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

November 27, 2020

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

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

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

Contents

1.0 Introduction

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

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

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

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

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1.2 Medical Health Officer (MHO) Orders

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

1.3 Key Contacts

This document is updated frequently with the most current direction, guidance and resources regarding COVID-19.

If your specific questions are not covered in either of those places, questions and comments related to the COVID-19 pandemic can be submitted to the following:

- Questions related to Contracted Services: Paul.Champness@interiorhealth.ca
- Single Site: SingleSiteFeedback@interiorhealth.ca
- General Questions can be sent to Licensing Direct: LicensingDirect@interiorhealth.ca
- IH's Communicable Disease Unit: CDunit@interiorhealth.ca
- IH COVID-19 Hub: **Accessing the Hub** The new COVID-19 Hub is **best viewed, and saved as a bookmark, in Chrome** at: COVID-19 Hub for IH Employee & Medical Staff. (Not accessible to Contracted Partners)
- For additional questions contact (Director of Long-term Care Services): Becky.Marlatt@interiorhealth.ca

Questions will be monitored from Monday to Friday from 0800 – 1600 PST.

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

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

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

1.4 Who should be tested for COVID-19?

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

1.5 Definitions for Terms with in the Toolkit

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

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

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

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

2.0 Outbreak Management

2.1 Client and Staff Daily COVID-19 Illness Reporting

Interior Health's COVID-19 response resources have been mobilized to increase support for Long-term care, Assisted Living, and Independent - Supportive Living Sites. As part of this work an active monitoring process has been implemented for these sites. This process allows for timely reporting of COVID-19 symptoms for clients and staff within sites. This information will allow IH to work with you to identify any COVID-19 cases and quickly respond. IH is using the TELUS Home Health Monitoring (HHM) system to support the collection of this valuable monitoring information. This HHM system is a platform that is also being used in Home Health for client monitoring as well COVID-19 contact tracing symptom check in. Each facility is provided with access to the HHM web based system to complete a very short daily questionnaire that includes questions about if there is any known illness in clients, staff, and if any testing has occurred.

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

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

2.2 Presentation (Symptoms)

COVID-19: Adult Viral Testing Guidelines for British Columbia (Sept 2020)

Clients 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 (>38°C) or a temperature that is above normal for that individual and one or more of the following:

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

2. Respiratory infection:

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

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

3. Fever of unknown cause:

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

4. Other atypical symptoms associated with COVID-19:

Includes, but not limited to:

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

See "Presentations Definitions" on page 11 of the BCCDC Guidelines.

2.3 UPDATE! Monitoring and Initial Response for Possible COVID-19 Cases

- All clients are monitored twice daily for signs and symptoms of COVID-19
- Individuals who show suspect signs and symptoms of COVID-19 should be tested by a nasopharyngeal swab (BCCDC COVID-19 Testing Viral Testing.)
- **DO NOT test for COVID-19 in asymptomatic individuals, unless directed by MHO**
- Staff are monitored daily prior to start of shift or if during shift symptoms develop: COVID-19 Manager's Resources for Staff Screening Assessment

2.4 NEW! Determination of COVID-19 Exposure Event

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

Exposure event:

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

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

2.5 UPDATE! Determination of COVID-19 Site Outbreak

Outbreak:

- A single resident case, **or**
- **Two or more cases** (staff, visitors or residents)
- Where the MHO has assessed transmission within the facility has likely occurred

2.6 Outbreak Stages

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

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

2.7 Update! ONE (Resident) or two or More Positive Cases (Staff, Visitor, or Residents) COVID-19 test result = Outbreak

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

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

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

BCCDC ATTENTION: COVID-19 OUTBREAK Poster

2.8 Site Outbreak Management Team

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

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

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

If staffing shortages impact a Long-term Care sites' capacity to provide safe client care, the OMT Lead/MHO may activate the COVID-19 Long-term Care Emergency Response Team (ERT). The Emergency Response Team consists of a combination of RNs, RPNs, LPNs, health care aides, and allied health professionals.

2.9 Long-term Care Emergency Response Team (ERT)

The Emergency Response Team has been created to augment nursing and care aide services for Long-term Care sites (IH owned &operated, contracted and private) experiencing critical staffing shortages related to COVID-19 outbreaks. If the site identifies staffing needs:

- The IH Lead and Facility Lead consult with the CD Unit on staff and client safety needs.
- The IH Lead works with the Facility Lead to ensure they have exhausted all options to secure staffing from within their campus, organization, staffing provider, including overtime, new hires, reassignment, agency staffing, etc., prior to requesting IH Emergency Response Team.
- Once requested the ERT Team can be deployed to the facility within 24 hours as per the MHO, CD Unit and IH Pandemic Response Coordinating Committee (PRCC).

2.10 Post-Outbreak Debrief

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

3.0 Operations

3.1 Transfers between Long-term Care Sites and Assisted Living

Effective July 15, 2020 the Ministry of Health has directed health authorities to resume admissions from Assisted Living to LTC, and transfers between LTC for the purpose of meeting client choice.

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

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

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

Community clients being admitted to LTC and Assisted Living sites should be preferentially placed in isolation in a single person room for 14 days from date of the admission. Staff are to use Routine Practices including mask, eye protection and gloves as per Optimal Use of PPE Guidelines.

Clients transferring from acute care or other Long-term Care sites (inclusive of Short Stay Convalescent, End of Life, and Respite) **are not** required to isolate if they had already been in the previous facility for more than 14 days.

For further information: Resuming Transfers between Long -term Care Homes (LTC)

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

Information related to MHO requirements for transfers of clients to acute, and repatriation of clients from acute, as well as requirements for admission to LTC from acute is referenced in the following class order: COVID-19 Infection Control Practices for all LTC and Seniors' Assisted Living.

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

3.3 Respite – Resumption of In-facility Overnight Services

Effective July 15th, 2020, the Ministry of Health (MoH) has directed health authorities to resume In-facility overnight respite services. This means that Interior Health (IH) case managers may resume previous processes for booking, documenting, and supporting facility respite while collaborating with LTC providers to arrange for service provision.

Respite Admission – COVID-19 Safety Requirements and Considerations

- Individuals ***from Community and Assisted Living (AL) sites*** should be preferentially placed in isolation in a single person room for 14 days from date of the admission. Staff are to use Routine

Practices including mask, eye protection and gloves as per Optimal Use of Personal Protective Equipment (PPE).

- Individuals from Acute Care or other Long-term Care (LTC) homes (inclusive of short-stay Convalescent, End of Life, and Respite) are **not required to isolate** if they had already been in the previous facility for more than 14 days.
- Case managers are to ensure clear communication with clients and families related to the requirement to isolate for 14 days upon admission as well as inform of limitations and restrictions on visiting in LTC homes.

3.4 Essential Medical Appointments

Long-term Care Off-site Medical Appointments and Treatments

At this time, all non-essential off-site medical appointments are on hold. The resident's physician will be contacted to determine if a specific appointment is medically-essential.

If the off-site medical appointment(s) are identified by resident's physician as medically-essential, the individual appointment or recurring medical appointments will continue, as long as the following conditions are met:

- Resident has no symptoms of possible early COVID-19 infection
- Resident is transferred directly to the appropriate department for the appointment and right back to the LTC facility following
- Resident does not require 14 days isolation and symptom monitoring
- Resident, transportation personnel, and acute care staff wear appropriate personal protective equipment
- Any potential breaches or potential COVID-19 exposures during transfer are reported immediately to the facility

Clients requiring transfer to essential medical appointments, a higher level of care or to an acute setting during the COVID-19 pandemic will be transferred according to the:
Process to Decrease Risk of Contamination for Transport of Patients with Suspected or Confirmed COVID-19 Clinical Practice Standard and Procedure.

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

If a LTC client attends an essential medical appointment off site at a controlled health care setting, the expectation is that the settings are applying the necessary infection control measures; therefore, there is no need for the client to isolate upon return.

Non-essential appointments off-site are discouraged as this poses a risk to the general LTC population. Long-term Care clients who do not abide by this recommendation are required to self-isolate upon return for 14 days.

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

Same day medically essential or recurring treatments or appointments that cannot be deferred or modified (e.g. renal dialysis) do not require MHO approval as long as the following conditions are met:

- Client is asymptomatic.
- All transport and acute care staff must maintain contact and droplet precautions at all times.
- Client is transferred directly to appropriate department for procedure and back to LTC facility.
- If no exposure to the client was identified during visit to acute care facility, then client may return to the LTC facility without requiring 14 days isolation and symptom monitoring.
- Any potential breaches are to be reported immediately to the MHO.

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

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

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

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

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

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

Principles: Transporting clients should only be done for urgent, essential needs that cannot be accommodated by alternate means. Examples include:

- Urgent medical appointments or treatment that cannot be supported by telephone/video (medical, psychiatric, etc.) or done on behalf of the client.
- Urgent financial/legal appointments, etc., that cannot be supported online or by telephone/video or done on behalf of the client (where possible, support clients to use online banking/legal services).

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

Emergent: call 911 for BC Ambulance and advise that the client is symptomatic, awaiting test results, or presumed/confirmed COVID-19 positive.

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

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

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

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

3.8 Admissions to Assisted Living Guidelines

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

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

- Complete symptom screening prior to visit and upon arrival to site
- Plan visit at non-peak hours if possible
- All clients/visitors are to wear a mask
- All clients/visitors to hand sanitize/hand wash upon arrival and prior to leaving site
- Site to support clients/visitors to practice regular hand-washing/hand sanitizing during the visit
- Clients/visitors are to maintain 2 meter physical distance from others during the visit
- Only one family member/friend is allowed for one client
- Log visitor details on the Visitor log for future tracing needs & keep x 28 days

Before Onsite Pre-admission Visit & Tour

Initial phone conversation:

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

- Upon admission to the site the client will be isolated to their suite and put on standard COVID-19 pandemic precautions for 14 days.
- During the 14 day isolation period the client will not be able to leave the AL site other than for essential medical appointments.
- No visitors are allowed to AL suite for the duration of the 14 day isolation, other than essential visitors for compassionate care.
- At any step of the assessment, it is at AL provider's discretion to decline the client if the provider does not believe they can meet the needs of the client.

- Discuss the opportunities AL provider can offer to meet the needs for client's physical, emotional, social and psychological well-being during the isolation (e.g. having Zoom/Facetime with family, one-to-one staff time with client, etc.)

Admission package delivery to client:

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

Virtual tour

- Look at creative ways for touring the clients. Consider offering the virtual tours and asking existing clients to provide testimonials.

Onsite pre-admission visit & tour day

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

- The room arranged for onsite meeting needs to accommodate for required physical distancing between client, family member/friend and the AL provider staff.
- If the suite offer is made, minimize the duration of onsite visit by reviewing essential pieces of documentation only and giving the rest of the package to the client/family to review at home.
- Consider creating a consent form outlining the rules for COVID-19 pandemic for post-move in 14 days and have the client sign/initial the form (e.g., isolation, essential medical visits only, essential visitor only).

On Move-in/Out Day

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

3.9 NEW! Social Activities for Assisted Living Residents

Interior Health MHO's have agreed to incorporate the concept of 'social bubbles/cohorts' in LTC and AL for congregate dining, recreation programming and scenic bus outings.

BCCDC:

- Assisted Living clients can engage in social and external activities that are **aligned with general public** health guidance. BC Province Wide Restrictions Social Gatherings (Nov 25, 2020).
- Current information suggests that older people with chronic health conditions are at higher risk of developing more severe illness or complications and should take the measures to protect themselves including avoiding large gatherings and stay away from other people who are ill. They should maintain safe physical distance at all times and wear a non-medical mask when in enclosed spaces such as transit or stores where safe physical distances cannot be maintained.

Social gatherings:

No social gatherings of any size at your residence with anyone other than your household or core bubble.

For example:

- Do not invite friends or extended family to your household
- Do not host gathering outdoors
- Do not gather in your backyard

Core bubble:

For most people, their core bubble is their immediate household. An immediate household is a group of people who live in the same dwelling.

For example:

- If you have a rental suite in your home, the suite is a separate household
- If you live in an apartment or house with roommates, you are all members of the same household
- For others, including people who live alone, their core bubble may also contain a partner, relative, friend or co-parent who lives in a different household. This should be a maximum of two people outside of those living in your immediate household.

People who live alone:
For people who live alone, a **core bubble** is a maximum of two people you see regularly. You must not host gatherings.

3.10 NEW! Standard Precautions during COVID Pandemic (For All Clients/Visitors) in Assisted Living

- All clients/visitors are to wear a mask
- Complete symptom screening prior to visit and upon arrival to site
- Plan visit at non-peak hours if possible
- All clients/visitors to hand sanitize/hand wash upon arrival and prior to leaving site
- Site to support clients/visitors to practice regular hand-washing/hand sanitizing during the visit
- Clients/visitors are to maintain 2 metre physical distance from others during the visit
- Only one family member/friend is allowed for client's onsite visit to minimize the risk of other tenants and staff exposure.
- AL tenants are free to leave and return to their AL suite, after the 14 day initial admission self-isolation period, and encouraged to follow standard precautions including physical distancing, wearing a mask when physical distancing is not possible, and diligent hand hygiene.

