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mechanical ventilation (n=397, multinational). The study reported no significant difference between the 5- day and the 10-day course of treatment after adjustment for baseline clinical status, in respect to distribution of clinical status at day 14 (p=0.14), median duration of hospitalization among patients discharged on or before day 14 (7 days vs. 8 days, respectively), clinical improvement at 14 days (64% vs. 54% of patients, respectively), time to clinical improvement for 50% of patients (10 days vs. 11 days, respectively), and mortality at 14 days (8% vs. 11%, respectively). Notably, 1) patients randomly assigned to the 10-day treatment course had a significantly worse clinical status at baseline than patients assigned to the 5-day treatment course (p=0.02), and 2) fewer patients completed their treatment course in the 10-day treatment arm than in the 5-day treatment arm (43% of patients vs. 85% of patients) [3].

- On June 1, 2020, Gilead released a media statement reporting preliminary findings from their ongoing randomized open-label phase 3 trial comparing a 5-day vs. a 10-day treatment course of remdesivir to standard of care, to treat hospitalized patient (≥ 12 years old) with moderate COVID-19 (n=584 at time of press release). Preliminary evidence suggested remdesivir treatment was associated with clinical benefit compared to standard of care where a 5-day but not a 10-day treatment significantly increased likelihood of clinical improvement on day 11 (p=0.026) [4].

Clinical Evidence of Safety to Date:

- Phase 1 safety data arising from administration to healthy volunteers included evidence of elevated transaminase levels (Grade 1-Grade 2) when administered using the same dosing strategy as that used for COVID-19, for both a 5- and 10-day treatment duration (Study GS-US-399-5505; 200 mg followed by 100 mg dosing for 5–10 days) as well as using a lower dosing regimen (Study GS-US-399-1954; 150 mg daily for 7 or 14 days). Levels normalized after discontinuation of remdesivir [5].
- All above studies in COVID-19 patients reported on safety and no study reported serious safety signals.
- Wang et al. reported a similar percentage of patients reporting adverse events (AEs) between remdesivir-treatment and placebo, however more patients in the remdesivir discontinued treatment due to AEs (12% vs. 5%) [1].
- In Beigel et al., less patients reported a serious AE (SAE) in the remdesivir treated group compared to standard of care (27% vs. 21.1%); this trend was consistent with reporting of grade 3 or 4 AEs (28.8% of patients in the remdesivir arm vs. 33% of patients in the standard of care arm). There was similar incidence of treatment discontinuation due to AE reporting [2].
- Goldman et al. noted more SAEs and discontinuations due to AEs in the 10-day treatment course compared to the 5-day treatment course with remdesivir [3].
- Preliminary safety data from the ongoing Gilead-led randomized open-label phase 3 trial comparing a 5-day vs. a 10-day treatment course of remdesivir to standard of care, reported no increased incidence of AE reporting or SAE reporting associated with 5- or 10-day treatment with remdesivir [4].

Authorization/Licensure Status Worldwide:

- Remdesivir is not currently licensed for use anywhere in the world, for any indication. On April 2, 2020, the European Medicines Agency (EMA) permitted access to remdesivir through the compassionate access programs of the European Union (EU) member states.
- On May 1, 2020, the US FDA issued an Emergency Use Authorization to allow access to the drug for treatment of COVID-19 patients.

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- On May 7, 2020, Japan issued a similar authorization for their population, as did South Korea on June 3, 2020, India on June 13, 2020, and Israel on June 16, 2020.
- Singapore granted conditional approval of its use on June 10, 2020, limiting its access to only treat COVID-19 patients with severe disease.
- On June 12, 2020, the ad-hoc COVID-19 CPTG met, and part of the discussions included a benefit-risk profile of Remdesivir to be included in the pandemic response. The Task Group discussed recent global changes in evidence and clinical practice and were provided an evidence summary prepared by the Canadian Agency for Drugs and Technologies in Health (CADTH) [6].

