed controls within Kiwanis that support the orders, directives, recommendations and advice received from credible, responsible, validated sources? How do we share these and monitor their effectiveness?
- How do we control the number of workers and other visitors within the Village and within each building in the Village?
- How do we screen and support staff and appropriate visitors to be present at Kiwanis and is this effective?
- How do we prohibit workers (or other visitors) from being present who are sick, exposed to others who may be sick or who have returned to Canada (BC)?
- How do we support access to testing?
- How do we support workers (and visitors) who display symptoms being absent?
- How do we ensure that increased cleaning and attention to high touch points is being performed at all times across the Village? How do we require accountability?
- What does social distancing look like within the different services across the Village?
- How are we supporting workers to meet the requirements for exposure control and personal wellness?
- How do we support workers to report to us any concerns within the workplace or home community, which may influence exposure?
- How are we procuring, monitoring, and tracking essential items such as PPE, cleaning products, single use items, hand sanitizers, etc., and how are we advocating for any issues revealed during Covid-19?
- How are we communicating the changes in the availability of PPE to staff and supporting staff safety as issues arise with accessibility to PPE? How are we planning to address a change in the allocation of PPE if it increases from a level 4?

To ensure suitability of our plan for Novel Coronavirus (Covid-19), Kiwanis Village has reviewed the following guidelines to ensure that any information that is supplemental or additional to that provided in our infection control manual has been added to this current plan.

Documents used to support this plan:

1. Residential Care Infection Prevention and Control Manual: For Non-affiliated Residential Care Facilities (picnet)
2. Infection Prevention and Control for Novel Coronavirus (COVID-19): Interim guidance for Long-term Care and Assisted Living Facilities: Provincial Coronavirus Response Mar. 13, 2020-Published by BC Centre for Disease Control and the BC Ministry of Health's jointly published guidelines
3. WSCB Guide for Employers March 31 2020
4. Covid-19 Emergency prioritization in a Pandemic PPE Equipment-Allocation framework March 25 2020 (CDC)
5. Covid-19 Ethical Decision Making Framework March 28 2020 (CDC)
6. MOH- Assisted Living registrants April 27 2020
7. MOH Health Authority Chief Executives March 25 2020
8. Island Health publications and written directives

Kiwanis Village Nanaimo has adopted and altered, for our own purposes, these guidelines to reflect the roles, responsibilities, and controls of Kiwanis Village Nanaimo, and has provided adaptation that intends to maintain all of the intent of the original documents.

The purpose of the *Kiwanis Village Nanaimo: Novel Coronavirus Infection Prevention and Control and Exposure Control Plan for Healthcare Professionals in LTC-AL-IL-SL* is to be used in conjunction with our regular Infection Control Plan. The goals of this plan are: (1) to reduce the risk of residents and staff being exposed to COVID-19, to prevent the introduction of the virus to our site; (2) if someone in interaction with our site develops COVID-19, the next goal is to prevent the transmission of it, including by isolating and cohorting residents with potential and diagnosed cases; and (3) to protect staff. The content of this plan is for utilization across the Village with specific additional supports in place in long-term care. Considerable operational changes have occurred across the site, in response to COVID-19, and this document, where relevant, identifies which controls and practices apply to specific locations within the Village.

This document provides interim guidance to healthcare professionals (HCPs) for the prevention and control of novel coronavirus (COVID-19) in long-term care (LTC), assisted living (AL), and in the other buildings at Kiwanis Village Nanaimo.

This guidance document is based on the latest available scientific evidence about this emerging disease, and may change as new information becomes available. It is reviewed through both the exposure control lens and the Covid-19 ethical decision making framework March 28 2020 from the CDC. Kiwanis Village Nanaimo monitors and reflects the updates and information for health care facilities in BC regarding COVID-19 (see Responsibilities section below).

At this time the evidence suggests that the incubation period for COVID-19 is up to 14 days. The length of the infectious period of COVID-19 has not been established. As of May 12, 2020, staff will be referring to and following the interim guidance on discontinuing isolation precautions for suspected or confirmed individuals with COVID-19, please see Appendix K for the discontinuation criteria. In outbreak situations, where some symptomatic residents may not be tested, the period of isolation is at the discretion of the MHO. Once clinical criteria for the end of isolation are established, this guidance will be updated.

Infection Prevention and Control and Exposure Control Practices for COVID-19

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

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

Screening for Symptoms

Screening and restricting access to the site include administrative and environmentals controls that help to prevent potential exposure to COVID-19. Multi-point screening occurs at Kiwanis Village prior to entry to any building.

Site Entry Screening

RESIDENTS, VISITORS AND STAFF: As of March 16, 2020, all entryways and exits from Kiwanis Village are blocked, with one remaining open and secured with a 24-hour security guard. Staff on shift are permitted entry. All visitors to the entire site are screened and are only allowed to visit with prior consent of the Executive Director or her designate and only if their visit is essential. All visitors permitted entry complete a symptom screening assessment and sign in to acknowledge the assessment and their entry to the site (Appendix A).

On May 19, 2020, Dr. Bonnie Henry updated a policy regarding essential visits of family and visitors into health care facilities. Kiwanis Village will continue to restrict visitors to essential visits only and a visit will continue to be determined if it is essential by the Executive Director or her designate. We have submitted our plan on July 10, 2020 to the Provincial Health Officer for review to have non-essential visits allowed as per the LTC and public health guidance and it has been approved as of July 15, 2020. Please see Kiwanis Village Visiting Guidelines below for our LTC and Assisted Living facility.

Kiwanis Village Visiting Guidelines

For LTC:

The following criteria will be used to guide Island Health program and Licensing staff to approve required Designated Visitor plans. The governing principles to ensure implementation of this policy change are:

» That designated visits will be maximized at all sites while ensuring compliance with appropriate safety procedures.
» Sites will follow all existing infection control procedures required by the MHO.
» Resident and staff safety at the site remain the priority for each site and should not be compromised for unsafe designated visits.
» Each site will be responsible for developing, implementing and evaluating its own plan.

Decision Making

» As per the BC CDC and Ministry of Health Guideline, the decision of who the designated visitor will be must be done in a collaborative manner (care team must include resident/family +/- health care rep or TSDM)
» Plan reflects resident as primary decision maker for determining designated visitor unless they have been deemed incapable of making the decision of who their visitor should be and/or if they want to include their family, health care rep or TSDM

- Recreation Coordinator will facilitate the visiting guidelines in LTC in collaboration with nursing and care or other as appropriate
- Recreation staff on each floor will connect with residents about designating their visitor in collaboration with nursing and care or other as appropriate
- Those unable to decide – will reach out to family member

» Designated Visitor will be one single person (no changes to occur)
» Communication re: expectations be provided to resident and family (verbal & written), outlining the following:
  - Importance of facilitating designated visits.
  - Collective Risk (i.e. health and safety for COVID-19 transmission for residents and visitors)
  - Collective Accountability and commitment to adhering to agreed guidelines to reduce risk for other visitors/residents/care providers
  - That the site is committed to maximizing designated visits within the stated safety guidelines.

- See Visiting Guidelines KV LTC commencement between 15-20 July

Operational Considerations: Does the plan reflect the below:

» How many visitors will be approved per day into the site (how to consider doing this safely)

- Start with 4 – 6 and increase from there – dependent on length of time booked and desire of the resident/family
- Give choice of 30 or 60 minute visits

» How to balance essential visitors and social visitors (does it consider as well essential visitor as one in the same?)

- Meaningful matching of residents with varying and fluctuating needs- work with nursing and care teams to establish the difference between social visiting and essential visiting- changes in health status or desire to decline/change mind re a visitor will be discussed at daily huddles
- Staff will understand and collaborate with recreation specific or unique family dynamics to support personal choices that reflect the residents preferences and needs first before the needs of the resident

» What additional financial support is required to safely manage the agreed number of visitors at one time?

- # of FTE's –

- 1.3 FTE
- Respite recreation staff have been redeployed to resident care and will be supporting the visiting guidelines and process
- This supports 7 day per week visiting (1.3 FTE)
- Should respite re open then an additional FTE would be required to continue to support this service as rec respite would return to deliver therapy to respite clients

- Type of position(s) – **Rec staff schedules, screens, cleans between a visit**
- Annual cost including benefits for each position –n/a until respite opens
- Environmental Adaptation costs
- Screen tent-heaters- aesthetic enhancements to visiting space (heart

» Process of determining whether visits can occur on a given day if local circumstances indicate increased temporary risk (eg, active outbreak or potential, inadequate staffing to supervise)

- There is at least 1 staff member 7 days/week to facilitate visits
- Active outbreak = visits cancelled
- Resident on precautions = visit cancelled
- Resident is unwell = visits rescheduled or rerouted to essential (palliative)
- Each visit will be reviewed in advance by rec working with nursing to ensure appropriate steps are taken and avoid miscommunication
- Rec will connect with visitors to address and changes or questions

» Process for scheduling visits: How appointments will be booked while considering the number of people the site can safely support

- Residents/family/friends in LTC call 250-740-2727 hotline to book appointments for 'heart park' visits and be pre screened
- 4-6 day to start and increasing from there
- Daily collaboration with nursing to understand any changes or needs.
- In advance of the visit nursing will meet with the visitor to update and review resident wellness before the visit begins to ensure that understanding has occurred, to answer questions and offer support – this is scheduled at the time of appointment booking and a calendar is available to staff.