3.11 Congregate Dining, Recreation Programming and Scenic Bus Outings

Interior Health MHO's have agreed to incorporate the concept of 'social bubbles/cohorts' in LTC and AL for congregate dining, recreation programming and scenic bus outings. This step forward, in alignment with the implementation of the phase 3 BC Restart Plan, will support and improve the quality of life of the clients residing in all LTC and AL sites.

What this means is clients can be assigned to a cohort (or social bubble):

- Up to a maximum of 6 people per cohort.
- Must include the same people in the same cohort or social bubble over time.
- Physical distancing of 2 metres *must* be maintained between each cohort.
- The individuals within the cohort *do not* have to maintain 2 metres distancing from each other during their group activity (i.e., when they are at their dining table).
- There may be some change in each cohort's composition over time, due to discharge, death or new admissions of clients.

The following guidelines must be applied when implementing the individual cohorts or social bubbles for:

Congregate Dining

- *Maintain a maximum of six individuals in each 'social bubble'*
- Sites may choose to implement a staggered dining schedule to support physical distancing between cohort tables, and reduce the number of individuals in the dining area at any given time. For sites that can maintain physical distancing between the client cohort/social bubble

groups and between the tables, there may not need to be staggered meal times and a single mealtime may be sufficient
- Remove self-service food items and shared food containers (e.g. water/coffee/cream/milk dispensers, salt and pepper shakers), from communal areas
- Dispense shared food items for individuals while maintaining a minimum physical distance of 2 metres as much as possible
- Provide single-use condiment packages (e.g. salt, pepper, sugar, ketchup and mustard), directly to individuals from bulk food containers
- Pre-place utensils and cutlery for individuals prior to seating
- Ensure alcohol-based hand rub with at least 70% alcohol content is available in shared dining rooms
- Remind individuals to perform hand hygiene before handling or eating food

Recreation Programming
- *Maintain a maximum of six individuals in each 'social bubble'*
- Implement a staggered schedule to support physical distancing and reduce the number of individuals in recreation areas at any given time
- Apply the same guidelines as for congregate dining if food is being served
- Remind individuals to perform hand hygiene before and after the recreation activity
- Refrain from engaging in activities that promote multiple individuals touching the same surface area or object
- Ensure alcohol-based hand rub with at least 70% alcohol content is available in shared dining rooms
- Remind individuals to perform hand hygiene before/after participation in a recreation program

Scenic Bus Outings
- *Limit the number of individuals to a maximum of 6 from the same cohort on the bus at any given time* (in addition to the driver)
- All individuals should be monitored for new or worsening cough, sneezing, runny nose, fever, sore throat, difficulty breathing, or episodes of vomiting and/or diarrhea, prior to participating in a bus outing
- Driver is required to wear a mask and ideally a physical barrier, such as a clear partition between the driver and the passengers, should be installed if the driver is not a member of the LTC and AL staff
- Ensure alcohol-based hand rub with at least 70% alcohol content is available on the bus
- Remind individuals to perform hand hygiene before entering and after exiting the bus
- Ensure protocols are in place to disinfect the bus surfaces between outings
- Individuals are not permitted to exit the bus during the outing

It is imperative that sites maintain the same individuals in each cohort over the long term. When developing social bubbles, please keep in mind that if one individual in the social bubble becomes symptomatic, all individuals in that cohort or social bubble may have to be isolated until the sick individual's COVID-19 test is confirmed negative.

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

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

Forward any questions to Licensing Direct.

3.12 Adult Day Services

Selective re-opening of Adult Day Service sites began on Sept. 28, 2020. This time frame allowed for the reallocation of ADS staff, completion of site safety plans, and timely communication with ADS clients.

Only the following ADS sites as defined here will be reopening at this time:

- A stand-alone building or community building (i.e. church, community centre, etc.) that is not a Long-term Care (LTC) facility or Assisted Living (AL) setting
- A LTC facility or AL residence where there is no shared space, entrances, staff, activities, or equipment

To resume operations, sites must be in accordance with the following:

- MoH Guidelines for Adult Day Programs and COVID-19
- Regional MHO directions (including restricting programs within sites with active COVID-19 outbreaks).
- Must have an MHO (or delegate) approved COVID-19 Operating Plan

Where clients cannot or will not adhere to physical distancing requirements, sites should refer to COVID-19 Ethics Analysis: Intervening When Patients or Clients Pose a Risk of COVID-19 Transmission to Others, to inform any decision regarding participation in adult day programs.

Determination of program readiness to open is based on the program's ability to adhere to Provincial Health Officer Orders, Infection Prevention and Control Guidance, and the practice requirements outlined in an ADS site Operating Plan, approved by a MHO.

For support or questions, please contact:
Darlene Russell: Practice Lead, Home Health
Anne-Marie Savard: Regional Knowledge Coordinator for Home Health

3.13 Community Bathing Programs

Community bathing programs connected to LTC/AL sites: on hold

Community standalone bathing programs in Health units and Acute: Require MHO approved safety plan to re-open.

3.14 Volunteers

Volunteers must maintain physical distancing for all activities and use appropriate Personal Protective Equipment (PPE) or an environmental barrier may be necessary. If this cannot be achieved, the program should remain suspended at this time. Volunteers are required to adhere to the same PPE guidelines as those for non-clinical staff.

The determination of which volunteer activities can resume will be at the site's discretion. We are

encouraging each site to begin by focusing on reinstating volunteer activities that are low risk which include:

- No close physical contact between volunteers and clients
- Not entering patient rooms or going from department to department
- Maintaining physical distancing of two metres; if unable to maintain two metres distance, volunteers have access to, and know how to use PPE.

Examples of Low Risk Activities:

- Clinic volunteers (Medical Imaging, Cardiology, Ambulatory Care) who greet patients and provide way finding support
- Information desk volunteers
- Greeter volunteers
- Volunteers who support gift shops and/or cafes
- Volunteers who support programs that require minimal contact with clients such as recycling, gardening, and friendly shoppers programs
- Hospice Volunteers are permitted for end of life visits.

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

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

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

3.16 Virtual Care Delivery

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

IH: Virtual Care Toolkit - BC Telehealth Clinical Guidelines

Partners: BC Telehealth Clinical Guidelines

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

3.17 Using Zoom on Deployed iPads for Virtual Care Delivery

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

How should the iPads be used?

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

Technical Support:

More information on using Zoom is available as follows:

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

4.0 Visitors

4.1 Three Categories of Visitors:

A. Palliative/End of Life Visitors

The MRP determines that a client is at end-of-life and can receive visits without an exemption.

- Visits for compassionate care, including critical illness, palliative care, hospice care, end-of-life, and Medical Assistance in Dying.

B. Essential Visitors

Licensing exemptions are **no longer** required for essential visits which include:

- Visits considered paramount to resident care and well-being, to ensure care is provided as set out in a care plan may be allowed. These visits shall be granted as essential to maintaining the health and well-being of a resident in care. A request for essential visits can be made for one-time or ongoing visitations with the LTCF. The LTCF must ensure the visit(s) meet the Essential Visitor Criteria outlined in Appendix A. Visits paramount to the client's physical care and mental well-being, including:
    - Assistance with feeds, mobility, personal care.
    - Communication assistance for persons with hearing, visual, speech, cognitive, intellectual, or memory support.
    - Visits for supported decision making.
- Police, correctional officers, and peace officers accompanying a client for security reasons.
- Essential visits may not need to be scheduled in advance. A client can have more than one essential visitor but only one visitor is allowed at a time. (*A visitor who is a child may be accompanied by one parent, guardian or family member*.)

IH: Infection Control Practices Order - Classes of Visitors and Essential Visitor Criteria.
Partner: Infection Control Practices Order - Classes of Visitors and Essential Visitor Criteria

C. Family/Social Visitors

Family/Social visits are limited to a single designated visitor for each client and must be booked in advance.

- Visits are permitted in the Assisted Living clients' suite (including overnight visits); granted infection prevention practices are upheld. The visitor may not access common area, is required to wear a mask and practice hand hygiene.
- Spouses living in a campus of care are not 'counted' as the one designated social visitor. The spouse residing in AL is permitted visitation in the Long-term Care client's suite. The spouse needs to be screened as any other visitor and follow the same guidelines.
- Facility staff/operator can approve a change to the designated visitor under extenuating circumstances; for example, if the visitor moves away or becomes ill and is unable to visit
- For guidance on the expansion of the visit protocol to family/social visits, please reference page 7 of the BCCDC's Infection Prevention and Control Requirements for COVID-19 in Long Term Care and Seniors' Assisted Living.

4.2 Classes of Visitors and Essential Visitor Criteria

Following consultation with the Interior Health Long-term Care (LTC) team, medical health officers (MHO), and licensees of LTC facilities, a decision has been made that **Essential Visitors** will no longer require approval through an MHO Exemption process. These approvals will now be managed at the facility level.

Licensees of LTC sites will be responsible for assessing and approving the requests for essential visitor(s) for residents. For requests to be approved, the LTC site must:

- implement and follow a written request and approval process; and
- the proposed essential visits must meet specific criteria as outlined in the following orders:

IH: Infection Control Practices Order - Classes of Visitors and Essential Visitor Criteria.
Partner: Infection Control Practices Order - Classes of Visitors and Essential Visitor Criteria

The new Oct. 13, 2020 MHO Order repeals and replaces the Chief Medical Officer Order of May 8, 2020 with respect to Infection Control practices in Long-term Care Facilities.

For guidance on the expansion of the visit protocol to family/social visits, please reference page 7 of the BCCDC's Infection Prevention and Control Requirements for COVID-19 in Long-term Care and Seniors Assisted Living.

4.3 Appendix A – Criteria for Essential Visitor Approvals

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

1. In order for the visitor request to be considered by the LTCF, they must meet the definition of an Essential Visitor: *"Visitor is considered paramount to the health and well-being of the person in care to ensure care is provided as set out in a person in care's care plan".*

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

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

4. The Essential Visitor/Visitation plan describes how:
    - The LTCF will screen the essential visitor(s) each time of entry using the greeter's script. If the essential visitor(s) does not pass the screening questions in the greeter's script, the LTCF will not allow admission to the LTCF.
    - The LTCF will provide education and training on infection control processes, and applicable policies and procedures.
    - The essential visitor(s) will meet the expectations for the provision of required PPE.
    - The LTCF will assess the essential visitor's comprehension and implementation of infection control measures, PPE use, and all facility policies.
    - The LTCF will monitor the essential visitor's adherence with the infection control measures and all expectations as set out in policy.
    - The plan includes a plan should the essential visitor(s) fail/refuse to abide by the expectations set out in the request for visitation.

- The operator will escort the essential visitor(s) to and from the specified room and ensure that the essential visitor(s) is confined to that area that ensures social distancing or avoids contact with other persons in care, and does not engage in activities outside of the specified room.
- The essential visitor(s) has access only to a prescribed person in care in the specified room at the time of the visit.
- The plan includes specific days and times for the essential visitor(s) attending the LTCF.

5. If an LTCF has an outbreak of COVID-19 or Influenza declared by an Interior Health MHO, all visitations should be temporarily postponed from the LTCF for the duration of the outbreak. The LTCF must have a communication plan in place on how they will inform any and all visitors seeking to visit persons in care of this prohibition and also when the visitations can re-commence.

4.4 NEW! Paid Companions

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

As a service provider, the Paid Companion must follow best practices with Personal Protective Equipment (PPE), hand hygiene and social distancing while on site.

- In addition to the standard requirements, the following are conditions required for the Paid Companion as an exempted individual:
- Paid Companions must follow the Single Site order and sign a **Single Site Declaration(add the form)**
- They may see more than one resident in a single facility ensuring they follow all ICP and PPE requirements between visits with residents.
- Follows PPE Guidelines when in patient care areas: procedural mask, gloves (during direct patient care) and eye protection at all times.
- The site will provide education and training on infection control processes and applicable policies and procedures to the Paid Companion, and will assess the comprehension and implementation of infection control measures, PPE use and all facility policies.
- The site will monitor the adherence with the infection control measures and all expectations as set out in policy.
- The site will provide appropriate PPE to the Paid Companion
- Complete screening and sign in process
- Gowns are not required unless resident is suspect or confirmed COVID in which case the paid companion will not be visiting.

Paid Companion as an Essential Visitor:

Sites must ensure the following criteria are met as outlined in **Appendix A**:

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

Visitor Policy Required Signage and Key Messages

- Long-term Care and Assisted Living Providers are required to have Visitor Policy Signage posted inside the main entrances to clearly communicate essential and social visit policies, with the

phone number of the LTC facility so visitors can call if they have questions or need immediate assistance.