CONSIDERATIONS:

- There is currently limited evidence on the efficacy of remdesivir for COVID-19.
- Reported safety signals following the use of remdesivir in healthy or COVID-19 patient populations include potential impact on liver function.
- Current clinical data on remdesivir as a treatment for COVID-19 is limited to intravenous administration in hospitalized patients with severe COVID-19.
- Therefore, the risk-to-benefit ratio of remdesivir as a treatment for COVID-19 warrants critical evaluation, especially in severe COVID-19 patients requiring mechanical ventilation in the intensive care unit, and in patients with renal injury / failure.
- Strict criteria should be defined to determine the patient population suitable for Remdesivir treatment where those who are least likely to experience adverse effects and most likely to benefit from the drug are prioritized for treatment based on the evidence as it emerges, and based on availability of data for different demographic subgroups such as sex and age.
- The CPTG will re-evaluate the risk benefit profile of remdesivir for use as treatment of COVID-19 following knowledge of cost of treatment, availability of doses for Canada, and as additional results from RCT are disseminated for publication.

CONCLUSIONS:

The CPTG recommends that remdesivir should only be administered in RCT to monitor whether potential benefits of remdesivir outweigh known and potential risks in the treatment of patients hospitalized with COVID-19.

The group will review emerging evidence as provided by PHAC on an ongoing basis in order to make evidence-informed recommendations in a timely manner.

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This statement was prepared by: *N Forbes, M Patel, M Rieder, and M Salvadori*, on behalf of the Clinical Pharmacology Task Group (CPTG).

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Approved by the Clinical Pharmacology Task Group on June 29, 2020

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Appendix F: National Early Warning Score (NEWS) 2 - Chart 1

Chart 1: The NEWS scoring system

Physiological parameter	Score						
	3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

Reproduced by: Royal College of Physicians. *National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS*. Updated report of a working party. London: RCP, 2017.

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Appendix G: National Early Warning Score (NEWS) 2 - Chart 2

Chart 2: NEWS thresholds and triggers

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low–medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.
**The response team must also include staff with critical care skills, including airway management.

Reproduced by: Royal College of Physicians. *National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS*. Updated report of a working party. London: RCP, 2017

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Appendix H: National Early Warning Score (NEWS) 2 - Chart 4

Chart 4: Clinical response to the NEWS trigger thresholds

NEW score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• Continue routine NEWS monitoring
Total 1–4	Minimum 4–6 hourly	• Inform registered nurse, who must assess the patient • Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required
3 in single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
Total 5 or more Urgent response threshold	Minimum 1 hourly	• Registered nurse to immediately inform the medical team caring for the patient • Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients • Provide clinical care in an environment with monitoring facilities
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level • Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills • Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency unit or ICU • Clinical care in an environment with monitoring facilities

Reproduced by: Royal College of Physicians. *National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS*. Updated report of a working party. London: RCP, 2017

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Appendix I: Dietary Recommendations during COVID-19

Maintaining a healthy balanced diet will help to support a patient's resistance to the virus.

Meals

- Encourage patients to eat 3 meals per day;
- Encourage patients to try to eat as much as they can at each meal;
- If a patient has a low appetite, encourage them to eat more frequently (in between meals);
- Encourage patients to choose fruits and vegetables rich in colour (dark green, orange, red, etc.) to increase intake of antioxidants and other nutrients that support immune function.

Fluids

- Water is naturally part of many foods like vegetables and fruit; milk products; hot and cold beverages as well as soup;
- Encourage patients to drink cold or warm liquids according to their preference;
- Encourage patients to drink often, with meals and in between meals.

Other tips

- Encourage patients to get plenty of rest (at least 7 to 9 hours every night)
- If a patient is age 60 years or older, consider whether it would be helpful if they took a multivitamin.

A patient cannot "boost" their immune system through diet, and no specific food or supplement will prevent the patient catching COVID-19/Coronavirus. Remind the patient that infection prevention and control measures remains (such as hand hygiene, physical distancing, respiratory hygiene, wearing a mask, etc.) the best means of avoiding infection.

As no one food or supplement can prevent illness, remind the patient to eat a variety of foods to maintain a healthy balanced diet.

If a patient indicates their appetite is poor and/or they have lost weight, please contact the Regional Dietitian for advice.

Caution: If a patient has specific nutrition needs, it is important that they continue to follow the dietary recommendations made by the dietitian / doctor. If a patient has any dietary concerns, please request a consultation with the regional dietitian for advice.

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Appendix J: Dietary Recommendations for a patient with COVID-19 - Confirmed or Suspected

Drink often

It is important that a patient drink often because fever makes a person sweat. This causes a person to lose water and electrolytes.

Water is naturally part of many foods like vegetables and fruit; milk products; hot and cold beverages as well as soup.

Encourage the patient to drink cold or warm liquids according to their preference.