» How will the site monitor the visit to adhere with safety protocols (PPE use, hand hygiene, physical distancing)

- Recreation staff will schedule visits
- When scheduling visits, recreation will let visitor know that schedules will be confirmed the morning of the visit. If a change needs to occur, the visit will be rescheduled
- Recreation staff will greet visitor and complete screening process including hand hygiene, physical distancing, PPE use
- Rec staff will be available to support, advise and interrupt or modify the visit if necessary

» How will locations be assigned and can physical distancing be accommodated? What cleaning tasks are required between appointment times (outdoor, indoor designated locations or individual single-client room)

- Primary visiting location will be outside on the patio in a covered area with access to heat, water, garbage, Kleenex etc.
- All products for the visit will be removed and replaced with sanitized products between visits. Front tent area outdoors
- Inside space, within a separate area, is available for particular visits where the outside is not deemed suitable, this space will be supported as mentioned above
- Navigation tools such as arrows and social distancing Orange hearts painted to illustrate physical distance
- Between appointments Rec staff will disinfect (using appropriate products) all touch points as well as remove any garbage left and restock water bottles

» Adequate Signage to identify visiting rooms and spaces

- Signage to identify visitor parking
- Arrows directing to 'Heart Park'

» Documentation: Outlines where the decision making and process will be documented and stored AND the plan must be available for Licensing or Assisted Living Registrar if requested

- Recreation and nursing will have list of residents + their designated visitor
- Recreation and nursing will have visit schedule

Plan for Review Process

» Review of site Social Visitation Process: Who will do this and how frequently (should be at least monthly)

- Operational Leadership weekly – updates given by Recreation Coordinator

» Managing Complaints are indicated in the plan (Local management escalating to PCQO-Island Health, Licensing and/or AL registrar)

- Feedback directed to Recreation staff > rec coordinator > Nursing/Leadership > PCQO-
Island Health
- IH complaints Flow chart

Pre-Visit, Visit and Post-Visit Process

Pre-Visit

» Visitor Screening at Greeter Station (must comply with facility policy)

- Rec will give information to visitor and generally pre screen at time of booking
- On site-'wait at the gate' Footprints security at gate use approved greeter questions and temp scan

» Visiting Location is cleaned prior to visit and how this will be identifiable

Cleaned & ready to go sign – laminated, flipped to appropriate side when ready to be used

» Communication process to resident and visitor prior to visit

See Visiting plan – given to resident @ designate decision discussion, and to visitor upon arrival

» Process of how visitors will be instructed re: hand hygiene, personal protective equipment, respiratory etiquette and safe physical distancing

» Visitor List with Contact Information (Phone number or email for Public Health Contact Tracing)

- Pre screening and education at time of booking
- Reiterated and supported at the beginning of the visit
- Visitors will have secondary screening by rec staff prior to visit
- Mask & education re: proper use of PPE, both donning and doffing
- Hand hygiene
- Respiratory etiquette
- Physical distance
- Name & contact taken for contact tracing

Visit requirements

» Completion of required screening on arrival
» Visitor must go directly to location for visit
» Visits are limited to 90 minutes
» AL: one visit per day unless essential visitor, operator & AL CHS to determine
» LTC: # of daily, weekly visits based on operations and ability to accommodate safely
» PPE: Mask provided by visitor to be worn for duration of visit (note: Island health reviewing possible supply of Medical Grade Masks TBD). For outside visits, mask to be worn if unable to maintain 2m physical distance
» Minimize physical touching

Post Visit Requirements

» Visitor must leave facility immediately after visit

Visitor will be shown how to properly dispose of their mask and PPE, as well as hand hygiene before leaving

» Infection control processes outlined (i.e. Process of supporting visitors off site, doffing PPE appropriately and hand hygiene and cleaning post visit)

- PPE disposed of appropriately
- Recreation staff to clean and disinfect area
- Signage to show when area is clean and ready to go

For AL:

Decision Making

» As per the BC CDC and Ministry of Health Guideline, the decision of who the designated visitor will be must be done in a collaborative manner (care team must include resident/family +/- health care rep or TSDM)

» Plan reflects resident as primary decision maker for determining designated visitor unless they have been deemed incapable of making the decision of who their visitor should be and/or if they want to include their family, health care rep or TSDM

- Recreation Coordinator and Admin assistant will facilitate the visiting guidelines in AL in collaboration with others as appropriate
- Recreation staff and admin assistant will connect with residents about designating their visitor in collaboration with other as appropriate
- Those unable to decide – will work with specific needs of Villager and maintain privacy and confidentiality while problem solving

» Designated Visitor will be one single person (no changes to occur)

» Communication re: expectations be provided to resident and family (verbal & written), outlining the following:

- Importance of facilitating designated visits.
- Collective Risk (i.e. health and safety for COVID-19 transmission for residents and visitors)
- Collective Accountability and commitment to adhering to agreed guidelines to reduce risk for other visitors/residents/care providers
- That the site is committed to maximizing designated visits within the stated safety guidelines.

- See Visiting Guidelines KV AL

Operational Considerations: Does the plan reflect the below:

» How many visitors will be approved per day into the site (how to consider doing this safely)

- Start with 4 – 6 and increase from there – dependent on length of time booked and desire of the Villager/family
- Give choice of 30 or 60 minute visits

» How to balance essential visitors and social visitors (does it consider as well essential visitor as one in the same?)

- Meaningful matching of Villagers with varying and fluctuating needs- work with wider housing teams to establish the difference between social visiting and essential visiting- changes in health status or desire to decline/change mind re a visitor will be discussed at daily huddles
- Staff will understand and collaborate with recreation specific or unique family dynamics to support personal choices that reflect the Villager preferences and needs first before the needs of the resident

» What additional financial support is required to safely manage the agreed number of visitors at one time?

- # of FTE's –

- 1.3 FTE
- Adult Day Program recreation staff have been redeployed to Villager services and will be supporting the visiting guidelines and process
- This supports 7 day per week visiting (1.3 FTE)
- Should ADP re open then an additional FTE would be required to continue to support this service as rec ADP would return to deliver therapy ADP clients

- Type of position(s) – **Rec staff schedules, screens, cleans in between visits**
- Annual cost including benefits for each position –n/a until ADP reopens
- Environmental Adaptation costs
- Screen tent-heaters- aesthetic enhancements to visiting space (heart

» Process of determining whether visits can occur on a given day if local circumstances indicate increased temporary risk (eg, active outbreak or potential, inadequate staffing to supervise)

- There is at least 1 staff member 7 days/week to facilitate visits
- Active outbreak = visits cancelled
- Villager on precautions = visit cancelled
- Villager is unwell = visits rescheduled or rerouted to essential (palliative)
- Each visit will be reviewed in advance by rec/admin assist working with housing teams to ensure appropriate steps are taken and avoid miscommunication
- Rec-admin asssit will connect with visitors to address and changes or questions

» Process for scheduling visits: How appointments will be booked while considering the number of people the site can safely support

- Villagers/family/friends in AL-IL-SL call 250- 753 6471 ext 1 (Villager Wellness Line) hotline to book appointments for 'heart park' visits and be pre screened
- 4-6 day to start and increasing from there
- Daily collaboration with housing team to understand any changes or needs

» How will the site monitor the visit to adhere with safety protocols (PPE use, hand hygiene, physical distancing)

- Recreation-admin assist staff will schedule visits
- When scheduling visits, recreation will advise that schedules will be confirmed the morning of the visit. If a change needs to occur, the visit will be rescheduled
- Staff will greet visitor and complete screening process including hand hygiene, physical distancing, PPE use
- Rec and security staff will be available to support, advise and interrupt or modify the visit if necessary

» How will locations be assigned and can physical distancing be accommodated? What cleaning tasks are required between appointment times (outdoor, indoor designated locations or individual single-client room)

- Primary visiting location will be outside on patios in a covered area with access to heat, water, garbage, Kleenex etc.
- All products for the visit will be removed and replaced with sanitized products between visits.
- No Inside space at this time other than essential visits
- Navigation tools such as arrows and social distancing Orange hearts painted to illustrate physical distance
- Between appointments staff will disinfect (using appropriate products) all touch points as well as remove any garbage left and restock water bottles

» Adequate Signage to identify visiting rooms and spaces

- Signage to identify visitor parking
- Arrows directing to 'Heart Park'

» Documentation: Outlines where the decision making and process will be documented and stored AND the plan must be available for Licensing or Assisted Living Registrar if requested

- Staff will have list of residents + their designated visitor
- Staff will have visit schedule

Plan for Review Process

» Review of site Social Visitation Process: Who will do this and how frequently (should be at least monthly)

Operational Leadership weekly – updates given by Recreation Coordinator-manager of community engagement-admin assist

» Managing Complaints are indicated in the plan (Local management escalating to PCQO-Island Health, Licensing and/or AL registrar)

- Feedback directed to Recreation staff > rec coordinator > Leadership > PCQO-Island Health
- IH complaints Flow chart
- Internal site complaints flow chart

Pre-Visit, Visit and Post-Visit Process

Pre-Visit

» Visitor Screening at Greeter Station (must comply with facility policy)

- Rec will give information to visitor and generally pre screen at time of booking
- On site-'wait at the gate' Footprints security at gate use approved greeter questions and temp scan

» Visiting Location is cleaned prior to visit and how this will be identifiable

Cleaned & ready to go sign – laminated, flipped to appropriate side when ready to be used

» Communication process to resident and visitor prior to visit

See Visiting plan – given to Villager @ designate decision discussion, and to visitor upon arrival

» Process of how visitors will be instructed re: hand hygiene, personal protective equipment, respiratory etiquette and safe physical distancing

» Visitor List with Contact Information (Phone number or email for Public Health Contact Tracing)

- Pre screening and education at time of booking
- Reiterated and supported at the beginning of the visit
- Mask & education re: proper use of PPE, both donning and doffing
- Hand hygiene
- Respiratory etiquette
- Physical distance
- Name & contact taken for contact tracing

Visit requirements

» Completion of required screening on arrival
» Visitor must go directly to location for visit
» Visits are limited to 90 minutes
» AL: one visit per day unless essential visitor, operator & AL CHS to determine
» LTC: # of daily, weekly visits based on operations and ability to accommodate safely
» PPE: Mask provided by visitor to be worn for duration of visit (note: Island health reviewing possible supply of Medical Grade Masks TBD). For outside visits, mask to be worn if unable to maintain 2m physical distance
» Minimize physical touching