- The Ministry of Health has provided Key Messages to communicate with the public. Sites are required to monitor visits; "monitoring of visits" would include scheduling, greeting, screening, and information/guidance regarding PPE and other processes and then checking out at end of visit. Supervision of visit is not expected and may be considered intrusive.

4.5 Complaint Escalation Visitor Process for LTC & AL

(Applicable to IH Owned, Operated and Contracted Providers)

Addressing social visitor disputes in a clear, consistent, timely, and transparent manner to meet individual client needs is an important commitment we've made across Interior Health.

To support site managers to maintain this commitment to clients and their families, the Complaint Escalation Visitor Process Algorithm has been developed. The algorithm provides a systematic process to expedite the timely resolution of complaints and disputes. If the LTC or AL manager cannot resolve the visitor complaint, it outlines the escalation process to be engaged:

- Disputes over the decision to decline entry into a facility based on the visitor's screening are best addressed and resolved at the time and place that they occur. If this is not possible, the ideal period for dispute resolution is within 24 hours.

Managers must notify screeners of the complaint escalation process.

IH Sites: LTC and AL Complaint Escalation Visitor Process Algorithm
Partners: LTC and AL Complaint Escalation Visitor Process Algorithm

LTC and AL Complaint Escalation Process:

Client/Family Member contacts site manager/manager on call.

- **Scenario A.** Manager resolves complaint and records complaint at the site level as per licensing regulations and on the new LTC AL Complaint Escalation Visitor Process Complaint Log.
- **Scenario B**. Manager/delegate cannot resolve the dispute within 24 hours. Manager is required to contact the respective IH Clinical Director of Operations to support the facility in resolving the matter.

Complaint Logs:

- Complaint Logs are to be maintained at the facility and emailed to Becky Marlatt on the first business day of each month beginning on October 1st, 2020 for the preceding month.
- If there are no complaints during the reporting period, please check the box above and submit.
- Please note: Log information may be shared with the Ministry of Health.
- Disputes over the decision to decline entry into a facility, based on the visitor's screening, are best addressed and resolved at the time and place that they occur. If this is not possible, the ideal time frame for dispute resolution is within 24 hours.
- If the manager/delegate cannot resolve a dispute within 24 hours, the Manager is required to contact the respective IH Clinical Director of Operations to support the facility in resolving the matter.

IH Sites: LTC AL Complaint Escalation Visitor Process Complaint Log
Partners: LTC AL Complaint Escalation Visitor Process Complaint Log

4.6 Exemptions – Infection Control Order

Exemption *IS* Required Under 1(c)(i) of the Order:

Visits considered paramount to client care and well-being, to ensure care is provided as set out in a care plan prior to the order may be allowed. Where it is felt that other situations exist in which an exemption to this class Order should be granted as essential to maintaining the health and well-being of a client in care, then a request for exemption can be made for one-time or ongoing visitations. The Long-term Care Facility should make the request to LicensingDirect@interiorhealth.ca using the Infection Control Practices Exemption Request Form. The Licensing Direct inbox is monitored after hours and on weekends. Urgent requests may be discussed with the MHO on call at 1-866-457-5648.

Exemption is *NOT* required under 1(c)(i) of the Order:

For clients who the most responsible practitioner (MRP) has assessed as being at 'end-of-life' (estimated as weeks to months of life as per the BC Center for Excellence in Palliative Care) in-person visits of a limited number of immediate family member(s) or spiritual advisor can occur on an ongoing or one-time basis.

- **Please refer to section 3.15 above regarding Essential Visitors.**

For further information: Infection Control Order Exemptions May 8, 2020

4.7 Family Member Communication

Sites are instructed to insert a link on site specific newsletters to website IH news:

- news@IH Long-term Care and Assisted Living
- news@IH Visitor Information (for all other departments)

4.8 Supporting Information Resources for Screeners

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

Visitor Screening:

- Facility Manager/Delegate will provide the Screener with an up-to-date, authorized visitor list each day, with the time and location of visit listed.
- Screener will complete:
    - Facility Entry Screening Checklist, and
    - Facility Screening – Visitor Sign In/Out log for all visitors.
- If the Screener observes that the visitor is unwilling or unable to comply with the infection control practices as identified in Step C of the Facility Entry Screening Script, please inform the Administrator/Delegate for the facility.
- Screeners are to escalate visitor complaints as per the Complaint Escalation Visitor Process to the manager/manager on call.
- Family and visitors who are **not** permitted entry and wish to have an immediate review of the decision shall be provided guidance according to the site's specific policy.

Partners:
Facility Entry Screening Script
Complaint Escalation Visitor Process

Staff Screening:

- All staff entering the building will be screened before the start of their shift.
- Staff screening will consist of asking the COVID-19 questions and recording the answers.
- Screeners do NOT take the staff's temperature (*temperatures must still be taken as per site process)*.
- All screened staff will have their information recorded on Staff Screening Sheet.
- Submit staff and visitor screening documents to the manager/designate at the end of each day.

Personal Care Packages:

Residents may receive care packages of food, clothing, and treasured personal or cultural items. These items can be delivered by essential, designated social or end-of-life visitors. Care packages will require sanitization; follow your site-specific process for this.

Additional Resources to Support Greeters/Managers:

Supporting Information for Facility Screeners
Facility Authorized Visitor List
IH Sites: Facility Screening - Visitor Sign In/Out Log
Partners: Facility Screening - Visitor Sign In/Out Log
IH Sites: Updated Visitor Guidelines for Long-term Care and Assisted Living Sites
Partners: Updated Visitor Guidelines for Long-term Care and Assisted Living Sites
IH Sites: Manager's Resources for Staff Screening Assessment
Partners: Manager's Resources for Staff Screening Assessment

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

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

Long-term Care/Assisted Living:

- Patient Ambassador positions are approved for 18 months
- Rotations have been completed for you. You will receive a copy of the rotation from a rotations specialist
- Once you have your rotation proceed with posting
- Interview applicants using questions recommended in the Interview Tool

For further information contact: Deb Runge

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

A new IH i-Learn curriculum has been developed to support onboarding of employees being hired to fill the newly created positions of the Patient Ambassador (also referred to as: Screener or Greeter).

As of Oct 27, 2020, IH Managers can assign the new curriculum to the employee (Curriculums # 231, 232, and 233) and the program will be uploaded to the employee learning opportunities.

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

IH Sites: Manager's Checklist - Screener/Greeter/Patient Ambassador Orientation - October 27, 2020
Partners: Coming soon!

5.0 Single Site Transition Framework

5.1 Single Site Order

Here is the classes of occupations that are exempted from the Single Site Order and the infection control requirements for these individuals when they are working in your facility.

biomedical engineers	nurse practitioners	psychometric technicians
certified foot care nurses	occupational therapists	recreation therapists
critical delivery persons	paramedics	red seal chefs and cooks
critical facility managers/leaders	pharmacists	regular and biochemical waste removal people
dental hygienists	pharmacy technicians	rehabilitation attendants
dentists	physicians	client physicians
dieticians	physiotherapists	respiratory therapists
inter-facility transport staff	plant operators and trades people	social workers
medical laboratory assistants	podiatrists	speech language pathologists
medical laboratory technologists	psychiatrists	wound care nurses
music therapists	psychologists	regional knowledge coordinators for complex behaviours

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

Please review the Infection Prevention and Control Requirements for COVID-19 in Long-term Care and Seniors' Assisted Living (June 30, 2020) and ensure that you are aware of the most up-to-date requirements.

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

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

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

Questions regarding exemptions:singlesitefeedback@interiorhealth.ca

Questions regarding other operational issues: licensingdirect@interiorhealth.ca

Links to original MoH directives:

April 10, 2020 Single Site Transition Framework

April 15, 2020 Facility Staff Assignment Order

5.2 Enforcement Action

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

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

5.3 Hair Salon Services

Long-term Care Sites (LTC)

- Hair stylists are screened and follow the precautions outlined by Work Safe BC for personal services (i.e. both persons in care and Hair stylists wear a mask).
- The Work Safe BC Covid-19 Safety plan must be completed, reviewed and approved by the Manager of the LTC Facility and posted outside the hair salon for the persons in care to view.
- Hair stylists must comply with the Single Site order:
    - Same hair stylists for a facility, versus multiple different hair stylists, AND
    - The hair stylist is designated to a single site facility (hair stylists can work in a salon, just not in multiple LTC sites).
    - One hair stylist is permitted for a campus of care, i.e. the same hair stylist provides services to LTC and AL clients.

Assisted Living (AL):

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

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

5.4 Dental Hygienists/Dentists

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

5.5 Foot Care Services

Certified Foot Care Nursing Services can resume in Long-term Care and Assisted Living. As per the single site order, exemptions are not required.

5.6 Personal Services

Massage, reflexology, private paid companions are on hold.

5.7 Public Trustees

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

5.8 Student Placement Strategy

Students are welcomed into a site during COVID, and precautions to ensure the safety of students, staff and clients are in place.

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

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

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

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

Q. Are student placements still allowed at affected sites?

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

5.9 Guidance for External Contractors

Non-essential repairs are not permitted. Essential repairs are permitted.

5.10 Movers

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

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

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

For the steps to request a consultation:

IH: Consultation Process

Partners: Consultation Process

6.0 Logistics

6.1 Nasopharyngeal Swabs

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

- All specimens (cylindrical tube) must have an attached label with:
  - Patient name
  - PHN or Date of Birth (DOB)
  - Specimen type (e.g., NP swab)
  - Date & time of collection

* Please add one of the following codes to the specimen label:

- HCW1 – Health Care Worker – Direct Care
- HCW2 – Health Care Worker – Non Direct Care
- LTC – Long-term Care Facility
- OBK – Outbreaks, clusters or case contacts
- HOS – Hospitalized
- CMM – Community or Outpatient, including Urgent and Primary Care Centres
- CGT – People living in congregate settings such as work-camps, correctional facilities, shelters, group homes, assisted living and seniors' residences.
- TREEPL – Tree planters
- SCHOOL – People attending school in-person including students, teachers and support staff

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

6.2 Virology Requisition Form

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

6.3 Interior Health COVID-19 Testing & Assessment Centres

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

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

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

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

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

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

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

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

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

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

Ordering Decals and Signage:

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

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

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

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

6.6 Signage

Droplet & Contact Precautions

Facility Entry Poster - COVID-19 Symptoms

Poster - Be Kind

7.0 Infection Control Practices

7.1 UPDATED SECTION! Hand Hygiene

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

Hand Hygiene Resources

- Infection Prevention and Control Hand Hygiene Guidelines
- Hand Hygiene Policy
- BCCDC Hand Hygiene Poster

7.2 Enhanced Cleaning Measures for COVID-19

When to Use Gloves with Cleaning Agents

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

Please pay particular attention to the following:

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

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

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

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

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

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

Cleaning Process

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

Step 1: Clean

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

Step 2: Disinfect

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

Step 3: Dry

- Let surface air dry.

IH Approved Cleaners & Disinfectants Effective Against COVID-19

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

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

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

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

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

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

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

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

Reminder for Staff receiving deliveries for themselves

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

Reminder – Non-Essential Delivery Services Remain Suspended.

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

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

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

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

7.5 Staff Change Rooms

Employees who have direct contact with clients are required to change their clothing upon entry/exit from Long-term Care and Assisted Living sites.