Monitor for signs of dehydration:

- Extreme thirst, dry mouth and tongue, infrequent urination or very dark urine, feelings of dizziness, confusion or headaches.
- Encourage patients to report any concerning symptoms to Health Services

Sore throat

Hard candies or pastilles, preferably without sugar, can also be used to soothe a sore throat.

Fatigue affecting oral intake

It is important that to encourage the patient to eat and drink regularly even if you have a low appetite.

Encourage patients to eat fruits and vegetables rich in colour (dark green, orange, red, etc.) to increase intake of antioxidants and other nutrients that support their body's immune function.

Encourage patients to try to eat as much as they can at each meal.

If a patient's appetite is poor and they are having trouble eating, consult the Regional Dietitian for advice.

GI complaints (nausea, vomiting, diarrhea or severe abdominal pain) that may affect oral intake

It is important that the patient eat and drink, even if they are not feeling well.

If their appetite is poor and they are having trouble eating, speak with the Regional Dietitian for advice.

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Appendix K: Guidance on Staff Communication & Engagement with Patients about COVID-19, April 20, 2020

Communication tips

The purpose of these Communication Tips is to help support Healthcare Staff in conversations with patients diagnosed with COVID-19.

As Healthcare Professionals, you are playing a critical role in identifying, reporting and managing cases of COVID-19 within CSC's Institutions.

As there is currently no cure for this virus, infection can sometimes lead to death especially for those most vulnerable (those aged 65 and older; those with compromised immune systems; and those with underlying medical conditions such as, but not limited to, diabetes, heart disease and asthma).

These are unprecedented times and while most of those who contract COVID-19 will recover, it is important to remind all patients to:

- focus on staying healthy;
- practice physical distancing as much as possible;
- wash hands frequently;
- wear a mask; and
- follow their current treatment plans.

Acknowledge fears and feelings of uncertainty

Given the potential seriousness of the diagnosis, patients may show signs of anxiety and uncertainty. Some may verbalize their fears and express anxiety about what kind of care they will receive.

- It is important to acknowledge their fears and take the time to talk about their concerns.
- Asking what they are worried about in particular may open the dialogue.
- They may ask how they contracted the virus. Did they infect others?
- Some may be worried about their family and friends and ask if they can connect with them; some may seek spiritual care and guidance for comfort.
- All efforts should be made to reassure patients they will receive the appropriate medical care and that most with the virus will recover.
- In addition, it is important that patients understand the importance of staying as healthy as possible and to follow treatment recommendations for existing conditions.

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Discuss goals of care

- When a patient is diagnosed with COVID-19, it will be important to explain the kinds of care they will receive and assure them they will be included in all care planning decisions.
- Discuss the range of outcomes, noting that most people infected with COVID -19 virus have mild symptoms and recover. For example about 80% of patients have mild to moderate symptoms. Older persons and those with underlying conditions (hypertension, diabetes, cardiovascular disease etc.) are at higher risk for more severe disease. Therefore, it is important to carefully follow treatment recommendations for existing conditions to stay as healthy as possible.
- Assure the patient they will receive the care they need, including comfort care to avoid distress or discomfort.
- While there may be hope for a patient's full recovery, this is an opportunity to ask the patient whether they have an advanced care plan, should their condition deteriorate.
- Inquire as to whether or not they have completed a DNR.
- Have they identified a substitute decision maker?
- If no advance care planning is in place, initiate the conversation and document the patient's wishes.
- Ask if they have any wishes or messages for loved ones and assure them, you will do your best, within your power, to convey those messages.

Be honest, direct and empathic

- It is important to be honest, direct and empathetic when talking with a patient who has been diagnosed with COVID-19.
- Start the conversation early while the patient is well enough and has the energy for the discussion.
- As some patients may have limited literacy skills, it is important that the information shared, be in words the patient understands so they are better able to participate in discussions about their future care.
- You may also wish to take the time to explain the extra precautions Healthcare Staff are taking (i.e. face masks, gloves, etc.) to avoid the spread of the virus.

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Take a moment to prepare yourself for the conversation

- You may be very familiar with the patient as you may have been providing healthcare to them for many years, especially those with underlying chronic conditions. They will be looking to you for reassurance that they are being kept as safe as possible.
- Given that the information on COVID -19 is evolving daily, provide a response based on the most current messaging from Public Health.
- Some discussions will not be easy. Take a moment, to gather your thoughts.

