



Coronavirus COVID-19

BC Centre for Disease Control | BC Ministry of Health



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

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Ministry of Health



BC Centre for Disease Control



Key Terms

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

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

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

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

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

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

Introduction

This document is intended to provide guidance and recommendations to the operators of LTC facilities and seniors' AL residences¹ in B.C. for the prevention and control of COVID-19. This is based on current scientific evidence about this disease. This guidance may change in the future as new information becomes available. For COVID-19 variants of concern, recommendations for IPC measures remain the same and should be strictly followed and reinforced. See [guidance on SARS-CoV-2 variants of concern](#) for more information.

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

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

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

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

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

An essential practice requirement for HCWs is providing care and services that promote and maintain the safety and well-being of residents and families. In addition to adhering to the guidelines outlined in this document, HCWs are required to draw on their foundational knowledge, skills and abilities, as well as their entry to practice competencies³ to:

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

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

¹ This guidance does not apply to mental health and supportive recovery AL facilities and independent living facilities.

² <https://www.worksafebc.com/en/about-us/covid-19-updates/health-and-safety>

³ https://www.health.gov.bc.ca/library/publications/year/2014/HCA-Core-Competency-Profile_March2014.pdf

COVID-19 Immunization

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

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

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

For further information, please see the following resources:

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

Infection Prevention and Exposure Control Measures

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

1. Screening

Passive Screening (Signage)

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

Active Screening (Managing Facility Entry Points)

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

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

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

Screening of Staff

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

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

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

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

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

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

Screening of Visitors

LTC and seniors' AL facilities:

All visitors must be screened for signs and symptoms of COVID-19, prior to every visit.

To reduce the possibility of transmitting infection, oral thermometers must not be used for visitor screening.

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

Screening of Residents

LTC facilities:

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

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

Seniors' AL residences:

Encourage residents to self-monitor for COVID-19 symptoms and get tested in accordance with [provincial testing guidelines](#)

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

Lab Testing of Residents

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

If a resident is suspected of having COVID-19:

LTC Facilities:

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

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

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

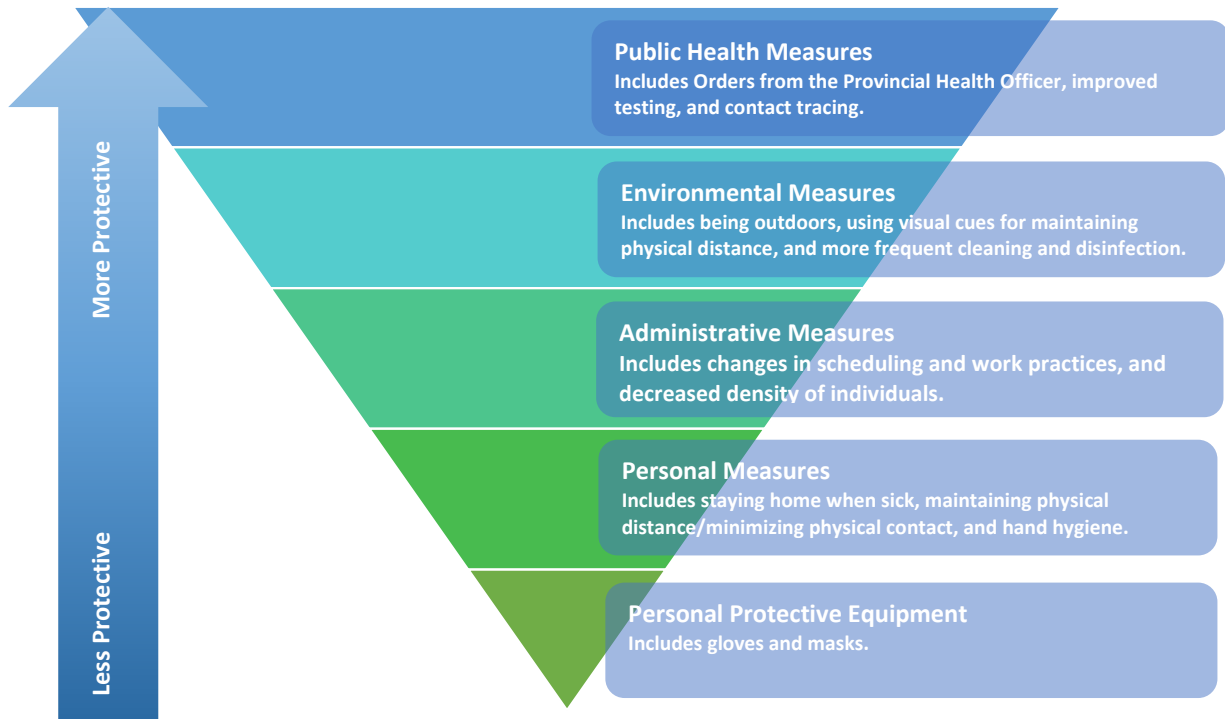
Set up a PPE station/cart outside the resident's room. Ensure all staff entering the resident's room follow routine practices and droplet and contact precautions, including using appropriate PPE and practicing rigorous hand hygiene. Maintain an increased level of surveillance of other residents and for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

Seniors' AL Residence:

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

2. Source Control and Physical Distancing

Hierarchy for Infection Prevention and Exposure Control Measures for Communicable Disease



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

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

Properly maintain building ventilation systems.