Before Work:

- Wear clean clothes to work; bring a change of clothes or scrubs in a plastic laundry bag
- Bring lunch in a disposable bag
- Use proper hand hygiene

After Work:

- Wear clean clothes home, including shoes; put work clothes in a plastic laundry bag, wash them when you get home and dispose of the bag
- Clean and disinfect work shoes and leave them at work
- Shower at work or immediately when you get home
- Disinfect hard surfaces on your vehicle
- Leave outside shoes in garage or outside front door

7.6 Common Areas, Break Rooms and Physical Distancing – Guidelines

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

7.7 NEW! Safer Celebrations – Tips for Holiday Decorations and Gatherings

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

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

Tips for Safer Celebrations in the Workplace

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

Considerations for Holiday Decorating

- Wash hands or use hand sanitizer often.
- Disinfect all surfaces before and after decorating (decorating surfaces makes it difficult to clean properly).
- Maintain physical distancing and keep groups small.
- Where possible, reduce the number of decorations.
- Do not use decorations that invite interaction or touching (e.g., props that move).
- Use decorations that can be put up and then left alone.
- Avoid multiple people touching the same decoration. One person – one decoration.
- Each person should have their own individual supplies to use while decorating (e.g., tape, scissors).
- For specific details on safe holiday decorating:
  IH: IPAC Recommendations for Holiday Decorations and Activities; October 30, 2020
  Partner: IPAC Recommendations for Holiday Decorations and Activities; October 30, 2020

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

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

Decoration Selection:

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

Decoration Display:

- Ceiling tiles are not to be lifted or compromised in order to hang decorations or signs
- Keep nursing stations and other work surfaces clear to allow for Housekeeping to clean and disinfect
- Live trees (with or without soil) and artificial trees should not be used in patient care areas. Artificial trees may be placed in public spaces (e.g. main lobbies)
- Decorations in health care setting such as waiting rooms and public areas should be reduced as much as possible to allow for proper environmental cleaning and placed in an area or cordoned off to avoid touching and contamination via droplets

Do not place decorations in the following areas:

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

Storage and Handling

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

Costumes, Special Character Visits & Activities

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

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

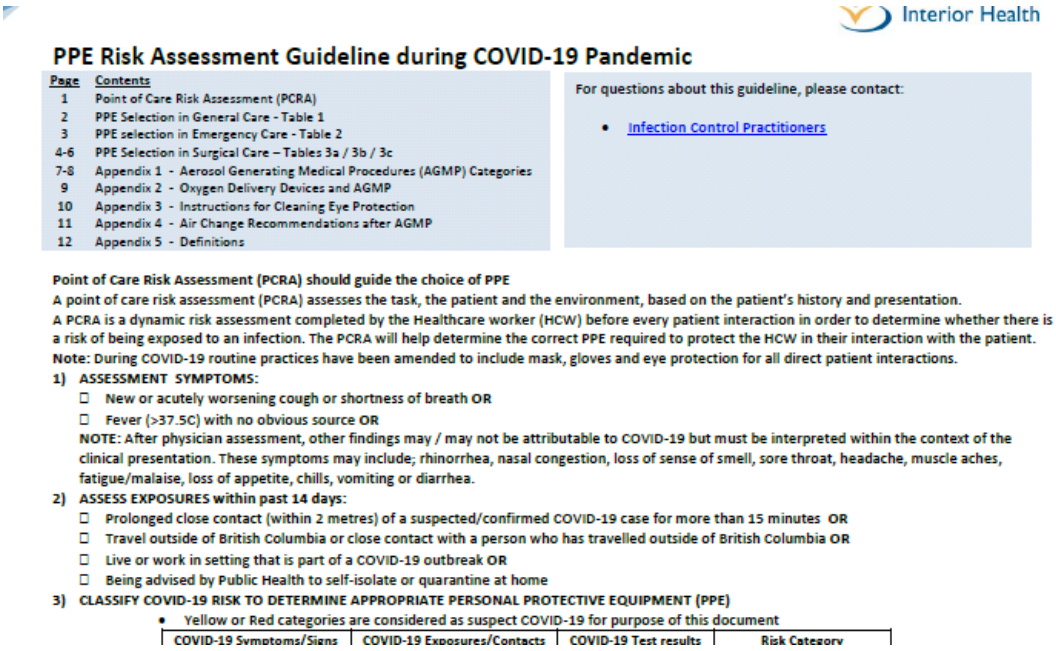
Partner: IPAC Recommendations for Holiday Decorations and Activities; October 30, 2020

8.0 Personal Protective Equipment

8.1 PPE Risk Assessment Guideline during COVID-19 Pandemic

To prevent potential exposures to COVID-19, and all communicable diseases, it is important you do your part to ensure the correct personal protective equipment (PPE) is used. An overview of the most up-to-date information that is in alignment with Provincial Guidelines of the use of PPE across Interior Health (Sept, 2020) can be accessed here:

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



Interior Health

PPE Risk Assessment Guideline during COVID-19 Pandemic

Page	Contents
1	Point of Care Risk Assessment (PCRA)
2	PPE Selection in General Care - Table 1
3	PPE selection in Emergency Care - Table 2
4-6	PPE Selection in Surgical Care – Tables 3a / 3b / 3c
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9	Appendix 2 - Oxygen Delivery Devices and AGMP
10	Appendix 3 - Instructions for Cleaning Eye Protection
11	Appendix 4 - Air Change Recommendations after AGMP
12	Appendix 5 - Definitions

For questions about this guideline, please contact:

- Infection Control Practitioners

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

1) **ASSESSMENT SYMPTOMS:**
   - ☐ New or acutely worsening cough or shortness of breath **OR**
   - ☐ Fever (>37.5C) with no obvious source **OR**

   NOTE: After physician assessment, other findings may / may not be attributable to COVID-19 but must be interpreted within the context of the clinical presentation. These symptoms may include; rhinorrhea, nasal congestion, loss of sense of smell, sore throat, headache, muscle aches, fatigue/malaise, loss of appetite, chills, vomiting or diarrhea.
2) **ASSESS EXPOSURES within past 14 days:**
   - ☐ Prolonged close contact (within 2 metres) of a suspected/confirmed COVID-19 case for more than 15 minutes **OR**
   - ☐ Travel outside of British Columbia or close contact with a person who has travelled outside of British Columbia **OR**
   - ☐ Live or work in setting that is part of a COVID-19 outbreak **OR**
   - ☐ Being advised by Public Health to self-isolate or quarantine at home
3) **CLASSIFY COVID-19 RISK TO DETERMINE APPROPRIATE PERSONAL PROTECTIVE EQUIPMENT (PPE)**
   - Yellow or Red categories are considered as suspect COVID-19 for purpose of this document

COVID-19 Symptoms/Signs	COVID-19 Exposures/Contacts	COVID-19 Test results	Risk Category

8.2 UPDATED SECTION! Routine Patient Care PPE Guidelines

Droplet and Contact Precautions

Required PPE:

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

More pieces and layers of PPE doesn't mean more protection

- BCCDC: Appropriate Personal Protective Equipment (PPE) for COVID-19 in Healthcare Settings.

8.3 UPDATED SECTION! PPE and ICP Guidelines for Social Visiting

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

8.4 UPDATED SECTION! How to Access PPE Supplies

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

pandemicresponseppe@interiorhealth.ca
COVID-19 - Pandemic Response - PPE Central Supply Hub Master Contact List (Sept 25, 2020)

Regular PPE from Known Supplier

The Provincial Health Services Authority (PHSA) Supply Chain has long-standing relationships with suppliers that provide PPE from trusted manufacturers. Item models that are already part of the Supply Chain inventory system (e.g. 3M N95 respirators) received from a known supplier can go directly to the PHSA distribution warehouses without further assessment or testing.

Product Documentation: Standard/Certification Validation

Certified PPE typically arrives with appropriate documentation, packing and markings. In the current supply chain environment, documentation from an unknown manufacturer cannot be trusted blindly. Product must be assessed to ensure documentation is valid and the product bears the appropriate labelling.

At the product documentation stage of assessment, alternative PPE (see step B), fabricated PPE (see step C) and donated PPE (see step D) will be assessed to determine if it:

• **Meets and passes all criteria**. In this case, it will move to the next stage of visual and manual inspection (see step H).

• **Is uncertain, unknown or incomplete**. In this case, it will move to the next stage of visual and manual inspection (see step H). If these products pass: visual and manual inspection, fitting characteristic assessment (see step I), as well as quantitative fit-testing (for respiratory protection only, see step J), it will still be required to undergo laboratory testing (see steps K and L).

• **Fails**. These would be cases where the product is determined to be counterfeit or misrepresenting standard/certification approvals. These products will be categorized (see step M) as Category 4 PPE (unacceptable) and will not be used in the health-care environment.

Each type of PPE has specific criteria and requirements for standard/certification or equivalency.

Distribution: Deliver to PHSA Distribution Warehouses

PHSA has distribution warehouses in Langley, Victoria, Kelowna, and Prince George. These warehouses serve as the regional supply hubs for regional/local distribution, under direction from PHSA Supply Chain.

Any PPE stored in PHSA distribution warehouses must be either known PPE from known suppliers, or PPE that has been assessed, tested and categorized (see step M) for use under the appropriate stage of the PPE Allocation Framework. To avoid sub-standard PPE making its way into the health system, there shall be no PPE in the PHSA distribution warehouses that is inappropriate for distribution to health facilities. Categorized PPE must be clearly labelled, organized and inventoried (see Step O) to ensure items outside of Category 1 are not distributed without explicit approval from the Ministry of Health.

Deliver to Health Authorities

Delivery to health authorities is managed by PHSA Supply Chain. Health authorities are responsible for identifying need (orders) to PHSA and PHSA Supply Chain, with advice from the PPE supply working group.

Health authorities are encouraged to order PPE based on needs over the next five to seven days. With scarcity of PPE and unreliability of supply chains, providing PPE stock to health authorities for more than one week is not possible.

Health authorities must have central locations to secure their PPE inventory and must allocate PPE to facilities and health-care workers based on the guidance and direction found in the Framework.

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Health authorities must have central locations to secure their PPE inventory and must allocate PPE to facilities and health-care workers based on the guidance and direction found in the Framework.

BCCDC: B.C. Personal Protective Equipment (PPE) Supply, Assessment, Testing and Distribution Protocol

8.5 UPDATED SECTION! Work Place Health and Safety Q&A

Workplace Health and Safety COVID-19 Questions and Answers
For any questions, contact Workplace Health and Safety (WHS):
workplaceinjury.prevention@interiorhealth.ca

Q7. Does Interior Health endorse health care providers purchasing their own Personal Protective Equipment (PPE)?

- **Interior health (IH) does not endorse employees or physicians purchasing or procuring their own personal PPE.** In order to ensure the health and safety of health care providers, it is essential that PPE used within IH be selected and implemented according to regulatory requirements. Using PPE provided by IH helps to ensure that: it will provide you with the level of protection required; you are trained on its appropriate use; disposal and/or cleaning/reprocessing protocols are in place; and that is appropriate for the care environment. There are specific minimum requirements for selection of gowns, masks and respirators that must be met to ensure your safety in the workplace.
- With respect to respirators, these requirements include education, hands-on training and fit testing for all respirators (except PAPRs). The Workplace Health and Safety department is actively working to implement both standard and alternate respirators across IH. In order to do this successfully and effectively utilize available resources, a targeted centralized approach is being used. Implementation of alternate PPE will be based on risk, availability and usage rates.
- The PPE shortages and backorders are universal, and PHSA Supply Chain is working closely with Health Authority stakeholders and various vendors to purchase products that are suitable for use in our healthcare environment and meet the Occupational Health and Safety (OHS) and Infection Control requirements to ensure the safety of health care providers and their patients/clients.

Q8. What if I already purchased my own eye protection, can I still use it?

- Yes, if your eye protection is CSA approved, latex-free and able to be cleaned and disinfected you may use it. Remember:
    - **Prescription eyeglasses are not appropriate eye protection**
    - Select close-fitting eye protection that provides maximum coverage of your eyes

- **Q9. Can we make our own procedure masks or respirators?**

Interior Health does not recommend or approve making your own personal protective equipment. There are certain standards which regulate PPE items and ensure its efficacy. For example, procedure masks are certified by ASTM F2100 standard for fluid resistance, particle filtration efficiency and bacterial filtration efficiency. Self-made masks are not certified by the standard thus they are not appropriate to use to protect staff members from being exposed to workplace hazards.

Q10. I am developing skin irritations and discomfort from wearing a procedure mask (or N95) throughout my shifts; is it ok to use a headband with notches or buttons on which to secure my mask ear loops?

We recognize that depending on the fit of your mask, it could rub the skin and start to cause irritation. Employees and medical practitioners who are experiencing or at risk of PPE related adverse skin reaction should review the recommendations for PPE related skin integrity concerns memo, the Guidelines for the use of Ear Savers, and the prevention and remediation guidelines and follow recommendations.

IH: Prevention and Remediation Guidelines; Skin Integrity Concerns Related to PPE

Partner: Prevention and Remediation Guidelines; Skin Integrity Concerns Related to PPE

BCCDC: Management of PPE-Related Skin Damage for Health Care Workers

Q. Can I wear the same procedure mask all day? How often should I change it?

Procedure masks can be used between clients, regardless of client's COVID-19 status, as long as the mask is not removed between clients. Keep your mask on, removing and safely discarding only when it is damp or soiled or you take a break. Any time you remove your mask, replace it with a new mask.

If you are working in a congregate care setting and using a face mask with a shield, you may keep the mask and shield on between clients. If you need to remove the mask with shield at any time it must be discarded and replaced with a new procedure mask and eye protection.
Important: always perform hand hygiene if you touch, adjust or remove your mask.

8.6 Up-to-date Resources for Optimal Use of PPE

- Optimal Use of PPE
- IH: Safety Huddle – Appropriate use of PPE
  Partner: Safety Huddle – Appropriate use of PPE

8.7 NEW! Masks

As per the Nov 5, MOH Policy for Mask Use in Health Care Facilities during the COVID-19 Pandemic in Long-Term Care/Seniors Assisted Living Settings

Health care workers and non-clinical staff:

- All persons working in a Long-Term Care facility or Seniors Assisted Living residence **must** wear a medical mask at all times, including in common areas and break rooms unless eating and/or drinking.