Post Visit Requirements

» Visitor must leave facility immediately after visit

Visitor will be shown how to properly dispose of their mask and PPE, as well as hand hygiene before leaving

» Infection control processes outlined (i.e. Process of supporting visitors off site, doffing PPE appropriately and hand hygiene and cleaning post visit)

- PPE disposed of appropriately
- Recreation staff to clean and disinfect area
- Signage to show when area is clean and ready to go

As per the policy, essential visits can include, but are not limited to:

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

- Existing registered volunteers providing the services described above.
- Visits required to move belongings in or out of a client's room.
- Police, correctional officers and peace officers accompanying a patient/client for security reasons.
- Essential visits can occur with a COVID+ patient or client.
- Essential visits will be limited to one visitor per patient/client within the facility at a time. A visitor who is a child may be accompanied by one parent, guardian or family member.
- All visitors will continued to be screened for signs and symptoms of illness, including COVID-19, prior to every visit.
- Visitors with signs or symptoms of illness, as well as those in self-isolation or quarantine in accordance with public health directives, will not be permitted to visit.
- Visitors will be instructed when to perform hand hygiene, respiratory etiquette and safe physical distancing.
- Visitors will be instructed on how to put on and remove any required PPE when visiting or caring for patients/clients who are on Droplet and Contact precautions. If the visitor is unable to adhere to appropriate precautions, the visitor will be excluded from visiting.
- Visitors will go directly to the patient/client they are visiting and exit the facility directly after their visit.
- Virtual visitation is strongly encouraged and should be supported where in-person visitation is not possible.

This family and visitor policy will be posted on the Kiwanis Village Website as well as the Staff Access Portal. This family and visitor policy, and all related expectations, will be communicated in plain language to visitors prior to arrival or upon arrival at the facility. Family and visitors not deemed essential who wish to have an immediate review of the decision will be provided the

ability to speak with an administrator or administrator on call. Family and visitors can request a formal review of a decision through the health authority Patient Care Quality Office (PCQO). If you have already been to the PCQO and are not satisfied, you can request a review of concerns from the Patient Care Quality Review Board contact@patientcarequalityreviewboard.ca 1-866-952-2448

Please note that orders from the Provincial Health Officer or a Medical Health Officer take precedent over this policy.

AL and LTC Entry Screening

RESIDENTS, VISITORS AND STAFF: As of March 13, 2020, every building at Kiwanis Village Nanaimo has posted at entrance the Long Term Care Essential Visitors Only Poster (Appendix B), in response to the letter directing only essential visitation, written by Dr. Bonnie Henry (Appendix C). Long Term Care is locked and provides no access to any person without authorization. Once within the buildings, visitors must screen and sign a log as they enter and exit the building.

As of April 23, 2020, there is a staff person assigned to completing staff temperature screening.

As of June 30, 2020, the public health orders have changed to allow for nonessential visits in AL, with various guidelines to ensure safety. Kiwanis Village is submitting its LTC and AL visiting plan to Island Health on July 10, 2020, and the visiting guidelines will be updated upon approval of our plan.

Screening Tool

The Staff/Visitors/Contractors Screening Tool Used for COVID-19 is found in Appendix D. It was initiated on March 13, 2020. All visitors, staff and contractors are screened with questions seen in Appendix D.

Please also see Appendix E for Staff Temperature Tracking Sheet

Ongoing Screening of Residents

In Long-term care, residents are screened twice daily for symptoms, following a formal monitoring process that is documented (see Resident Screening/Temperature Log Sheet in Appendix F).

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

1. Influenza-like illness (ILI):
- New or worsening cough with fever (>38oC) or a temperature that is above normal for that individual and one or more of the following:
• Sore throat,
• Arthralgia (joint pain),

• Myalgia (muscle pain),
• Headache,
• Prostration (physical or/and mental exhaustion).

2. Respiratory infection:
- Includes new/acute onset of any of the following symptoms*:
• Cough** (or worsening cough),
• Fever,
• Shortness of breath,
• Sore throat,
• Rhinorrhea (runny nose).
* Does not include ongoing, chronic respiratory symptoms that are expected for a client, unless those symptoms are worsening for unknown reasons.
** Cough that is not due to seasonal allergies or known pre-existing conditions.

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

4. Other atypical symptoms associated with COVID-19:
- Includes, but not limited to:
• Nausea/vomiting,
• Diarrhea,
• Increased fatigue,
• Acute functional decline,
• Loss of smell and/or taste.

For all residents in Assisted and Supportive Living, they have been provided with documentation of all the symptoms to monitor for, and can either alert staff via pendant press, phone call, or by a notice on their door, if they are experiencing symptoms. CHWs (Home and Community Care Community Health Workers, who are Island Health staff) and Kiwanis staff are also maintaining the usual “watchful eye” over this group to monitor for symptoms and these are reported to the Home Support Supervisor (by Island Health staff) and the Hospitality Services Coordinator or Manager on Call (by Kiwanis Village staff) for immediate action for further screening.

Hand Hygiene

Hand hygiene is everybody’s responsibility: staff, residents, visitors and volunteers. Hand hygiene is the most effective way to prevent the transmission of microorganisms. Compliance with hand hygiene recommendations requires continuous reinforcement.

- ABHR with at least 60% alcohol by volume or soap and warm water are accepted methods of hand hygiene.
    - soap and water is required if hands are visibly soiled
    - ABHR is recommended at “point of care” places in resident care areas
- Residents who are able to participate in self-care are taught, encouraged and reminded of the importance of hand hygiene before eating or preparing food, after using the toilet or other personal hygiene activities, before leaving their homes for common/public areas and when returning home from public places.

- Residents who are unable to assume responsibility for self-care are assisted in performing hand hygiene whenever their hands are soiled or may be contaminated, and as recommended above.
- Healthcare professionals (HCPs) use single-use disposable paper hand towels to dry hands, not multi-use hand towels.
- Plain soap is used for handwashing.

Hand Hygiene is mandatory before and after all resident care
Examples when hand hygiene must be performed:

- Before any sterile procedure
- Before preparing medications
- Before starting work and before leaving the work area
- Before direct resident care
- Before handling food, feeding or assisting in the feeding of residents
- When necessary during resident care to prevent spread of organisms to other body sites.
- When hands are visibly soiled.
- Before and after eating, drinking, smoking, handling personal care products.
- Before and after contact with open areas, urinary catheters, respiratory suctioning equipment, or any invasive procedure, even though gloves have been worn.
- After providing care to any resident regardless of whether gloves are worn;
- After contact with the resident's personal environment area regardless of whether gloves are worn.
- Immediately following removal of gloves.
- After using the toilet.

Use a hand lotion frequently to maintain skin integrity. Cover any open lesion on hands with an occlusive (air and water tight) bandage before starting work. If the lesions are extensive, the caregiver should consult with his or her physician or occupational health service about appropriate coverage of the affected area, or exclusion from the work setting.

Controls Specific to Hand Hygiene

Hand Hygiene - Staff

ABHR (Alcohol-Based Hand Rub) is installed at the entrance/exit to each building, floor, dining room, within each Nursing Station, and throughout hallways.

Handwashing soap and dispensers are located in each resident room, together with a sink. We have a large number of installed ABHR dispensers. At this point, we are awaiting delivery of additional ABHR dispensers to install them in every resident room.

Hand hygiene posters (e.g. CDC Reference; Appendix G) are displayed in each public washroom above the sink.

Staff orientation for new employees includes, as of March, 2020, an infection control component where the infection transmission process, infection/exposure controls are reviewed and proper

handwashing is demonstrated and applied by all staff. Due to social distancing, we have changed the structure of new employee orientation.

We now have an identified RN, who is our MSIP and Infection control/Covid Coach for LTC and AL. She is assigned to spend onboarding time to train MSIP, hand hygiene, and infection control to new staff members - this will be documented as it occurs when staff are hired. As of April 28, 2020 she has implemented hand hygiene reminders as part of her coaching rounds for all LTC staff.

Kiwanis Village Nanaimo has a long-term documented and shared practice of completing within Kiwanis Lodge a minimum of 25 audited observations per month, where staff hand hygiene is monitored and if necessary, corrected with training for proper technique. Our Registered Nurses are responsible for completing these audits monthly and reports are provided to the Director of Care. The appropriate Manager provides follow-up for any staff person that has recurring issues maintaining appropriate hand hygiene. Kiwanis Village has recent documented performance management conversations in respect to hand hygiene.

Hand Hygiene - Residents

Staff use hand washing for residents, and ABRH for those that will not tolerate handwashing, prior to each meal and activity.

The LPN's on each floor plan to continue to support able residents, with completion and documentation by May 5, 2020, to learn appropriate hand hygiene and respiratory etiquette (see below).

Respiratory Hygiene (also known as Respiratory/ Cough Etiquette)

By May 5, 2020, long-term care residents will be taught by LPNs (see above in Hand Hygiene) how to perform respiratory hygiene practices (e.g. coughing into sleeves, using tissues, wearing a mask), if physically/ cognitively feasible.

Residents with respiratory symptoms are asked to wear a mask (if tolerated) when HCPs, or other staff or visitors are present.

Point of Care Risk Assessment (PCRA)

Prior to every resident interaction, all HCPs have a responsibility to assess the infectious risk posed to themselves and others by a resident, situation or procedure. The PCRA is an evaluation of the variables (risk factors) related to the interaction between the HCP, the resident and the resident's environment to assess and analyze the potential for exposure to infectious agents and identify risks for transmission.

Control measures such as the use of personal protective equipment are based on the evaluation of the variables (risk factors) identified.

In reality, HCPs conduct general point of care risk assessments many times a day for their safety and the safety of others in the healthcare environment. For example, when they approach a resident they automatically note their mental status, ease of breathing, skin colour, etc. During a respiratory illness (RI) outbreak such as COVID-19 it is especially important that HCPs are vigilant in identifying risk of exposure to RI pathogens when assisting those who are acutely ill (e.g. fever, cough).