Physical Distancing

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

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

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

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

3. Point-of-Care Risk Assessment

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

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

4. Hand Hygiene

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

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

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

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

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

In addition, all staff must clean their hands:

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

5. Respiratory Etiquette

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

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

6. Cleaning and Disinfection

Equipment:

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

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

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

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

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

Environmental cleaning/laundry/waste management:

Please see the BCCDC's [environmental cleaning and disinfectants for clinic settings](#) and the [information sheet for environmental service providers in health-care settings](#) for guidance on environmental cleaning, laundry and waste management.

7. Food Service Delivery and Pick Up

Delivery and pick up:

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

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

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

Food carts:

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

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

Communal dining:

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

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

Food sharing:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Resident Transfer/Outings

Residents transferring from a LTC or seniors' AL residence:

Residents with confirmed or suspected COVID-19 infection should stay in their room unless there is essential need for movement and/or transport. Transfers within and between buildings should be avoided unless medically indicated.

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

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

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

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

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

Personal Protective Equipment

10. Access to and Distribution of PPE

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

11. PPE Use

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

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

12. Mask and Eye Protection Use

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

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

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

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

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

Extending the use of PPE during the COVID-19 pandemic:

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

Extended PPE use can include:

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

When using PPE always:

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

Signage to guide PPE use:

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

13. Droplet and Contact Precautions

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

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

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

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

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

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

14. Discontinuation of Droplet and Contact Precautions

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

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

Resources:

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

Public Health Measures

15. Facility Staff Assignment Order

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

16. Laboratory Testing

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

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

17. Notification & Reporting

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

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

18. Contact Tracing

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

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

19. Managing Deceased Persons

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

20. Psychosocial Supports

Support for residents:

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

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

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

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

Support for staff:

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

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

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

Please see BCCDC's [COVID-19 health-care worker self-check and safety checklist](#) for more information.

Visitors

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

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

21. Hairdressing and Other Services

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

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

Key Sources of Provincial COVID-19 Guidance

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

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

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

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

General IPC Measures

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

PPE and Mask Use

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

Screening

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

- Develop and implement an appropriate script and process for active COVID-19 screening at the entry point for symptoms and risk factors of COVID-19. See [BCCDC COVID-19 entrance screening tool for visitors, patients & staff](#) for more information.
- During business hours, post a staff member at all entry points to actively screen every person who enters the building.
- Outside of business hours, implement a comparable process to screen and log all people entering the building.
- Increase protections for screeners by installing physical distancing supports, including spacing markers on the floor (two metres apart) and transparent barriers that prevent droplet transmission without interfering with communication between the screeners and others.
- Maintain a list of all staff and facility visitors.
- Ensure supplies for implementing these measures are available at all building entry points including medical masks, alcohol-based hand sanitizer (minimum 70% alcohol content), tissues, no-touch waste receptacles and disinfectant wipes
- Staff must actively self-monitor for symptoms related to COVID-19 and follow measures in the [COVID-19 staff self-checklist and safety checklist](#).
- Staff must not come to work if they are experiencing acute respiratory or gastrointestinal symptoms.
- Post signage at all building entry points to support the active screening process.
 - [Visitor restrictions in place](#).
 - [Do not to enter if they are sick or required to self-isolate](#) in accordance with public health directives.
 - [Guide](#) symptomatic individuals to perform hand hygiene, put on a medical mask and self-identify to reception or a health-care provider.
 - [Cough etiquette, hand hygiene and physical distancing](#).
 - [How to put on a face mask](#).

Cleaning and Disinfection

- Identify which staff are responsible for cleaning resident care equipment and inform them about all required duties.
- Dedicate reusable equipment and supplies specifically to individual residents with suspected or confirmed COVID-19 infections.
- If dedicating equipment and supplies to an individual resident is not possible, all reusable equipment that is shared between multiple residents must be cleaned and disinfected with a hospital grade disinfectant after each use.
- Items that cannot be easily cleaned and disinfected should not be shared among residents.
- Discard all single-use items into waste bins after use.

Appendix B: Visitor Sign-in Sheet

| First & Last Name | Phone Number | Email | Date |
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Appendix C: How to Collect a Nasopharyngeal Swab

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

Watch the [How to take a Nasopharyngeal Swab](#) video.

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

Assemble supplies:

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

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

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



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

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

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

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

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

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

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

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