Visitors:

- All visitors in a Long-Term Care facility or Seniors Assisted Living residence **must** wear a medical mask at all times

All health care facilities must provide medical masks for all health care workers, nonclinical staff, patients and visitors where indicated in this Policy.

Definitions:

- **Medical mask:** A medical grade face mask that meets ASTM International and ISO (or equivalent) performance requirements for bacterial filtration efficiency, particulate filtration efficiency, fluid resistance, pressure differential, flame spread, skin sensitivity and cytotoxic testing.
- **Must:** A mandatory requirement based on BC Ministry of Health directive (MHO Order).
- Non-clinical staff: All staff that are not providing clinical care including, but not limited to, administrative and office staff, facilities staff, contracted staff and volunteers.

BCCDC How to Wear a Face Mask

IH: Guidelines for the use of Ear Savers

Partner: Guidelines for the use of Ear Savers

8.8 NEW! Medical Masks for All Persons Working in LTC and AL Facilities

This includes offices in the facility

During the COVID-19 pandemic, all persons working in a Long-term Care (LTC) facility or Seniors Assisted Living (AL) residence should wear a surgical/procedure mask for the full duration of their shift. This includes wearing a surgical/procedure mask throughout the entire shift, even if not directly interacting with clients or patients.

Key reminders

- Surgical/procedures masks should be:
  - Worn according to this poster (cover mouth and nose fully).
  - Changed if the masks become wet, damaged or visibly soiled.
- Learn about the:
  - IH: Difference between a surgical and procedure mask
  - Partners: Difference between a surgical and procedure mask
- Only if consuming drinks/food should surgical/procedure masks be removed during breaks. Maintain physical distancing during the break.
- Staff should always follow droplet and contact precautions when entering COVID-19 units or rooms on droplet and contact precautions (i.e., rooms where clients diagnosed with confirmed or suspected COVID-19 have been admitted).
- All direct patient care requires gloves, procedure mask, and eye protection.
  - A gown is required in addition to the above for droplet and contact precautions.
  - IH: PPE Risk Assessment Guideline during COVID-19 Pandemic
  - Partners: PPE Risk Assessment Guideline during COVID-19 Pandemic
- If an airborne precautions sign is posted, wear an N95 respirator.
  - Use of a fit-tested N95 respirator is only required when performing aerosol-generating medical procedure (AGMPs) on a person with suspected or confirmed COVID-19.
- In LTC and AL settings, AGMPs on clients suspected or confirmed to have COVID-19 should only be performed when medically necessary to reduce the need for N95 respirators.
  - If an AGMP is performed, ensure the fewest number of staff necessary to perform the procedure are present.

8.9 UPDATED SECTION! Gloves

Gloves are **not** required to be worn for every task. Glove use should be in alignment with the BCCDC PPE Allocation Framework and based on a Point of Care Risk Assessment. Wearing gloves for extended periods of time can increase the risk of skin irritation from moisture within the gloves.

- IH: PPE Risk Assessment Guideline during COVID-19 Pandemic
- Partners: PPE Risk Assessment Guideline during COVID-19 Pandemic

- IH: Selection Guide for Non-Sterile Exam Glove
- Partner: Selection Guide for Non-Sterile Exam Glove

8.10 UPDATED SECTION! Eye Protection/Face Shields/Safety Goggles

Eye protection is worn to protect the mucous membranes of the nose, mouth and eyes during procedures or activities likely to generate splashes of blood, body fluids, secretions or excretions or within two metres of a coughing patient.

Eye Protection can be any one of the following:

- Face shield,
- Goggles
- Safety glasses
- Procedure mask with attached visor
- **Prescription eye glasses are not acceptable as eye protection**

Remove and discard the eye protection after use if disposable; if re-usable, clean with a disinfectant after each use.

- The outside of the mask and eye protection are considered contaminated.
- Clean hands after removing the mask and eye protection.

Cleaning:

BCCDC Cleaning and Disinfection Instructions for Eye/Facial Protection

IH: Instructions for Cleaning Face Shields, Eye Goggles or Safety Glasses

Partners: Instructions for Cleaning Face Shields, Eye Goggles or Safety Glasses

How do I clean my face shield/goggles?

- Important: Surgical/procedural masks with visors attached cannot be cleaned and re-used.

Instructions for cleaning eye protection:

- Doff other PPE as per usual procedures and perform hand hygiene with an alcohol-based hand rub.
- Open a blue pad and place the pad on clean surface (e.g. vehicle seat) and perform hand hygiene with an alcohol-based hand rub.
- Carefully remove the eye protection and place on blue pad and perform hand hygiene with an alcohol- based hand rub.
- Don gloves and wipe the inside (portion facing face), followed by the outside of the face shield with a clean cloth saturated, with neutral detergent solution or a cleaner wipe (e.g. baby wipe).
- Carefully wipe the outside of the face shield with the Accel wipes, to visibly dampen it, and allow one minute of contact time on the blue pad.
- Avoid using Accel wipes on the foam and elastic band of face shields or eye goggles.
- Wipe the outside of the face shield with clean water or alcohol wipe to remove residue.
- Allow face shield to air dry on the blue pad.

- Remove gloves and perform hand hygiene.
- Once face shield is dry, move to a storage container or bag, being careful not to touch inner surface and perform hand hygiene with an alcohol-based hand rub.
- Eye protection can stay on in a congregate housing environment between clients if HCW does not touch their face and practices diligent hand washing.

8.11 UPDATED SECTION!Gowns

BCCDC: The Association for the Advancement of Medical Instrumentation (AAMI) standards are designed to help medical-device companies meet global standards for the safe use of medical devices. *ANSI/AAMI PB70:2012, Liquid Barrier Performance and Classification of Protective Apparel and Drapes Intended for Use in Health-Care Facilities* classifies gowns according to four levels of barrier performance.

Gowns will be assessed against the AAMI barrier protection certification criteria for appropriateness.

- IH: Gown Selection Guide
- Partner: Gown Selection Guide

8.12 N95 Respirators

N95 respirators are required when performing Aerosol Generating Medical Procedures, including CPR on a COVID suspected or positive Client. The number of staff to be fit tested should be determined by each site manager, based on the number of clients receiving care which includes AGMPs, as well as where these individuals reside within the facility. Respirator fit testing should follow WorkSafeBC Regulations 8.32-8.45. More information can be found in this WorkSafeBC Resource – Breathe Safer.

N95 Respirator Guidelines; What You Need to Know

Note: staff & medical staff who have already been fit tested to an N95 respirator, should not be re-fit tested to find an additional fit.

To ensure the health and safety of staff and medical staff LTC sites should ensure:

- Staff and medical staff requiring fit testing have been identified
- Fit testers have been identified and training arranged
- Fit testing equipment is procured
- N95 respirators are obtained, if inventory is required.

Resources:

- WorkSafeBC – Fit testing your respirator
- BC Centre for Disease Control – Personal Protective Equipment
- WorkSafeBC Occupational Health & Safety Regulation 8.32 – 8.45
- WorkSafeBC – Breathe Safer: How to Use Respirators Safely and Start a Respirator Program

AV1900 Respiratory Protection Program Policy

8.13 UPDATED SECTION!N95 Supply Resources

An integrated provincial model combines centralized and decentralized business functions, always recognizing the needs of the local regions. Supply Chain has regional branch offices in each health authority to ensure local presence and attention to each authority's needs.

PHSA Contact Supply Chain

SafeCare BC provides the following information to assist organizations to locate alternate suppliers of personal protective equipment (PPE) during the COVID-19 pandemic. This is not an exhaustive list, as there may be other alternate suppliers of PPE. SafeCare BC does not in any way vet or endorse the alternate suppliers or the products they offer.

SafeCare BC Alternative Suppliers

8.14 UPDATED SECTION! N95 External Fit-Testers (e.g. Agencies contracted to conduct fit-testing)

Fit-testing will only be provided by:

- Fit-testers having successfully completed the WHS Department respirator fit-tester training session;
- Quantitative Fit Testing Process Training Flowchart
- Qualitative Fit Testing Process Training Flowchart
- WHS Department; or
- External contractors approved/recognized by the WHS Department.

Where a Health Authority's fit-testing (all or a portion) has been contracted to an external agency that group will:

- Ensure that fit-tests are completed in accordance with the *WSBC Occupational Health & Safety Regulation* and CSA Standard Z94.4-11.
- Ensure that fit-testing and any other relevant education/training is conducted in a manner with approval by the Interior Health.
- Utilize respirator models currently used by Interior Health.
- Provide proof of fit-testing completion that details the fit-test date, respirator brand, model and size and name of fit-tester and company.

IH: Observation Checklist Quantitative Fit Test

Workplace Health and Safety Respirator Fit Test Record

Criteria for Requiring Respiratory Protection: Airborne Infectious Agents

*Please reach out to the COVID Recovery Team or your local Regional Knowledge Coordinator for the Fit Test forms

8.15 Donning & Doffing

- Donning PPE - Droplet & Contact Precautions Poster
- Doffing PPE - Droplet & Contact Precautions Poster
- Donning Enhanced PPE – Aerosol Generating Medical Procedures
- Doffing Enhanced PPE – Aerosol Generating Medical Procedures

8.16 Signage for Droplet & Precaution Signage

IH: Droplet & Contact Precautions Signage

IH: Droplet & Contact with Enhanced PPE Signage

Partner: Droplet & Contact Precautions Signage
Partner: Droplet & Contact with Enhanced PPE Signage

9.0 Clinical Practice Resources

9.1 UPDATED! Nasopharyngeal Swab Toolkit

Note: In May the Provincial Health Officer temporarily removed the requirement For Licensed Practical Nurses to have a client-specific order prior to performing nasopharyngeal swabs if being done as part of a screening program approved by a Medical Health Officer.

As per the PHO orders of November 16, 2020 registrants other than nurses may also perform the Screening Activity, without undue risk to the health or safety of the patient or any other person.

Health Authority Regulated Health Professionals SARS-CoV-2 Swabbing

Midwives and Certified Practice Speech Language Pathologist SARS-CoV-2 Swabbing

British Columbia Emergency Health Services SARS-CoV-2 Swabbing

To support staff in collecting a nasopharyngeal swab, please click on the link:

- IH: Nasopharyngeal Swab-Toolkit
- IH: Nasopharyngeal Swab-Competency Validation Instructions
- Partners: IH Practice Skills – Specimen Collection : Nose and Throat – CE
  Partners: Nasopharyngeal Swab Collection Instructions poster
  Partners: Clinical Skills – Nose and Throat Swab Collection – CE - Elsevier Extended Text
  Partners: Nasopharyngeal Swab Competency Validation Instructions – *This is a sample validation document – some links cannot be opened.*
  Partners: Nose and Throat Swab Collection – Elsevier Nursing Skills Competency Checklist
- IH Only: Nasopharyngeal Swab Collection Competency Validation iLearn 2498
- BCCNM: Scope of Practice Standards (RN/LPN/RPN)

The following **video** demonstrates how to perform a nasopharyngeal swab:

- How to perform a Nasopharyngeal Swab

9.2 Contact Precautions

Contact Precautions refer to infection prevention and control interventions to be used in addition to Routine Practices and are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact:

- IH0400: Contact Precautions

9.3 Droplet Precautions

Additional precautions used for patients suspected or known to have an infection caused by microorganisms that are transmitted via large droplets. Droplets are expelled into the air immediately after someone coughs or sneezes remain suspended for a very short time and then settle onto environmental surfaces. Droplets that have settled on surfaces are a risk if a person comes into contact with them; therefore droplet precautions encompass contact precautions. Droplet precautions were previously known as droplet/contact precautions.

- Infection Prevention and Control Section 04H – IH0300 (Droplet Precautions) Oct 2019
- Droplet & Contact Precautions Signage

9.4 UPDATED SECTION! Medical Masks for All Persons Working in LTC and AL Sites

As part of the Ministry of Health Infection Prevention and Control Requirements for COVID-19 in Long-term Care (LTC) and Senior's Assisted Living (AL):

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

This includes wearing a surgical/procedure mask throughout the entire shift, even if not directly interacting with clients or patients.

Key reminders

- Surgical/procedures masks should be:
  - Worn according to this poster (cover mouth and nose fully).
  - Changed if the masks become wet, damaged or visibly soiled.
- Learn about the:
  - IH: Difference between a surgical and procedure mask
  - Partners: Difference between a surgical and procedure mask
- Only if consuming drinks/food should surgical/procedure masks be removed just prior to breaks. Maintain physical distancing during the break.
- Staff should always follow droplet and contact precautions when entering COVID-19 units or rooms on droplet and contact precautions (i.e., rooms where clients diagnosed with confirmed or suspected COVID-19 have been admitted).
- All direct patient care requires gloves, procedure mask, and eye protection.
  - A gown is required in addition to the above for droplet and contact precautions.
  - See the Interior Health PPE Guide for more information.
- If an airborne precautions sign is posted, wear an N95 respirator.
  - Use of a fit-tested N95 respirator is only required when performing aerosol-generating medical procedure (AGMPs) on a person with suspected or confirmed COVID-19.
- In LTC and AL settings, AGMPs on clients suspected or confirmed to have COVID-19 should only be performed when medically necessary to reduce the need for N95 respirators.
  - If an AGMP is performed, ensure the fewest number of staff necessary to perform the procedure are present.