An infection control PCRA is simply an extension of this assessment.

Questions a HCP should ask themselves during a PCRA include:

- What contact am I going to have with the resident? (direct hands on care vs. no hands on care) (contact with mucus membranes or non-intact skin)
- What task(s) or procedures(s) am I going to perform?
- Is there a risk of splashes/sprays? Likely to stimulate a cough? Or gagging?
- If the resident has diarrhea, is she/he continent? If incontinent, can stool be contained in an adult incontinence product?
- Is the resident able and willing to perform hand hygiene? Respiratory hygiene?
- Is the resident able to comply with instructions?
- Is there personal protective equipment that I should put on prior to this task?

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

Droplet/Contact Precautions/ Respiratory Protection and Use of Personal Protective Equipment (PPE)

In addition to routine practices, Droplet and Contact Precautions must be implemented for symptomatic residents as well as for new admissions (14-days) and for any resident visits to hospital for procedures or urgent/acute care (14-days). This involves staff appropriately donning and doffing PPE. See correct procedure steps below.

On March 13, 2020, in coordination with their respective physicians, all residents' aerosols were discontinued and switched to puffers, which ensure Droplet and Contact precautions are adequate for all care (limits likelihood of need for Airborne Precautions).

On March 16, 2020, fit testing for N95 respirator masks was completed for RNs and LPNs. This will allow staff to practice Airborne Precautions should they become necessary for any patient care.

Surgical/procedural masks are effective at capturing droplets which is the main transmission route of Covid-19. For this reason, surgical/procedural masks provide adequate protection for health care workers caring for clients with Covid-19. On April 23, 2020, all staff were given appropriate PPE and informed that they must wear a surgical/procedural mask and eye protection for the full duration of their shift.

- Surgical/procedure masks should be changed if the masks become wet, damaged or visibly soiled.
- Surgical/procedure masks should be removed just prior to breaks or when leaving the facility.

Donning and Doffing PPE

On March 9, 2020, donning and doffing videos were installed on all on-site computers. Staff sign in books were circulated to various areas for staff to watch the videos and sign their completion of this education. A new cycle of sign-in books was circulated on April 20, 2020, when PPE usage changed (see below), and again as before, staff sign that they have watched these videos. As alterations to the use and availability of PPE evolve, staff are informed and re-educated on its use. This education is logged in our HR database.

Steps to Donning (putting on) PPE

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

Steps to Doffing (taking off) PPE

1. Gloves – Remember, the outside of gloves are contaminated. Grasp palm area of one gloved hand and peel off first glove. Slide fingers of hand under other glove at wrist and peel off. Discard in regular waste. 2. Gown – Unfasten ties, pull gown away from neck and shoulders, touching ONLY the inside of the gown. Turn gown inside out and roll into a bundle. Discard in regular garbage.
2. Hand hygiene – Clean hands and use a paper towel to touch the doorknob to exit the room. If paper towel is not available then clean hands again after leaving room before removing gown.

3. Eye protection (face shield or goggles) – Do NOT touch the front of them. Discard in regular garbage or put in receptacle for reprocessing.
4. Surgical/Procedural mask – Grasp ties or elastics at back and remove WITHOUT touching the front. Discard in regular garbage. 6. Hand Hygiene – Clean all surfaces of hands and wrists.

COVID-19 Pandemic: Special PPE Usage

The Ministry of Health for British Columbia released a document on March 25, 2020, *COVID-10 Emergency Prioritization in a Pandemics: Personal Protective Equipment (PPE) Allocation Framework.* This provides guidance to prioritize allocation of PPE. This document is being fully implemented, at a Stage 4 level of the PPE Framework, as of April 27, 2020.

As of April 20, 2020, we implemented messaging to staff via management and RNs doing rounds to share the information verbally, and posted it in writing on bulletin boards, that all HCPs whose roles require direct contact with patients, clients, and residents wear surgical/procedural masks when providing direct care to patients, clients and residents across Island Health (*Personal Protective Equipment*, Island Health, April 15, 2020). With some efforts to secure more PPE that are ongoing, we extended the provision of PPE on April 27, 2020 to include availability of surgical/procedural masks for all staff who are unable to maintain distance of 2 metres or greater from any other person during their shift. This information was shared again by staff leaders and management on rounds, and was provided in writing on April 30, 2020.

We recognize that donning and doffing PPE can feel exhausting and restrictive for staff. As of April 28, 2020, we have supported staff by promoting more rest breaks on shift, supporting staff to ensure hydration and nutrition and to seek us out for help and support if necessary.

Source Control

Source control includes engineering controls (e.g. use of partitions to establish 2 metre distance between residents with respiratory symptoms and others) and administrative controls (e.g. limiting access for visitors with respiratory symptoms). Applying administrative and engineering controls is the first strategy in protecting residents and HCPs from exposure to infectious agents in the LTC facility. During the week of 9th -13th March we commenced staff education related to Covid-19 in the form of daily huddle/staff report where information sharing occurred related to transmission, social distancing at work and at home, cough etiquette, and hand hygiene limits. On March 16th we closed the Village to all but essential visitors or contractors and increased staff education related to evolving information related to Covid-19.

Kiwanis Village Nanaimo has assessed the areas of our LTC home including the physical plan (e.g. all single rooms, ability to establish 2 metre distance between residents with respiratory symptoms and others) and the types of resident care activities undertaken in residential areas.

<u>Based on these and previous assessments, we have implemented a number of controls</u>:

On February 28, 2020, we posted information about COVID-19 from the CDC at staff entryways.

Week of March 9th to 13th: Completed a walkthrough to assess amount of ABHR and installed more; Completed a laundry walkthrough and created a plan to move personal laundry to floors, for implementation by mid-May; Assessed touchpoints at entry and exit points to determine which road access to leave open (one entry and one exit point by vehicle), where to direct staff entry (to one door only), where to direct resident entry (to one door only), and where to direct visitor entry (to one door only); Implemented all of the screening as described above; Assessed cleaning of touchpoints and implemented additional staff hours (see Cleaning and Disinfection of Equipment and Environments); redirected staff parking to accommodate best entry; implemented an extra cleaning audit for all staff (see Cleaning and Disinfection of Equipment and Environments); and emailed LPN floor leads to remind all staff to wash hands as residents come into dining rooms and prior to activity.

On March 12, 2020 we ceased Adult Day Program Services, in order to limit the number of site visitors who live in the community.

Our Respite Unit is located on the first floor of our Long-term care home. On March 13, 2020, we responded to the risk related to community-living clients and their caregivers coming into our long-term care unit, and have closed the Unit indefinitely.

On March 13, 2020, we increased the screening questions for staff who call in with symptoms, and we have provided our staffing and the RN on Call with the appropriate contact information for direction on testing or to request testing. Additionally, we have requested staff with unreported but visible symptoms leave the site and go for testing and have also conducted performance management where indicated.

On March 16, 2020, we secured full-time 24-hour support from Footprints security to monitor who is coming and going from the facility and to limit access as appropriate (see Screening).

On March 17, 2020, our Recreation team stopped doing group programs and started doing 1-1 support and changed to a Household Model for staffing (one Recreation employee per floor).

On April 2, 2020, we audited the dining rooms, following specific recommendations from the Dietitians of Canada and implemented steps to control distance of persons and to separate clean and dirty tasks.

On April 23 and 24, 2020, management provided an increase of appropriate Personal Protective Equipment for each staff member that they are required to be wearing at work when within 2 meters of another person.

On May 6, 2020, our front gate Footprints security guards started taking/recording temperatures along with asking the screening questions of all visitors.

On May 22, 2020, our maintenance team installed sneeze-guards, glass partitions, at the serveries on all floors in our LTC facility in order to further enhance infection control for food services.

On May 25, 2020, our HR department sent out staff surveys to get a general consensus on how staff were coping, how they felt about our current restrictions in place at Kiwanis, what they were doing to stay mentally and physically healthy, and how they envisioned the reopening of Kiwanis. We had a total of 121 staff responses. The results from the staff survey showed that 69% of staff were very satisfied with the current safety protocols in place, 92-100% were maintaining physical distancing, wearing a mask, avoiding gatherings and practicing diligent hand washing in order to stay healthy. 72% stated that they support the introduction of visiting hours at Kiwanis for residents and their families as long as it is safe, gradual and with precautions in place.

Resident surveys were also sent out on May 25, 2020. Out of 132 residents, 100 of them felt very satisfied with the current safety protocols in place. 93 residents stated they were doing very well with following the recommendations outlined by the Provincial Health Officer by ensuring physical distancing, good hand hygiene, avoiding gatherings and wearing a mask. The majority of residents also stated that they envision the reopening of Kiwanis to be slow, gradual and carefully done.

In June 2020, our management team worked with Food Service and Housekeeping employees to envision a Household Model where staff in these departments work on one resident floor per shift rather than on multiple resident floors. This is important for infection control and containment strategies. The Household model is also highly desirable due to high rates of satisfaction and measurable improvement for quality of life measures for both residents and employees when implemented. We are planning towards August/September implementation of the Household model on all floors and are regularly hosting management and employee departmental and committee meetings towards this outcome.

On June 29, 2020, we started doing resident care conferences with family via zoom and at times with the physicians on the phone.

Our Executive Director composes regular communications directed for staff, family, and residents, and these are emailed, posted to the web site and on Facebook as well as on our Covid-19 Bulletin Boards, and invite staff to bring all feedback and concerns. If staff have concerns about being exposed they are also invited to talk to their supervisor/manager. All staff can (and do) call the manager on call if preferred or necessary.

Staff with Special Circumstances

We have supported staff who are medically vulnerable to COVID-19 to work from home and/or to be off from work during this time to eliminate their risk of exposure in the workplace.

How Do We Determine the Effectiveness of our Controls?