9.5 Donning and Doffing Instructional Videos, Resources and Signage

To support infection prevention and control, as well as health and safety in the workplace, the following donning and doffing *how-to videos are now available on* **YouTube:**

- Donning Enhanced PPE for Aerosol Generating Medical Procedures
- Doffing Enhanced PPE – Aerosol Generating Medical Procedures
- Donning PPE Droplet and Contact Precautions
- Doffing PPE for Droplet and Contact Precautions

Procedure:

- Donning Enhanced PPE – Aerosol Generating Medical Procedures (AGMP)
- Doffing Enhanced PPE - Aerosol Generating Medical Procedures (AGMP)

- Donning PPE - Droplet & Contact Precautions Procedure

9.6 Suture Kits

During the COVID-19 pandemic, Long-term Care (LTC) clients have been identified as a vulnerable population requiring protective measures. In an effort to minimize transfers and provide treatment in place, when appropriate and safe, all LTC sites will be required to have a suture kit available for MRP's, at all times by September 18th, 2020.

The kits should contain the following items:

- Medline Laceration Tray ER standard x1 (Item #0000368)
- Ethilon Suture 3-0 suture x1 (Item #0225806)
- Ethilon Suture 4-0 each x1 (Item #0225807)
- Suture removal tray x 1 (Item #0441407)
- Stanhexidine 450ml x 1 (000064)
- Adhesive skin mini Dermabond-check with physician(order from your pharmacy)
- Lidocaine 2% with AND without epinephrine x 1 each (order from your pharmacy)
- Glasses (Item # 0003010) (not available at this time)

Interior Health Sites: supplies ordered through your regular weekly order and from your pharmacy.
Contracted Provider Sites: suture kits are considered part of the funding for extraordinary costs relating to the COVID-19 pandemic response, funding for which was distributed the week of August 3, 2020. The list of items is the same for contracted providers, however; the item numbers will not be applicable.

Please ensure the location of kits is clearly communicated and the kit content is replenished as needed and checked for expired/missing items on a regular basis.

9.7 Interior Health Transportation of Dangerous Goods Policy

Please click on the link below to access IH policy for the transportation of dangerous goods. This document should be referenced to ensure proper handling of nasopharyngeal swab.

- AV0500 - Transportation of Dangerous Goods

9.8 Online Education for TDG Part 1-Transportation of Human Specimens by Ground

Before employee(s) ship (or offer for shipping), transport, deliver, receive, handle dangerous goods, or write up transportation documentation, follow TDG Training and Certification Requirement to have your employees receive TDG training and certificates accepted by Interior Health.

- IH: Transportation of Dangerous Goods Training & Certification
- Partners: Canadian Centre for Occupational Health and Safety (Government of Canada – Transportation of Dangerous Goods)
- Basic Competency Checklist for Transporting Dangerous Goods

9.9 Interior Health Manager's Guide to Transportation of Dangerous Goods

The Managers' Guide to TDG (IH Only) is intended to provide resources to help managers take correct actions to comply with the Transportation of Dangerous Goods (TDG) Regulations. Whenever Interior Health's employee(s) will be involved in any part of transportation of an item or product outside the boundary of an Interior Health's facility, the manager is responsible to verify if the TDG Regulations will apply and to ensure adequate compliance with the Regulations as per policy AV0500 - Transportation of Dangerous Goods

10.0 COVID-19 Clinical Resources for Long-term Care, Assisted Living and Hospice

10.1 Strategies for Supporting Client

Many of our clients are unable to appreciate the risks involved in the COVID-19 pandemic. Those who do may feel anxious or fearful of co-clients invading their space or spreading disease in our vulnerable population.

- Advanced neurocognitive impairment prevents many clients from understanding these risks and the need to adapt their behaviour; it is simply not within their cognitive capacity.
- During these exceptional circumstances, our role is to support our clients as best we can without added restraints or distress. Be kind and accept what is within the capacity of our clients, our teams, and yourselves

Strategies for Supporting Client: Anxiety and Restlessness

10.2 Supporting Communication and Connection between Client/Client and Family

Being separated from family members and socialization with others is difficult for everyone especially during uncertain times. Our clients and clients may not understand the reasons why this is happening but are likely to feel the sense of emotional distance and isolation.

- Never before have clients in long-term care and retirement communities felt more isolated and removed from normal life. The mental and emotional wellbeing of many are at stake.

Supporting Communication and Connection between Client/Client and Family

10.3 Dementia & Communication

Communication about COVID-19 for clients with cognitive impairment can be challenging.

- How will we explain what is happening to our clients?
- How can we seek their cooperation when asking them to physical distance, wash hands, and not have visitors?
- It is important to always remember that many of the people we are working with have cognitive impairments and losses in brain function – and can no longer communicate, process and comprehend what is happening in the external world.
- As the care team, we need to continue to work together to do the best that we can to reduce the risks to our clients and adhere to protocols. Our clients are doing the best that they can, and if we become too restrictive, we can evoke the emotional and behavioural responses we see.

Dementia & Communication

10.4 Traumatic Brain Injury & Communication

Communication is often more difficult for persons who have sustained a traumatic brain injury. It is common for them to have challenges with processing information, attention and concentration, speech and language, learning and memory, reasoning, planning, and problem-solving.

- Emotional and behavioural difficulties often occur when there is injury to the frontal lobes of the brain.

- It is important we recognize they may become overwhelmed, anxious, and stressed when our expectations or messages are more than they can manage. This contributes to the responsive behaviour we see.

Traumatic Brain Injury & Communication

10.5 Meaningful Activities to Support Distraction and Engagement

Being separated from family members and socialization with others is difficult for everyone, especially during uncertain times. Our clients and clients may not understand the reasons why this is happening, but are likely to feel the sense of emotional distance and isolation.

- Providing meaningful activities: keeps people engaged in a positive way; offers a proactive outlet for restless energy; and helps to decrease emotional triggers of boredom, loneliness, fear, sadness, anxiety, and isolation, which contribute to the responsive and challenging behaviours we see.
- Purposeful activity can be used to distract people away from known risks and provide an opportunity for physical separation from others, as well as supervision to mitigate risks of conflicts.

Meaningful Activities to Support Distraction and Engagement

10.6 Physical Distancing/Isolation, Non-Compliance

Residents who are unable to follow physical distancing/isolation orders may present a risk of infection within congregate living facilities; whether due to impaired capabilities or other.

- Teams may be able to mitigate risks by developing an interdisciplinary care plan including Resident/family, as appropriate, to address the root cause of behaviours, such as unmet needs and environment.
- Pharmacological interventions and/or Least Restraint may be used only as directed by MRP and/or MHO, if all other reasonable interventions have been tried and are unsuccessful.
- Interdisciplinary teams will negotiate and plan care for continued residency for all individuals. As a last resort, exit planning may be considered for those residents who are capable of understanding the risks of their actions and modifying their behaviour, but choose not to.

These guidelines and recommendations will aid clinicians to provide excellent client-centered care while balancing the safety of the facility community.

What we can do:

When a client is not maintaining recommended physical distancing/isolation to prevent the spread of COVID-19, the following investigations and considerations are required:

- Are they capable of understanding the risks of the COVID-19 infection?
- Have any barriers preventing the client from achieving capability been identified and mitigated?
- Have deficits such as language, vision, hearing or mental ability been considered?
- What is their understanding of physical distancing/isolation requirements asked of them?
- Are you able to negotiate behaviour change?
- If they are non-compliant with the physical distancing/isolation policies, what are the options to support them inside of the LTC facility?
- If they are incapable of understanding the risks of COVID-19 or unable to modify their

behaviours, what resources do we have to develop a plan of care?
- Who are the members of the interdisciplinary team and family that need to be involved?
- What other resources do we have in the event that all our on-site planning is not successful?

Additional Resources:

- AH2500 Policy: Least Restraint
- Health Care (Consent) and Care Facility (Admission) Act
- COVID-19 Ethical Decision-Making Framework BCCDC/BC Ministry of Health
- Ethical considerations for managing clients who lack the cognitive ability to adhere to IPAC protocols in long-term care settings, Regional Geriatric Program, Toronto
- Thinking About Removing Your Loved One from Long-term Care during COVID-19?, Canage.ca via BrainXchang

Algorithm (coming soon)

Support Services/Persons:
IH: RKC – Complex Behaviours – Contact and Site Responsibility
Partners: RKC – Complex Behaviours – Contact and Site Responsibility
All: Regional Knowledge Coordinators, Complex Behaviours Referral
Brett.Butchart@interiorhealth.ca (Knowledge Facilitator Vulnerable/Incapable Adults)

10.7 Protocol for Mitigating Risk for Capable Clients in LTC who Request to Leave the Facility for Nonessential Community Outings

This communication is intended to support managers to mitigate risk for capable clients with complex behaviours, who request to leave the Long-term Care sites for nonessential community outings. Despite being encouraged to refrain from nonessential community outings, clients who are unable to due to cognitive challenges, or chose (if deemed capable) not to follow physical distancing/isolation orders, may present a risk of infection within Long-term Care sites**. In recognition of this risk, it is crucial to weigh the respecting of individual rights and freedoms while attempting to satisfy the needs of and protecting the broader client population.**

In accordance with IH AH2500 Least Restraint Policy an adult who does not meet criteria for use of restraint under the Adult Guardianship Act, Mental Health Act or CD Unit Act must not be restrained. This includes any chemical, physical or environmental restraints that prohibit capable adults from leaving a care facility. *These resources are specific to situations whereas, clients prior to COVID-19 frequently left the Long-term Care Facility to partake in nonessential community outings.*

To assist teams in formulating a support plan for the client, an overview of the process is outlined below that must be documented and kept as part of the support plan in the individual's health care record.

Step 1: A capable client requests to leave the site for nonessential community outings. Site explains to the client that the Provincial Medical Health Officer and Ministry of Health direction: clients are advised to limit their external activities and outside appointments to essential only (i.e., medically necessary). In the event that the client determines that they will continue to pursue external activities the site initiates

a plan to support autonomy and safety in accordance with IH AH2500 Least Restraint Policy.
(See "*Physical Distancing/Isolation- Noncompliance Guidelines, Conversation and Algorithm" attached*)

Step 2: Site identifies potential risks to self or others and initiates a conversation with client to explore safe alternatives and strategies to mitigate risks.

Step 3: Client choices present a risk to self or others and safe alternatives have not been found. Determine health care capability as per IHA AL0100 Consent Policy Section 3.7. Connect with RKC-CB to support care planning to mitigate risks. Liaise with Work Place Health and Safety and Human Resources where appropriate.

Step 4: If care planning strategies are unsuccessful and an unsafe level of risk remains- follow process to connect with Clinical Director of Operations, MRP and MHO for further guidelines and direction.

10.8 Serious Illness Conversations: Tool for Clinicians

Conversations between patients and clinicians about what matters most lead to higher quality care and improved quality of life for patients and those who care for them. The COVID-19 pandemic makes communication both more difficult and more important than ever, particularly for people who are at highest risk of becoming very sick.
Specific script adaptation for COVID-19 from Ariadne Labs:

- Serious Illness Care Program COVID-19 Response Toolkit

Additional Resources:

- IH: Serious Illness Conversation Document
  Partner: Serious Illness Conversation Document
- Healthcare Provider Serious Illness Resources
- Clinician Reference Guide: Strategies for Common Scenarios
- Public Advance Care Planning Resources
- BC Centre for Palliative Care Serious Illness Conversations

10.9 Palliative Approach in Long-term Care

A palliative approach takes the principles of palliative care and adopts them earlier in the course of a person's advancing life-limiting condition, adapts care strategies to meet the whole needs of the person and family, and embeds this type of care into care settings that do not specialize in palliative care.
Comprehensive resources can be found here:

- IH: Palliative Approach in LTC Toolkit
  Coming Soon for Partners: Palliative Approach in LTC Toolkit

10.10 Essential Conversations in a Palliative Approach

Effective communication is at the core of the Palliative Approach. It supports collaboration within the team and ensures the wishes and concerns of those in care are being addressed and respected. Care Aides often spend the greatest amount of time with the individual and their family and are important members of the Circle of Communication within Long-term Care.

- IH: Essential Conversations – Fact Sheet
- Partners: Essential Conversations – Fact Sheet
- IH: In-the-Moment Essential Conversations for HCAs – Fact Sheet

- Partners: In-the Moment Essential Conversations for HCAs – Fact Sheet
- IH: Circle of Communication
- Partner: Circle of Communication
- IH: Essential Conversations - Tips
- Partners: Essential Conversations – Tips
- IH: Essential Conversations: Substitute Decision Maker-Worksheet
- Partners: Essential Conversations: Substitute Decision Maker-Worksheet
- IH: Essential Conversations: Client - Worksheet
- Partners: Essential Conversations: Client - Worksheet
- IH: Responding to Common Serious Illness Comments
- Partners: Responding to Common Serious Illness Comments

10.11 Clinical Criteria Recommendations

Clinical Markers to recognize and identify individuals who are living at the End of Life (weeks to months) *and* Last Days/Last Hours (imminently dying) in various care settings:

People coming into Community Hospice Beds (CHBs) from acute care and community care:

- End of Life: meet the CHB Access eligibility criteria:
  IH: Community Hospice Bed Access Referral Form # 821097 – see page 2.
  Partners: Community Hospice Bed Access Referral Form # 821097
- Last Days/Last Hours Care:
  IH: Palliative Performance Scale (PPSv2) is 10-20% (Form #811178)
  Partners: Palliative Performance Scale (PPSv2) is 10-20% (Form #811178)

People who live in a LTC facility:

- End of Life: a sudden or significant decline in condition/function with a RAI CHESS Outcome Scale of 4 or greater
- Last Days/Last Hours Care: Palliative Performance Scale (PPSv2) is 10-20% (Form #811178)
- Medical Assistance in Dying (MAiD)

Additionally, sites should recognize that visitor access will be required for individuals who are facing their end-of-life through the MAiD process. The end-of-life and last days/hours visitation recommendations apply to persons requesting MAiD.

Further Palliative resources can be located here:

- IH - Clinical Decision Support Tools
- Partners - Clinical Practice Supports

10.12 Afterhours Palliative Care Nurse Consult Line

The IH Afterhours Palliative Care Nurse Consult line is a new service for clinicians who require an urgent consult with a Palliative Care Nurse for clinical assistance or direction for persons with palliative needs.

For Urgent Assistance Afterhours Call:

- **1-844-851-4192** to speak with the on-call Palliative Care Nurse

For Urgent Assistance Monday to Friday - 08:00 –16:00

- Elisabeth Antifeau - 250-354-2883
- Vicki Kennedy - 250-212-7807

For non-urgent support please email: IH Palliative CNS

- Partners: Afterhours Palliative Nurse Consult Line – Memo
- Partners: Afterhours Palliative Nurse Consult Line – Clinical Resource Bulletin

10.13 Clinical Decision Pathway COVID-19 in Long-Term Care Clients

Caring for the client with COVID-19 is most appropriate in a familiar setting. Our Long-term Care staff knows the care needs, wishes and priorities of the clients and their families well. The COVID-19 Patient/Client Inter-Facility Transfers memo provides guidelines and an algorithm to aid clinicians to manage care of clients with COVID-19. It acknowledges that while there may be exceptions, on site supportive measures will ensure we are providing excellent supportive care as well as minimizing transfers to Acute Care.

For more information:

- Clinical Decision Pathway COVID-19 in LTC Clients algorithm
- Resources Supporting Clinical Decision Pathway COVID-19 Clients in LTC

10.14 CPR in LTC – When a Client is Suspect/Confirmed Positive for COVID

The Code Blue Clinical Algorithm has been updated to reflect the safe provision of CPR in Long-term Care when a client is suspect/confirmed positive for COVID-19. Chest compressions, as part of CPR, are considered to be an aerosolizing generating medical procedure (AGMP). During AGMP in COVID-19 infected clients, smaller droplets are produced, which can remain airborne and travel farther distances from the client. Without appropriate personal protective equipment (PPE), these aerosolized droplets could be inhaled, potentially causing infection.

Summary of the changes to CPR in LTC during COVID-19 Pandemic:

N-95 mask and **full face shield** is required as part of **enhanced PPE *prior to*** providing chest compressions when a client is suspected/confirmed positive for COVID-19.

- Donning and Doffing of enhanced PPE prior to providing CPR.
- Chest compressions only.
- Do Not Assist respirations.
- Additional signage for Aerosolizing Generating Medical Procedure (AGMP) Signage to be posted outside of room.
- Allow up to 2 hours for air to clear from AGMP/CPR.
- Enhanced cleaning of room/area post incident.
- Bag/Ziploc any paperwork coming from COVID-19 positive room for 9 days.

Please Note:

- CPR is to be provided for WITNESSED ARREST ONLY.
- CPR is only initiated on clients with a C2 MOST when it is a witnessed arrest.
- CPR is not initiated on clients for an unwitnessed arrest.
- Workplace Health Safety (WHS) will make direct contact with sites that have been identified as needing additional fit testing.

10.15 Aerosol Generating Medical Procedures (AGMP)

Aerosol Generating Medical Procedures (AGMP) are performed in some Long-term Care (LTC) and Assisted Living homes. During AGMP in COVID-19 infected clients, smaller droplets are produced, which

can remain airborne and travel farther distances from the client. Without appropriate personal protective equipment (PPE), these aerosolized droplets could be inhaled, potentially causing infection.

Examples of AGMP include:

- Bi-level Positive Airway Pressure (BiPAP)
- Continuous Positive Airway Pressure (CPAP)
- CPR intervention
- Nebulized medication therapy
- Suctioning airway (deep suctioning or open suctioning)
- Tracheostomy care
- Any humidified oxygen delivery systems
- High flow oxygen systems delivering ≥15L/min (including Optiflow and Airvo)

The CD Unit Agency of Canada has recommended that, in addition to routine precautions, healthcare workers (HCWs) follow droplet and contact precautions when caring for patients meeting clinical and exposure criteria for 2019-nCoV, unless performing an AGMP.
2019 Novel Coronavirus: Aerosol Generating Medical Procedures in Healthcare Settings

Enhanced Personal Protective Equipment (PPE) for AGMP should only be used for clients with **suspected or confirmed COVID-19**

- Do Not Enter AGMP Signage
- IH: Airborne Precautions Signage
  Partner: Airborne Precautions Signage
- Doffing Enhanced PPE - Aerosol Generating Medical Procedures (AGMP) Signage

Additional information can be found on the following memos:

- Additional Signage for AGMP in Droplet & Contact with Enhanced PPE
- High Flow Oxygen and Mechanical Ventilators as Aerosol Generating Medical Procedures

10.16 Hypodermoclysis in Long-term Care

Resources on the Long-term Care Clinical Care Resource Page on InsideNet for IH Owned, Operated Sites and on the Extranet for Contracted Partners. This resource is to support all Long-term Care sites to meet the needs for hydration if a client is COVID-19 positive; thereby promoting care in place if safe and appropriate.

- IH: Hypodermoclysis Toolkit
- Partners: Hypodermoclysis Toolkit

10.17 Oxygen Therapy

It is within regulatory scope of practice for nurses (Registered Nurses (RNs), Registered Psychiatric Nurses (RPNs), and Licensed Practical Nurse (LPNs)) to initiate oxygen therapy without an order to treat hypoxemia. IH has developed the Oxygen Therapy-Initiating without an Order guideline to meet this requirement. It also provides an excellent review resource for RNs and RPNs. For external partners, follow your organization's directives; refer to BCCNP LPN Scope of Practice, and request a copy of the IH guideline (contact a Regional Knowledge Coordinator-LTC).

Note: LPNs are required to complete additional education, competency validation and follow this CDST, prior to administering oxygen therapy without an order:

IH Only Document: Competency Validation Instruction: Initiation of Oxygen Therapy without an Order

Additional Education for IH Only: Autonomous Nursing Practice (i-Learn # 2412)

- Required for LPNs
- Recommended for RPNs and RNs

Partners: Oxygen Therapy-Initiating without an Order (IH Guideline for Partner consideration)

10.18 Diabetes Management End of Life Guidelines

The Regional Diabetes and Palliative Care and End of Life Services teams have recently released the IH Diabetes Management at End of Life Guidelines. The purpose of the guidelines is to provide best practice guidance for clinicians providing care for individuals with diabetes through their palliative journey.

Principles to manage diabetes at end of life:

- balancing diabetes interventions with goals of care and prognosis;
- minimizing interventions and monitoring to keep the individual comfortable without compromising safety;
- involving individuals and families in decisions about diabetes management;
- ensuring the effective symptom control is provided;
- tailoring glucose-lowering therapy and minimizing diabetes-related adverse treatment effects;
- avoiding complications, symptom distress and diabetes-related emergencies;
- providing an appropriate level of intervention according to the stage of illness, symptom profile, and respect for the individual's dignity; and
- supporting and maintaining the empowerment and autonomy of individuals and caregivers for as long as possible.

Partners: IH Diabetes Management at End of Life Guidelines

10.19 Bodies of Deceased Patients with Suspected or Confirmed COVID-19 – Safe Handling

The process outlined below provides interim guidance for the safe handling of deceased persons with suspected or confirmed COVID-19 in LTC, ALP and Congregate Living Sites:

1. Contact IH's Communicable Disease Unit, at CDunit@interiorhealth.ca for any deceased client with either suspected or confirmed COVID-19.
    - Include the client's name, Personal Health Number, and date of birth.
    - Indicate whether the site is awaiting swab results or the deceased has confirmed COVID-19.
2. Care of the Deceased:
    - Complete a Point of Care Risk Assessment to identify the PPE required.
    - At minimum, wear long-sleeved gown and gloves.
    - If risk assessment indicates additional precautions are required (e.g., risk of splashes from the client's body fluids or secretions onto the health worker's body or face), then wear a procedure mask, goggles or face shield, and a fluid-resistant gown
    - Follow the Safe Handling of Bodies of Deceased Persons with Suspected or Confirmed COVID-19: Interim Guidance from the BC Centre for disease Control.
3. Notifying Funeral Home:
    - Remind families to inform the funeral home if the deceased is either suspected or confirmed COVID-19 when the family contacts the funeral home to transport the body.
    - Long-term Care, Assisted Living, and Congregate Living staff will verify the deceased person's COVID-19 status with funeral home staff on their arrival.

4. As with current practice, the funeral home will transfer/transport the deceased in the appropriate body bag and the medical certificate of death will be completed by the physician.
5. Long-term Care homes should keep a very limited supply of fluid resistant gowns, LEVEL 3, for high-risk situations and re-order as needed:
IH: Gown Selection Guide
Partner: Gown Selection Guide
6. Health-care sites will follow standard organizational guidelines and processes regarding environmental cleaning and disinfection of the patient area, handling of linens and waste management.

10.20 Direction for Sudden Unexpected Death with Suspicion for COVID-19

During the COVID-19 pandemic, sudden unexpected deaths will still occur as they did pre-pandemic, but consideration will be increasingly given to COVID-19 as a possible cause.

Many sudden unexpected deaths occur outside of the healthcare system, while others present for medical attention with inadequate time to perform laboratory testing prior to death.

This flowchart outlines the appropriate steps for obtaining post-mortem COVID-19 testing and additional investigations as indicated to assist in ruling in and ruling out other potential causes of death.

Key Messages:

- Report all COVID-19 suspected deaths to the Medical Health Officer.
- Post-mortem testing for COVID-19 may be done at the request of the BC Coroner's Service or the Medical Health Officer, with the latter requiring consent from the next of kin.
- Additional post-mortem investigations, up to and including complete autopsy, may also be requested in consultation with pathology to accurately determine the cause of death.

Additional Resources:

- Reporting a Death to the BC Coroner's Service
- Collecting a Nasopharyngeal (NP) Swab
- Autopsy Consent Form
- Autopsy Consultation Request

10.21 Additional Clinical Resources

Watch a 35 minute video interview with Teepa Snow titled Managing dementia care in the time of COVID-19:
https://www.beingpatient.com/teepa-snow-managing-dementia-care-in-the-time- of-covid-19/.
British Geriatrics Society. March 25, 2020. Managing COVID-19 Pandemic in Care Homes. Good practice guide. Available at:
https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes
DementiAbility© (2020). Hand & personal hygiene in dementia care. Available at:
https://www.dementiability.com/resources/Hand-Hygiene-in-dementia-care.pdf

11.0 UPDATED SECTION! Employee and Human Resources

11.1 Human Resources – Employee COID-19 Q&A

- Human Resources: COVID-19 Q & A Sept 10,2020

11.2 Employee Vacation Planning

Vacation and COVID-19 Information (For IH O&O):
Employees returning to Canada following international travel are subject to the *Federal Government's Quarantine Act and the BC Provincial Health Officer's Order* requiring 14-day self-isolation. This self-isolation period applies to all staff, including those who perform essential work. This can have a significant impact on our ability to staff departments and care for our patients, residents and clients. **The 14-day self-isolation period does not qualify employees for sick leave.**

Please read Leave Planning Requirements for International Travel for more information.