It is important to determine how controls are working and whether they eliminate or minimize the risk of exposure. The COVID-19 pandemic has had a rapid onset globally and locally, with a short duration of scientific study of this condition from first known case (estimated date of November, 2019), and therefore as we learn more and public health experts provide guidance, there have been many changes, directives, and informational sharings that we have received from various credible sources (e.g. CDC, Public Health/MOH, Island Health LTC, Island Health AL, Assisted Living Registrar, WorkSafe BC, and BC Housing).

Utilizing existing communication methods within the Village we review all aspects of operations daily and share information within the JOSH-IPAC committee who meets monthly. We review and track staff and resident wellness working and living within the Village.

On March 28, 2020, all staff were informed regarding single site work, as a public health order is in place that prohibits people from working in more than one LTC site. 96% or higher of our staff have retained employment at Kiwanis Village when other LTC sites faced large changes in the size of their workforce.

- All members of the daily operations committee have regular interaction with frontline staff and have welcomed ongoing feedback as we have implemented many changes over a short amount of time. This occurs in person, through email, notices, memo's etc.
- Our Executive Director or designate does daily rounds at afternoon shift change, where she speaks to all staff present (see below) and provides the opportunity for regular feedback, with very little of a negative nature surfacing in these conversations.
- We have had no cases of COVID-19,
- Staff, residents, and families have repeatedly thanked us for our efforts and told us that what we are doing helps them to feel safe.
- We have received many questions but have NO written concerns of complaints from residents or staff related to our actions.
- Staff have high compliance with requirements.
- We review all feedback as we want to learn and grow as we navigate this new normal.
- We will implement a formal debriefing process for staff by the end of May 2020.

One of standard non-clinical Key Performance Indicators is staff attendance, measured via sick time, overtime, and workplace injury. We have recently been providing attendance management support to employees (e.g. February and March, 2020) and have seen a trend since that time where absenteeism rates are improving. We feel that particularly during a time of pandemic, this suggests that we have effectively supported a workplace that supports workers to feel safe and be well.

Communication with Staff

Our regular communication channels with staff include daily safety huddles, RN guidance for care and infection control, departmental staff meetings, assignment-specific staff meetings

(separated for LTC and Housing), sitewide staff meetings, email on-site, email to personal emails, and notes and notices in personnel folders and/or attached to paystubs. The largest communication disruption due to the pandemic has been the inability to hold departmental and assignment-specific staff meetings due to 2m distancing requirements. We have been navigating this challenge by having much more frequent one-on-one conversations with staff, including during the Executive Director's daily walkaround as described below. We have also been able to host some meetings by telephone and others using Zoom (web conferencing).

We understand our requirements with WorkSafe BC that any education and training that we provide staff must be robust and documented, and therefore documentation is now being implemented by the RN MSIP and Infection control/Covid Coach (see below) and we are in the process of implementing a Staff Access Portal.

Staff Access Portal

As we navigate these changes, we have identified that a web-based staff access portal will provide us with the opportunity to educate, train, and inform from a distance, while at the same time provide automatic tracking that staff are viewing the communications. We have been working with our website developers and IT team to build a highly secure staff portal that plugs into the back door of our website. This portal will be operational and in use for staff communication at the latest by May 15, 2020.

Responsibilities

Operations Meetings

We established an Emergency Operations Committee and staff roles within this that support information and communications, resident safety and security, Clinical Supports, a staffing team, equipment and supplies officers, and have held daily pandemic coordination meetings with a COVID-19 focus, since March 3, 2020 until June 2020, at 9:30am and 3pm daily. Since June, these meetings are now held weekly and as required. Managers have re-allocated time off to ensure weekend coverage and the ED is able to stay on site to provide support at any time. We disseminate and discuss any new information that we have received, discuss and troubleshoot any issues that have arisen within the last 24 hours, as well as implement strategic planning, health authority and public health directives, and provide daily reports. Reports at these meetings include: Number of staff ill and nature of illness; number of residents ill and nature of illness; admissions and discharges; vacancies; any tests for coronavirus that are pending, awaiting results, or confirmed results as available. Attendees participate in person and via telephone and web conference, and attendance varies yet includes: Executive Director, Director of Care, Registered Nurse, Manager of Community Engagement, Manager of Village Operations, Manager of Administration and Finance, HR and Payroll Clerk, Coordinator of Building Operations, Occupational Health and Safety members and the Hospitality Services Coordinator, with other invites as and when required. Minutes are kept and responsibility for action items is assigned at meetings. All staff and resident concerns that are unique to regular procedure and are special due to COVID-19 circumstances are forwarded to this group for

discussion and resolution. This group engages staff as much as possible in solution-finding, although with the ever-changing nature of operational practices since March, has also had to implement many practices with simple directives rather than engagement.

Board

The Board Promotes a culture of safety. The Board directs and encourages cultural change. The Board oversees quality and risk management, receives ED dashboard reporting, monitors clinical and non-clinical key performance indicators, and regularly discusses the related infection control and exposure control strategies. We held the April board meeting through webex. The ED provides written updates to the Board at minimum twice per month and where any new information or concerns arise related to our incident reporting and disclosure mechanisms.

Executive Director

Our Executive Director, Melanie Young, RN, facilitates the daily emergency operations meetings and is the person on site ultimately responsible for infection control practice decisions and for determining visitation and access to the site. In addition to responsibility for these meetings, she makes daily rounds to each floor to check in and update staff with new information. She also writes letters to residents and staff, to communicate operational changes and requirements (these are posted on the Covid-19 Information Board, our website, and circulated to residents as appropriate).

Supervisors and Managers

Managers and Supervisors have direct responsibility for meeting the requirements of contractual and licensing (LTC & AL) agreements, and of governing agencies (e.g. WorkSafe BC, Island Health, CDC, MOH, etc.).

Managers and Supervisors also have varied responsibilities as AL and LTC Operators, and the designated Operators are responsible for attending the LTC Operators meetings by teleconference (held at least twice weekly) and the AL Operators meeting (held at least once weekly) and receiving emails from Island Health, and to disseminate this information at the daily operations meetings, and to staff and others as appropriate.

Staff can report any concerns to their supervisor and/or manager. These concerns are brought to the Daily Operations Meetings.

Nursing staff-RNs/LPNs

LPNs are responsible for holding floor safety huddles/report at the start of every shift with their care staff to inform them of any new concerns regarding resident status, any admissions and/or discharges as well as which residents are on isolation precautions. This is where new information is shared from leadership related to changes, alterations, events etc and new information or education.

Assigned role: As of April 29, 2020 one RN checks weekly for updates and ensures this plan is updated accordingly, as well as distributes this updated information to the daily operations committee, to the RN on shift, and to our MSIP and Infection Control/Covid Coach. This RN checks: (1) the BC CDC website for updates, including to the *Infection Prevention and Control for Novel Coronavirus (COVID-19): Interim guidance for Long-term Care and Assisted Living Facilities: Provincial Coronavirus Response Mar. 13, 2020* and *COVID-19 Emergency Prioritization in a Pandemics: Personal Protective Equipment (PPE) Allocation Framework Mar. 25, 2020.*(2) as well as the web-based documents Guidance for Long Term Care Homes – Interim Guidance from the Public Health Agency of Canada and Clinical Management of Patients with Moderate to Severe COVID-19 - Interim Guidance for updates from the Public Health Agency of Canada; (3) for updates on the the BC Provincial website Health Resources Section: https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/current-health-topics/covid-19-novel-coronavirus; (4) and for the updates of other materials as listed as our guiding documents in the Introduction to this plan. This RN also sends any documents to the HR and Payroll Clerk for posting on the Covid-19 Information Boards for staff (one board is in the entryway to our LTC home and the second is at a central location within Kiwanis House).

Assigned role: As of April 23, 2020 one RN, is our MSIP and Infection control/Covid Coach for LTC and AL. In collaboration with the Executive Director and Director of Care, she has responsibility for receiving all information from the daily operations committee and Island Health and ensuring training and education to staff.

Joint Occupational Health and Safety and Infection Prevention & Control Committee (JOSH-IPAC)

The Occupational Health and Safety and Infection Control Committee meets monthly while ensuring social distancing to review identified risks and seeks additional input from other committees/ groups, including representation by Quality and Risk Management, Long-term Care Clinical Practice Committee, the wider management team, other representation from union, staff and/or external expertise. All staff are encouraged to report any unresolved risks to the committee via the JOSH-IPAC issue form. Updates are made to the plan as necessary, in accordance with lessons learned from implementation and evaluation. Also, the JOHS-IPAC bulletin board is updated monthly.

Accommodation

Any resident who is identified with respiratory symptoms is placed on additional (Droplet/Contact) precautions without delay. Kiwanis Village posts signage at the doorway that identifies the type of precautions and the PPE requirements for entering a symptomatic resident's room. In LTC an isolation cart is also placed outside the room with appropriate PPE. The resident is restricted to his/her room, including during meals and any other clinical or social

activity. Where residents are unable to understand the requirement to isolate in their room, one-to-one RCA care is implemented and/or increased surveillance as needed.

Laboratory Testing

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

On May 14, 2020 Dr. Bonnie Henry released a new order stating that LPNs are now allowed to perform Nasopharyngeal swabs without an order subject to the conditions below:

1. The Screening Activity must be performed in the course of providing a screening program approved by a medical health officer with responsibility for the geographic area in which the activity is performed.

2. The Screening Activity must be conducted in accordance with the guidelines issued by the BC Centre for Disease Control(the “Guidelines”) posted at the following website: http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/lab-testing

3. The licensed practical nurse’s employer or a medical health officer must first assess the licensed practical nurse’s competence to perform the Screening Activity in a manner that is safe for both the client and the licensed practical nurse, including by requiring the licensed practical nurse to demonstrate knowledge, in accordance with the Guidelines, respecting who to test, specimen collection and labelling, and the use of personal protective equipment. The licensed practical nurse’s employer may only make this assessment if the employer is a registrant, or is acting on the advice of a registrant, who has assessed the licensed practical nurse and who is authorized under a health profession regulation, and competent, to perform the Screening Activity without a client-specific order.

As of May 17,2020, one RN has started educating LPNs on how to perform a Nasopharyngeal swab collection so that they are trained in the event that a resident must be swabbed.

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

Contact Tracing

Contact tracing will be initiated if a patient tests positive for COVID-19, using CDC coronavirus tracking sheets for staff and residents.

Resident Transfer

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

Cleaning and Disinfection of Equipment and the Environment

Equipment is cleaned and disinfected after every use.

Additional Cleaning Assignments

Kiwanis Village has one role that is a 4-hour shift daily, which on March 12, 2020 we extended to an 8-hour shift daily to accommodate extra cleaning. Each shift, that environmental services worker has been assigned a cleaning routine that focuses on common room and entry-exit touchpoints, with special focus on areas that are accessed by staff. The housekeepers assigned to cleaning resident rooms have also been assigned extra cleaning with attention to common touchpoints in resident rooms.

Additional Cleaning Checklists

Increased frequency of cleaning high-touch surfaces in resident rooms and central areas is important for controlling the spread of microorganisms during a respiratory infection outbreak. We initiated extra cleaning checklists to all staff on March 12, 2020. These are completed during each shift to ensure cleaning of all surfaces during that shift. They are returned to the Manager of each department. These sheets are headed with a “Definitions” section that provides an explanation for the usage of each chemical/cleaner, as well as list that specifies the extra touchpoints that staff should attend to during each shift, and then a checklist follows that audits many essential cleaning tasks (see Appendix I). All resident room and central area surfaces, that are considered "high touch" (e.g. telephone, bedside table, overbed table, chair arms, call bell cords or buttons, door handles, light switches, bedrails, handwashing sink, bathroom sink, toilet and toilet handles and shower handles, faucets or shower chairs, grab bars, outside of paper towel dispenser) are cleaned and disinfected. Environmental staff wear the same PPE as direct care staff when cleaning and disinfecting resident rooms.

Special Cleaning for Presumptive or Diagnosed Covid-19 Cases and for Droplet Precautions

All reusable equipment is dedicated to the use of the resident with suspected or confirmed COVID-19 infection. When this is not feasible, equipment is cleaned and disinfected with a

hospital grade disinfectant before each use on another resident. Single-use disposable equipment and supplies are discarded into a no-touch waste receptacle after each use.

During droplet precautions, the isolated resident's room is cleaned twice per day with particular attention to touchpoints (see checklist in Appendix I). Our cleaning protocol for cleaning of residents' rooms after end-of-tenancy is utilized following discontinuation of Droplet and Contact precautions. Unused toilet paper and other disposable supplies are discarded.

All surfaces or items, outside of the resident room, that are touched by or in contact with staff (e.g. computer carts and/or screens, medication carts, charting desks or tables, computer screens, telephones, touch screens, chair arms) are cleaned and disinfected at least daily and when soiled (see checklist in Appendix I). Staff ensure that hands are cleaned before touching the above-mentioned equipment.

Chemicals Used

Oxivir – a disinfectant solution with Hydrogen peroxide that is used to sanitize non-porous surfaces that are not food contact areas. Housing: Diluted solution is dispensed into buckets and used with microfiber cloths. Lodge: Diluted solution is dispensed into pull wipe bucket pails with a lifespan of approximately 7 to 10 days.

Oxivir TB wipes – a disposable wipe that is purchased pre-mixed and comes in a wipes container.

Viper – sanitizing/cleaning chemical used in food contact areas. Viper is a no-rinse solution. Housing: these are dispensed as wipes in a container, and you can use the wipes. Lodge: Viper is dispensed as a diluted solution and used with a spray bottle or pails with cloths. As extra wipes become available through ordering we will also distribute these in the Lodge.

These chemicals each have a Drug Identification Number (DIN) on the label and are effective against enveloped viruses (e.g. influenza). Product instructions are followed for dilution and wet contact time. PPE usage for chemical use is identified in the SDS binder and is discussed during orientation of all new employees. Visibly soiled surfaces are cleaned before disinfecting (unless otherwise stated on the product instructions).

Visitors

Since February 28, 2020, sign in instructions have been posted requiring visitors to screen for symptoms and to not enter the site or building with these symptoms (see the BCCDC Health Professionals Page for signage). At this time, only essential visitors are permitted. If an essential visitor has symptoms or diagnosis of COVID-19, they are instructed to stay away until 14 days after their illness begins or once they no longer have symptoms. For those who are diagnosed positive, they may not return until they have had 2 negative tests taken 24 hours

apart, or after 14 days. If an ill visitor is allowed to visit for compassionate reasons, the visitor must wear a mask at all times, and practice fastidious hand hygiene when in the facility.

Social Activities and Outside Appointments

If a LTC resident has respiratory symptoms, all social activities and outside appointments are postponed unless medically necessary (See Resident Transfer). Symptomatic residents remain in their room and do NOT participate in group activities.

Reporting

Notify the Registered Nurse (LTC) or the Manager on Call (Other Housing) of residents with symptoms of COVID-19. The Registered Nurse in LTC will notify Public Health of suspected or confirmed cases of COVID19, as well as Island Health; the Manager on Call will notify Public Health in Housing, as well as Island Health for Assisted Living Residents. If there is no ability to contact one of the above, the LPN in charge will call the Communicable Disease Unit at our local public health unit.

See Appendix J: Outbreak Protocol for Covid-19.

Appendices

Appendix A: Visitor Sign-in Sheet and Screening Questions

Special Access: Kiwanis Village - Persons Who Have Been Permitted Site Access

What follows are screening requirements of the BC Ministry of Health and Island Health

By signing below upon entering this site, I am also acknowledging that the following statements are true:

1. I do not have any of the following symptoms: fever and/or chills; new or worsening cough (excludes allergies); stuffy or runny nose; muscle aches; sore throat; loss of appetite; painful swallowing; headache; difficulty breathing; loss of sense of smell or taste; diarrhea; conjunctivitis (pine eye); nausea and/or vomiting; abdominal pain (new or undiagnosed); fatigue; skin rashes or discoloration of fingers and toes.
2. I have not visited an international destination within the last 14 days;
3. I do not have children accompanying me, and realize that chidlren are restricted from Kiwanis Village;
4. I have not had close contact with a confirmed case of COVID-19;
5. I have not had close contact with a person experience the symptoms from Question #1;
6. I have allowed the security guard to take my temperature and it is below 37.9 degress Celsius. (Record Temperature)

Date	Full Name	Phone Number	Purpose of Visit	Signature	Temp

Appendix B: Long Term Care Essential Visitors Only Poster

Appendix C: Assisted Living Entry Letter from Dr. Bonnie Henry

BRITISH COLUMBIA

March 17, 2020

Dear Stakeholder:

The focus in BC continues to be to contain the spread of COVID-19 in our communities and at a provincial level. The majority of people who become infected with COVID-19 will experience a mild illness that will not require medical care, but those who are vulnerable to the disease – those who are elderly or who have underlying conditions that compromise the immune system – are at risk for severe illness.

To protect those most vulnerable, **I am advising Long-Term Care Facilities to restrict visitors to essential visits only**. Restricting visitors will minimize the risk of the introduction of COVID-19 into facilities and allow staff to focus on caring for residents, rather than monitoring and screening visitors. Effective immediately, visits to Long-Term Care Facilities in BC will be restricted to essential visits only. Examples of essential visits include, but are not limited to:

- visits for compassionate care (end of life and critical illness)
- visits considered paramount to resident care and well being, such as assistance with feeding or mobility
- existing registered volunteers providing services as described above only

This restriction to essential visits only allows health authorities and operators some implementation flexibility to ensure vital resident needs can continue to be met, while still applying a serious lens. There is a recognition that, at this time, stricter limitations on visitors has the potential to increase anxiety for residents and families, as well as put additional pressure on health care workers where families provide invaluable support with activities of daily living and non-clinical care to support their loved ones – however, in an effort to control transmission, it is essential.

Current direction/guidance regarding visitors to Long Term Care Facilities still applies to essential visitors:

- Increased communications and signage in facilities on infection prevention
    - Do not visit if you've travelled outside of the country;
    - Stay away if you're sick;
    - Wash your hands;
    - Visit in small groups and directly in resident rooms, rather than common areas.
- Early assessment and isolation of anyone experiencing symptoms
- Additional cleaning and disinfecting

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As per the Infection Prevention and Control Outbreak Protocol for COVID-19, in the event of an outbreak in a care facility, this direction changes and restricts visitors to Long Term Care Facilities in accordance with advice and direction from the local Medical Health Officer.

We expect that transmission of COVID-19 will continue to increase in the province and are providing direction and advice in response to the situation as it evolves in an effort to slow transmission and protect those most vulnerable to serious illness.

Please continue to monitor the BC Centre for Disease Control website on COVID-19 for updates, information, and resources: www.bccdc.ca/covid19.