Leave Planning Requirements for International Travel
During this extended and challenging period of Pandemic response, it is important that all employees take their vacation to rest and recharge. IH must also ensure that we can schedule staff appropriately at all times to maintain safe patient care.

Leave Requests:
Effective immediately and for 2021, any employees planning to travel outside of Canada are required to request and receive approved leave for their planned time away and the 14-day self-isolation period once they return to Canada.

This may be inconvenient for some employees, but Interior Health must abide by the Provincial and Federal government requirements and ensure sufficient staffing. We will update this requirement in accordance with Federal or Provincial changes to the isolation period as they occur.

Because travel outside of Canada may increase exposure to COVID-19 and will result in a 14 day isolation period, employees should be aware of implications associated with booking insufficient time off to account for the isolation period.

Exceptions
Employees whose work can be completed while self-isolating from home, and have been approved by their manager to work from home, may do so without requesting additional leave.

11.3 Provincial COVID-19 Health and Safety Guidelines for K-12 Settings

Q. What is the process if your child presents with COVID-19 like symptoms and is sent home from school?

- Any student who has symptoms of COVID-19 OR was identified as a close contact of a confirmed case or outbreak must stay home and self-isolate, including children of essential service workers.
- Any student who has cold, influenza, or COVID-19-like symptoms should seek assessment by a health-care provider and **self-isolate while they await the results**.
- Those unsure if they or a student should self-isolate or be tested for COVID-19 should be

directed to use the BC COVID-19 Self-Assessment Tool.

- **Contact 8-1-1** or the local CD Unit to seek further input.
- They can also be advised to contact a family physician or nurse practitioner to be assessed for COVID-19 and other infectious respiratory diseases.
- Students may still attend school if a member of their household has cold, influenza, or COVID19- like symptoms, provided the student/staff is asymptomatic. As per CD Unit guidance, it is expected the symptomatic household member is seeking assessment by a health-care provider.
- Students who experience seasonal allergies or other COVID-19-like symptoms, which are related to an existing condition, can continue to attend school when they are experiencing these symptoms as normal. If they experience any change in symptoms, they should seek assessment by a health-care provider.

For additional questions:

- Provincial COVID-19 Health & Safety Guidelines for K-12 Settings

11.4 Employee Wellness Resources

IH Employee and Family Assistance Program (EFAP):

Interior Health's EFAP provider has counseling services and other resources online and through the app 'My EAP'. For more information on the EFAP program see Guide to Employee Health and Wellness Services or workheatlhlife/com or call 1-844-880-9142

A list of physical and psychological wellness resources is available on the Employee Wellness & Psychological Health page on InsideNet.

Psychology works for COVID-19. Psychologists giving back to front line health providers:

If you are a front-line health service provider, and would like to contact a psychologist, please use the following link from the Canadian Psychological Association to see the list: https://cpa.ca/corona-virus/psychservices/. It is a listing of psychologists who have volunteered to provide psychological services to front line health care providers. The listing of psychologists is organized into province and territory as well as languages spoken. It is important that you choose one who is on the list of the province or territory in which you are located. The psychologists on the listing have agreed to return calls for requests for service within 24 hours of their receipt and to provide services at no charge.

- "Psychology Works" Fact Sheet: Emotional and Psychological Challenges Faced by Frontline Health Care Providers during the COVID-19 Pandemic
- Medical Staff Peer Support
- The Working Mind; COVID-19 Self-care & Resilience Guide
- A quick guide to wellness: Psychological First Aid for Frontline Health Care Providers during COVID-19

11.5 Reinstatement of Permanent Postings for Single-Site Facilities

Effective Oct. 19, 2020, Interior Health will post all new permanent vacancies as permanent postings. The only positions posted as temporary will be those that meet the collective agreement definition of temporary postings. Positions that were previously posted as temporary under the SSTF will remain as they are and only be posted permanently once vacated by the current occupant. This means that

employees will be able to apply on postings at any site where they are internal candidates and not just the single site to which they were assigned.

Applying for Permanent Positions

- All employees are encouraged to apply for internal postings on i-Site as they would normally.
- The parties to the agreement also negotiated a job board that is open to internal applicants on the Province's WorkBC website. However, Interior Health employees are encouraged to apply, as they normally would, through IH i-Site system which is accessible remotely.
- NBA employees who hold a temporary position, which would have been permanent if the temporary posting restriction in the SSTF was not in place, are not required to wait until their temporary appointment ends before starting a new permanent position. *(Reference: NBA Article 17.02)*

Right to Retain Employment

Employees who held multiple positions at multiple sites before the Single Site Order will be required to give up their combined full-time equivalent (FTE) when posting into a permanent position, but they may retain their employment at the other employer worksite where they were employed prior to the Single Site Order. Employees will be asked to advise the manager of that position, in writing, if they wish to resign or maintain their employment with a previous employer. The employee will also be required to acknowledge their decision on their internal offer letter.

Actions Required for Managers

- Effective Oct. 19, 2020, please post all permanent vacancies as permanent.
- Successful applicants are expected to commence work on the posted start date unless directed otherwise by the Medical Health Officer or the Provincial Health Officer. As such, managers must carefully consider the start date on their postings and postpone start dates if warranted by the circumstances.

For Questions & More Info

Employees are encouraged to contact their managers with questions about permanent postings, or the Recruitment team if there are questions specific to the job board or posting process.
Managers who have questions or require more information should contact their Employee Relations Advisor.

11.6 UPDATED SECTION! Principles for Definition of Essential Health-care Workers

Principles to guide managers in determining whether an employee is essential to the delivery of patient care and life-saving services:

The Provincial Health Officer (PHO) has defined **essential health-care workers** as those who are ***essential to the delivery of patient care and life-saving services***. Further, the PHO indicates that workers in essential services vary between organizations in the public and private sector.

Within the health sector, workers who provide direct patient care cannot do so without the support of other workers who do not provide direct patient care. Examples include those workers who provide support services such housekeeping, food services, laundry and supply chain services, or administrative employees who schedule employees for work and ensure employees are paid.

It is possible that a worker may be essential to the delivery of care on one day and not essential on another day (e.g. patient volume is below census due to service cancellations). In those cases, determination and designation of an essential worker is the responsibility of the worker's manager.

The following principles should be applied in advance of the worker's scheduled shift and are to be applied during the COVID-19 pandemic and until such time as the PHO declares an end to the pandemic:

- The worker provides direct patient care and, without the worker, safe direct patient care delivery and/or worker safety would be compromised (e.g. nurse, physician, care aides, etc.).
- The worker provides clinical support to direct patient care workers and, without the worker, safe direct patient care delivery and/or worker safety would be compromised (e.g. laboratory technicians, pathologists, pharmacists, etc.).
- The worker provides non-clinical support to direct patient care workers and, without the worker, safe direct patient care delivery and/or worker safety would be compromised (e.g. housekeeping, supply delivery, security, etc.).
- The worker provides administrative support to direct patient care workers and, without the worker, their duties would fall to the direct patient care worker. This would take the direct patient care worker away from providing direct safe patient care delivery and/or worker safety would be compromised (e.g. patient registration clerks, staffing clerks, etc.).
- The worker provides critical environmental support services that support the delivery of direct patient care providers (e.g. physical plant engineers; information technology workers, etc.).
- The worker provides direct support for the emergency response to COVID-19 (e.g. medical health officers, epidemiologists, planning leads, etc.).

All non-essential health-care workers – such as human resource, payroll, and financial services workers, etc. – who do not exhibit symptoms of illness must either work from home or follow the PHO's directions for non-essential worker environment constraints (such as self-isolation after international travel). It is important to note that these health-care workers may at some point during the COVID-19 pandemic be identified as essential, since they may be required to provide non-clinical support to direct patient care workers. Without these workers, these duties would fall to the direct patient care worker, taking them away from providing direct patient care and compromise safe patient care and worker safety.

11.7 NEW UPDATE! Employee (Staff) Screening for COVID-19

Employees are to ensure they are self-monitoring for COVID-19 symptoms before each shift and responding appropriately.

Guidance for COVID-19 Testing by Nucleic Acid Tests (NATs):

***Test all individuals with new symptoms compatible with COVID-19, however mild**.

The symptoms most commonly found with COVID-19 infection include:

- Fever
- Sore throat
- Loss of appetite
- Chills
- Loss of sense of smell or taste
- Nausea and vomiting

- Cough*
- Headache
- Muscle aches
- Shortness of breath
- Fatigue
- Runny nose
- Diarrhea

*Or exacerbation of chronic cough.

- Less common symptoms of COVID-19 infection include stuffy nose, conjunctivitis (pink eye), dizziness, confusion, abdominal pain, and skin rashes or discoloration of fingers or toes.

Clinical judgement remains important in the differential diagnosis and work-up of individuals presenting with these symptoms (e.g., people with allergies).

For more information on the diagnosis and management of COVID-19 infection, please refer to the clinical guidelines on the BCCDC website.

All Home Health and Assisted Living Staff are required to sign in, be screened for COVID-19 and have their information recorded on the Long-term Care and Assisted Living Staff Screening Sheet.

Screeners will screen all staff entering the building before the start of their shift. Screening consists of asking the COVID-19 questions and recording the answers. Taking of Staff temperature is not part of the Screener role but the staff's temperature MUST still be taken daily and recorded.

Reminder: All staff and visitor screening documents are submitted to the manager or designate at the end of each day for safety and security. It is mandatory for site management to securely store the Staff Screening Sheet for a minimum of 28 days in the event these are required by the Medical Health Officer for COVID–19 exposure tracing.

Staff who have symptoms as per the BCCDC (see: BCCDC Health Professionals Clinical Resources Viral Testing) will identify themselves to their supervisor. As per existing requirements any staff member who answers YES to any COVID-19 question will not be permitted to proceed past the Screener location and will need to contact their immediate supervisor who will provide direction. Supervisor reviews, with the individual staff, the list of assessment centres and gives contact information of the assessment centre site that is chosen by the staff (phone or link). The full list of BC Assessment Centres can be found here:

- Collection centre finder (Mobile and desktop)
- Collection centre finder for Internet Explorer users

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

- Call 8-1-1 or use the BC COVID-19 Self-Assessment Tool

Additional Resources:
Staff Respiratory Infection Outbreak Policy – AV1300
Q&A – WHS and HR Information for IH Employees

If you have any questions or concerns, please contact your Workplace Health & Safety Advisor
Recommendations for Risk Assessment and Management of Health Care Worker

11.8 NEW! Employees Presenting with Symptoms

1. If symptoms are mild and consistent with seasonal allergy (known allergic condition AND staff member is fairly confident the symptoms are related to their allergy), staff can continue working with expected PPEs.

2. Anyone with cold, influenza or COVID-like symptoms can be assessed and get a COVID-19 test**. If you are not experiencing symptoms**, a COVID-19 test is not effective or recommended.

3. If staff contact the manager/designate with COVID-19 like symptoms, prior to a shift:
    - Instruct staff to stay home, self-isolate and get tested.

4. If staff develops COVID-19 like symptoms during work:
    - Instruct staff to keep wearing PPE
    - Ask if any critical work is still required
    - Manager/delegate to send staff home, isolate and direct staff to get testing

Testing:

- Anyone with cold, influenza or COVID-like symptoms can now be assessed and get a COVID-19 test. There is no longer a requirement to be referred by a health care provider or by calling
  8-1-1.
- Testing should occur as soon as possible - no sooner than 24 hours after the onset of their symptoms.

Please advise staff to call their local testing centre for an appointment, as opposed to dropping in. IH's testing centres, and a link to centres across B.C, can be found on IH's COVID-19 testing webpage. It takes from 1-3 days for results once tested.

- **Request staff to report results**

If negative: Return to work:

- At the discretion of the employer, may return to work once well enough to work.
- Follow routine infection control practices, including mask, eye protection, and gloves

If positive, remind staff to:

- Public Health will follow up and provide further guidance.
- Typically the HCW will be asked to self-isolate until the following criteria are met:
- At least 10 days have passed since the start of their symptoms, AND
- Fever is resolved without the use of fever-reducing medications (e.g., Tylenol, Advil), AND
- Staff is feeling better (e.g., improvement in runny nose, sore throat, nausea, vomiting, diarrhea, fatigue).
- If public health provided staff with different advice, follow their instructions. A repeat swab is not required provided the above conditions have been met.

11.9 BC Health Care Worker Exposure

Risk assessment and management of health care workers exposed to COVID-19 patient is summarized in the BCCDC: BC Health Care Worker Exposures Risk Assessment Tool

BCCDC: Exposures and Return to Work for Health Care Workers

BCCDC: BC Health Care Worker Return to Work Decision Tree

BCCDC: Interim Guidance on Return to Work for Health-care Workers with Symptoms of COVID-19 (Apr 28, 2020)