Sincerely,

Bonnie Henry
MD, MPH, FRCPC
Provincial Health Officer

Appendix D: Staff/Visitors/Contractors Screening Tool Used for Covid-19

COVID-19 Script for Facility Greeters

Please complete the 2-step screening questions for all persons entering building (i.e. visitors, staff and contractors)

island health

Step A: Screening Questions for EVERYONE – Illness/Travel/Close Contacts (children and youth excluded from visiting at this time)	**Yes**	**No**
1. Do you have ANY the following symptoms **(even if mild):** □ Fever &/or Chills □ Stuffy or Runny Nose □ Sore Throat □ Painful Swallowing □ Difficulty Breathing □ Diarrhea □ Nausea &/or Vomiting □ Fatigue □ New or Worsening Cough (excludes allergies) □ Muscle Aches □ Loss of Appetite □ Headache □ Loss of Sense of smell or taste □ Conjunctivitis (pink eye) □ Abdominal Pain (new or undiagnosed) □ Skin rashes or discoloration of fingers or toes ***IF YES → Direct person to put on a mask, leave and call* 1-844-901-8442 or *811 for assessment & testing.***		
2. Have you traveled outside of Canada within the last 14 days? ***IF YES & STAFF → Direct person to wash hands and wear surgical mask (can wear same mask entire shift as not visibly soiled, damp or damaged).***		
3. Have you had close contact with a confirmed case of COVID-19? ***IF YES & STAFF → Clarify, the confirmed case is a patient/resident while wearing PPE*** ***IF Yes to PPE → Direct person to wash hands and wear surgical mask***		
4. Have you had close contact with a person experiencing new respiratory symptoms (i.e. fever, cough, shortness of breath, sore throat or runny nose excludes allergies)? ***IF YES & STAFF WITHOUT any respiratory symptoms → Staff member should wash hands and put on surgical mask.***		
5. Is the purpose of your visit valid? (i.e. work, approved Designated or essential visitor)		
6. FOR STAFF: Are you adhering to the single site order?		

Answer to Questions Must Match Highlighted Yellow, unless otherwise specified in body of question

Step B: Temperature Screening for all those who have passed part A	**Yes**	**No**
• Is the temperature normal? (i.e. less than or equal to 37.8°C or 100.04°F) ***IF TEMPERATURE IS 37.9.0°C or above → Direct to wash hands, put on surgical mask, leave site & call 811*** ***For staff → call* 1-844-901-8442**		

If you determine a person cannot enter the building and there are any further questions, please consult with charge nurse or manager on site.

EVERYONE must clean their hands with Hand Sanitizer before entering the facility AND wear appropriate personal protective equipment (i.e. mask or as directed by staff)

Appendix E: Staff Temperature Tracking Sheet

KIWANIS VILLAGE COVID-19 TEMPATURE LOG

May-20	1	2	3	4	5	6	7
Staff Name							
(Names removed for confidentiality purposes)							
CASUALS							
SIGNATURE							
DAYS							
EVENINGS							
NITES							

REVIEWED BY: _____ **POSITION** _____

REVIEWED BY: _____ **POSITION** _____

REVIEWED BY: _____ **POSITION** _____

Appendix F: Residents Screening/Temperature Log Sheet

KIWANIS VILLAGE NANAIMO

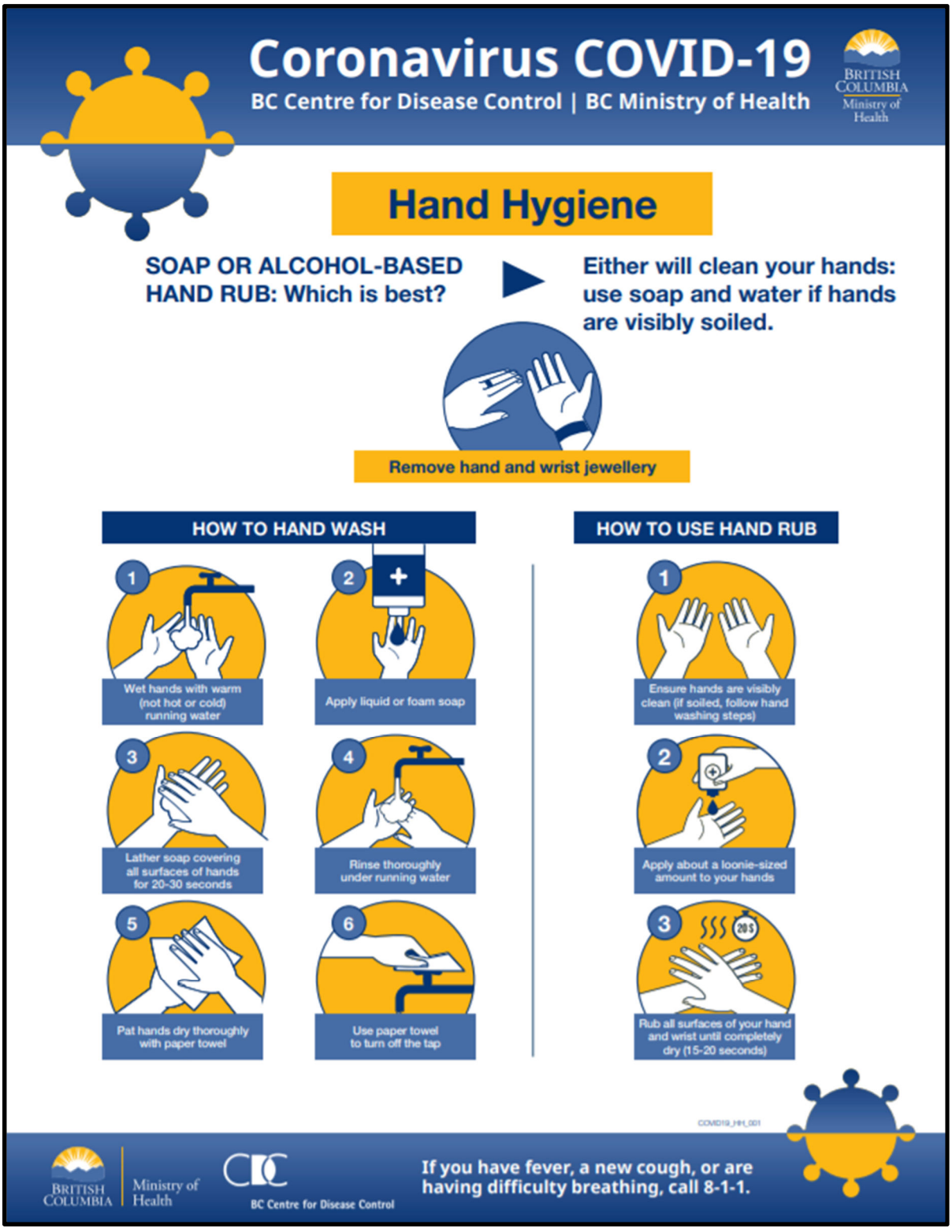
Resident Name	LTCF COVID-19 MONITORING PROTOCOL Every Resident requires ROUTINE monitoring by screening them for respiratory symptoms and obtain a temperature TWICE daily Baseline Temp	Room Number	Respiratory Screen (Positive or Negative)	Temp (°C)	Comments/Notes
[redacted]					

Details removed for Confidentiality

CHART IN PCC

Created March 27 2020

Appendix G: Proper Hand Washing Technique Poster



Appendix H: Instruction on how to collect a Nasopharyngeal Swab

- Review the latest BCCDC PHL COVID-19 Guidance for Testing (see the BCCDC Health Professionals Page).
- Assemble supplies;
  - USE the recommended collection devices that are routinely used for NP swabs for Influenza or other respiratory virus testing
  - Requisition and label, biohazard bag.
- Wash hands
- Put on PPE (gown, gloves, surgical/procedural mask with eye protection (face shield or goggles) to protect yourself if the patient/resident coughs or sneezes while you are collecting the specimen.
- Explain procedure to resident/patient.
- If the resident has a lot of mucous in their nose, this can interfere with the collection of cells. Ask the resident to use a tissue to gently clean out visible nasal mucous before a swab is taken. Respiratory viruses are located in cells that line the surface of the nasal cavity and are shed into respiratory secretions.
- Seat resident in a high-fowler's (70^0) position in bed with the back of the head supported. It may be necessary to have a second person available to assist with collection.
- Use the same collection devices that are routinely used for NP swabs for influenza or other respiratory virus testing and with a slow, steady motion along the floor of the nose (straight back, not up the nose) advance the swab until the posterior nasopharynx has been reached (distance from nostrils to external opening of ear). If nasal mucosa is swollen, rotating the swab during insertion may facilitate entry.
  - Place a finger on the tip of the patient/resident's nose and depress slightly once resistance is met (the swab should pass into the pharynx relatively easily), rotate the swab twice and allow it to remain in place for a few seconds to absorb the sample, then withdraw the swab.
- Place in the tube of transport medium (check with your local policy for sending specimens). Break the shaft of the swab at the constriction, and screw on the lid without cross-threading.
- Label the swab with 3 patient identifiers, and indicate "NP Swab".
- Remove PPE according to the steps of doffing (taking off) PPE. Ensure attention to hand hygiene.
- Complete the Virology Requisition form requisition indicating the tests requested and write COVID-19 testing is being requested, OR add a special label to the requisition indicating the need for COVID-19 testing.
- Ensure that the patient identifiers and ordering physician are correct.

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

Appendix I: Special Infection Control Precautions: Required Cleaning Procedures

Definitions

Oxivir – a disinfectant solution with Hydrogen peroxide that is used to sanitize non porous surfaces that are not food contact areas. Housing: free-poured into buckets and used with microfiber cloths. Lodge: Dispensed into pull wipe bucket bails with a lifespan of approximately 7 to 10 days.

Oxivir TB wipes – a disposable wipe that is purchased pre-mixed and comes in a wipes container.

Viper wipes – sanitizing/cleaning wipe used in food contact areas.

Personal protective equipment - Personal protective equipment, commonly referred to as "PPE", is equipment worn to minimize exposure to viruses, bacteria, and hazards. It includes disposable aprons/gowns, gloves, masks, visors/goggles, and booties.

Touch points- areas that are touch frequently by the public, residents or staff hands such as light switches, handles, key pads, elevator buttons, telephones, paper towel dispensers, hand soap dispensers, mail boxes, and handrails.

Food contact areas- areas where there is a possibility that food may touch a surface. These areas require special chemicals because chemicals can transfer to the food and then be ingested (e.g. table, counter, shelving, and prep areas)

All Staff & Nursing/Care Staff

- **Wipe down touch points in office areas with Oxivir.**
- **Wipe down kitchen and any food contact areas with Viper wipes (counters)**
- **Remove any garbage accumulation to dumpsters.**
- **Wipe down touch points with Oxivir TB (keys, med carts, telephones, printers, filing cabinets, keyboards, desk surfaces, chair arms, railings, light switches and door handles)**
- **Do not share food with residents or with other employees**
- **Reminder to sanitize your personal dishes (e.g. coffee cups) regularly**
- **Wear PPE as required, including when entering a room on isolation or when entering any outbreak area.**
- **Support residents to declutter – infection control cleaning is more successful when horizontal surfaces are free of objects.**

Daily Checklist **Date: _____**

Area	Initial as Completed			Comments
	Day	Evening	Night	
Nursing Areas				
Telephones				
Desk surfaces				
Desk items: pens, staplers, tape dispensers, etc.				
Keyboard				
Printer				
Chair arms				
Light switches				
Door handles				
Keys				
Carts				
Filing cabinets				
Railings				
Remove garbage				
Dispensers: hand sanitizer; hand soap; paper towel				
Med carts**				
Med rooms**				
Vitals machine after each use (signing this signifies that this has been audited daily)**				
Other areas				
Resident wheelchairs				
Commodes, bed pans, and similar items				
Nursing equipment after each use (signing this signifies that this has been audited daily)**				
Spa tubs after each use (signing this signifies that this has been audited daily)				
Other:				
Other:				
Other				

** Duties are LPN responsibility (RCAs primarily responsible for other tasks)

Housekeepers/Cleaners

- **Wear PPE as required, including when entering a room on isolation or when entering any outbreak area.**
- **For rooms on isolation: Provide daily cleaning and sanitization, with Oxivir wipes, to the area immediately outside of the room and to the inside of the room.**
- **Clean all touch points in common areas of the floor (other staff will be supporting this)**
- **Dispose of any garbage or recycling that may have accumulated regularly through the day.**
- **Thoroughly clean public washrooms.**
- **Food contact areas must be cleaned with Viper wipes.**

Daily Checklist Date: _____

Area	Completed	Signature	Comments
Office & Common Areas			
Telephones			
Desk surfaces			
Desk items: pens, staplers, tape dispensers, etc			
Keyboards			
Printers			
Remote controls			
Chair arms			
Light switches			
Door handles			

Keys			
Carts			
Filing cabinets			
Railings			
Elevators			
Counters			
Entrance way intercoms/keypads			
Dispensers: hand sanitizer; hand soap; paper towel			
Floors			
Garbage receptacles			
Remove garbage			
Other:			
Other:			
Other			
Resident Rooms			
Door handles			
Bed rails			

Light switches			
Remote controls			
Tables			
Telephones			
Sink faucets and handles			
Dispensers: hand sanitizer; hand soap; paper towel			
Mounted grab bars			
Floors			
Garbage receptacles			
Remove garbage			
Toilet			
Other:			
Other:			
Other			

Maintenance

- **Keep all stock updated.**
- **Wipe down all equipment used with Oxivir.**
- **Wash hands before and after leaving residents rooms.**

- **Wipe touch points in mechanical areas and workshop.**
- **Wear PPE when entering a room on isolation or when entering any outbreak area.**

Daily Checklist **Date: _____**

Area	Completed	Signature	Comments
Mechanical Areas			
Doorknobs			
Light switches			
All hard surfaces			
Equipment			
Maintenance Shops			
Telephones			
Desk surfaces			
Desk items: pens, staplers, tape dispensers, etc.			
Keyboards			
Printers			
Chair arms			
Door handles			
Keys			
Carts			
Dispensers: hand sanitizer; hand soap; paper towel			
Garbage receptacles			
Remove garbage			
Other:			
Other:			
Other			

Dietary staff

- **Wipe all food contact areas with Viper after each meal sitting.**
- **Wipe all touch points with Viper after each meal sitting. {Chair arms, telephone, light switches, cash register, door entry to kitchen area, and non-food contact counters}**
- **Remove all garbages from dining area to the dumpster that has accumulated after each meal sitting.**
- **Coffee pot handles wiped with Viper.**

Daily Checklist Date: _____

Area	Completed	Signature	Comments
Countertops/all hard surfaces			
Food contact surfaces			
Doorknobs			
Light switches			
Chair arms			
Door handles			
Keys			
Carts			
Dispensers: hand sanitizer; hand soap; paper towel			
Salt/pepper shakers/condiment holders			

Garbage receptacles			
Remove garbage, compost and recycling			
Other:			
Other:			
Other			

Activity staff / Adult day program

- **Wipe down touch points in office area with Oxivir.**
- **Wipe down non-food contact recreational areas with Oxivir.**
- **Wipe down recreational equipment that has been in use with Oxivir {Bowling balls, bingo, TV, remote controls}**
- **Wipe down kitchen and any food contact areas with Viper wipes.**
- **Remove any garbage accumulation to dumpsters.**
- **Office staff**
- **Wipe down touch points with Oxivir TB**

Area	Completed	Signature	Comments
Countertops/all hard surfaces			
Food contact surfaces			
Doorknobs			
Light switches			
Chair arms			

Door handles			
Keys			
Carts			
Dispensers: hand sanitizer; hand soap; paper towel			
All recreational equipment			
Garbage receptacles			
Remove garbage			
Other:			
Other:			

Appendix J: Outbreak Protocol for Covid-19

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

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

Outbreak Detection and Confirmation

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

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

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

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

1. **Facility**

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

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

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

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

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

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

2. Residents

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

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

3. Staff

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

4. Visitors and Volunteers:

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

Outbreak Termination

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

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

Appendix K: Discontinuing Isolation Precautions in Suspect or Confirmed Covid-19 Patients

Interim - Discontinuing Additional Precautions in Suspect and Confirmed COVID-19 Patients	
Scenario	**Discontinuation Criteria**
Asymptomatic patient on self-isolation	Self-isolation period is complete[1]
Low risk suspect COVID-19 patient with Fever NYD or GI symptoms but NO respiratory symptoms	NP swab is negative for COVID-19[2]
High risk suspect COVID-19 with Fever NYD or GI symptoms but NO respiratory symptoms	NP swab is negative for COVID-19[2] **AND** self-isolation period is complete[1]
Low risk suspect COVID-19 patient with ILI or Respiratory Symptoms (with or without fever)	NP swab is negative for COVID-19[2] **AND** Continue with regular Droplet/Contact precautions until the following criteria is met[3]: • *Bacterial respiratory infection or pneumonia:* Discontinue after 48 hours of appropriate antibiotic therapy • *Aspiration pneumonia:* Discontinue precautions • *Pertussis (confirmed or suspected):* Discontinue after 5 days of appropriate antibiotic • *Viral Respiratory infection:* Remove after 5 days[4] • *Influenza:* When Tamiflu treatment ends or after 5 days (whichever is longer)[4], unless severely immune-compromised, then consult IPAC.
High risk suspect COVID-19 patient with Respiratory Symptoms (with or without fever)	NP swab is negative for COVID-19[4] **AND** Continue with regular Droplet/Contact precautions until the following criteria is met[3]: • *Bacterial respiratory infection or pneumonia:* Discontinue after 48 hours of appropriate antibiotic therapy • *Aspiration pneumonia:* Discontinue precautions • *Pertussis (confirmed or suspected):* Discontinue after 5 days of appropriate antibiotic • *Viral Respiratory infection:* Remove after 5 days[4] • *Influenza:* When Tamiflu treatment ends or after 5 days (whichever is longer)[4], unless severely immune-compromised, then consult IPAC. **AND** Self-Isolation period is complete[1]
Confirmed non-ICU COVID-19 patient *(includes immunocompromised and Long Term Care Resident)*	10 days have passed since onset of symptoms[5] **AND** Fever has resolved without use of fever-reducing medication **AND** Symptoms (respiratory, gastrointestinal and systemic) have improved.[6,7]
Confirmed ICU COVID-19 patient *(currently in ICU, ventilated or not ventilated)*	**Non-Test Based Strategy:** 10 days have passed since onset of symptoms[5] **AND** Fever has resolved without the use of fever-reducing medication **AND** Symptoms (respiratory, gastrointestinal and systemic) have improved.[6,7] **OR** **Test Based Strategy:** Resolution of fever without the use of fever-reducing medication **AND** Improvement in symptoms (respiratory, gastrointestinal, and systemic)[6,7] **AND** Two negative NP swabs collected at least 24 hours apart *(One of which can be a lower respiratory tract specimen if diagnosis was initially confirmed by lower respiratory tract specimen)*
[1] *If they were directed to self-isolate by Public Health, 811 or primary care provider*	
[2] *Patients must also meet the criteria in the "Discontinuing Additional Precautions in Admitted Adults" or "Discontinuing Additional Precautions for Admitted Pediatric Patients".*	
[3] *Plus symptom resolution for pediatric patients only*	
[4] *Where clinical suspicion remains high and NP swab is negative, collection of specimens from the lower respiratory tract where readily available (throat/oropharyngeal swab, sputum ETT, sputum expectorated, bronchoscopy) may be considered.*	
[5] *If unable to determine symptom onset, use date of initial positive COVID result*	
[6] *Note: Coughing may persist for several weeks and does not mean the individual is infectious. Fever must have resolved without the use of fever-reducing medication and symptoms (respiratory, gastrointestinal and systemic) have improved.*	
Once Additional Precautions are discontinued, the patient can be transferred from a COVID Cohort Unit to another hospital ward, be transferred to Long Term Care or home with HCC supports. No test of cure is required. *Patients can be discharged home without meeting criteria if they no longer require medical care and are able to self-isolate at home.*	
Low risk: *No known close contact with a probable/confirmed COVID-19 patient and no travel outside of Canada in the last 14 days* ***High risk:*** *Close contact with a probable/confirmed COVID-19 patient or travel outside of Canada in the last 14 days* ***Fever NYD:*** *Fever greater than 37.5°C with no identified cause.*	

Last revised April 16, 2020