This is a difficult time in healthcare especially for those providing care in challenging environments such as correctional institutions. We recognize that as you come to work every day in CSC, you may also be worried about family and friends at home. We thank you for your professionalism, dedication and service.

CSC Health Services, April 20, 2020

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Appendix L: End-of-Life Care in the ED

End-of-Life Care in the ED for the patient imminently dying of a highly transmissible acute respiratory infection (like COVID19)

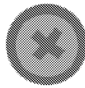
For all patients

- Document discussion around GOC and update category status
- Consider involving spiritual care or palliative care. Ensure COVID status is documented
- Place the patient in a private room with appropriate droplet/contact precautions
- Encourage telephone or video conferencing to minimize visitors
- Ensure my visitors are following appropriate PPE procedures

Non-pharmacological symptom management

- Frequent symptom assessment using validated tools for signs of distress
- Frequent patient repositioning
- Eye and mouth care (avoid deep suctioning)
- Emotional support to patient and and family
- Consider discontinuing any therapy or monitoring not contributing to patient comfort

Avoid the use of



- Fan
- Oxygen > 6 L/minute
- High flow nasal cannula oxygen
- BiPAP or CPAP
- ALL nebulized treatments

During withdrawal of life-sustaining therapy, do not extubate the patient in the ED, but decrease ventilatory support and ensure comfort throughout.

Pharmacological symptom management

Airway Secretions

- Glycopyrrolate 0.4mg subcut/IV q4h prn OR
- Scopolamine 0.4mg subcut/IV q4h prn (more sedating, may have a benefit with agitation)

Agitation/Delirium

- Haloperidol 0.5-lmg subcut/IV q2h prn
- 2nd line: Midazolam 0.5mg subcut/IV q30min prn
- Refractory: consider adding methotrimeprazine 12.5-25mg subcut/IV q4h prn

Pain

If opioid naive:
- Morphine 2.5-5 mg subcut/IV q2h prn OR
- Hydromorphone 0.5-lmg subcut/IV q2h prn

If opioid-tolerant, refer to opioid equi-analgesia and conversion tables

Dyspnea

If opioid-naive, low-dose morphine is the medication of choice:
- Morphine 1-2.5mg subcut/IV q30min prn
- or Hydromorphone 0.25-0.5mg subcut/IV q30min prn
- or Fentanyl 12.5-50mcg subcut/IV q15min prn

If opioid tolerant, give breakthrough doses to effect:
- Breakthrough dose = 10% of total daily dose of subcut/IV opioid in 24 hours

---

Second line: Midazolam 0.5-lmg subcut/IV q30min prn

For severe respiratory distress, consider Ketamine in dissociative dosing as a temporizing measure:
- Ketamine 1-2mg mg/kg IV or 4 mg/kg IM

Nausea

- Haloperidol 0.5-lmg subcut/IV q4h prn OR
- Ondansetron 4mg subcut/IV q6h prn

Fever

- Acetaminophen 650mg po/pr q4h prn

Infographic created by Dr. Shahbaz Syed, Department of Emergency Medicine, University of Ottawa
Hendin A., La Riviere CG., Williscroft OM., O'Connor E., Hughes J., Fischer, LM. End-of-life care in the Emergency Department for the patient imminently dying of a highly transmissible acute respiratory infection (such as COVID-19). CJEM. March 2020.

Image: EM Ottawa - https://emottawablog.com/2020/03/end-of-life-care-in-the-ed-related-to-covid-19/

Article: « End-of-life care in the emergency department for the patient imminently dying of a highly transmissible acute respiratory infection (such as COVID-19) ». Hendin, A., La Rivière, C., Williscroft, D., O'Connor, E., Hughes, J., & Fischer, L. (2020). CJEM, 1-4. doi:10.1017/cem.2020.352

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Additional Resources

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8. ICD-10-CA Coding Direction for Confirmed COVID-19 Cases - https://www.cihi.ca/en/bulletin/icd-10-ca-coding-direction-for-confirmed-covid-19-cases
    - As direction from the World Health Organization (WHO), when there is documentation of a confirmed case of COVID-19, assign *U07.1* Emergency use of U07.1.
    - Note: Do not assign U07.1 when COVID-19 is only suspected.

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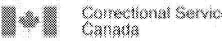
SHAPING THE NEW NORMAL

June 23, 2020



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Version Control

Version	Date	Comments/Changes
1	2020-06-23	Initial Risk Management Framework and Mitigation Strategies

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SHAPING THE NEW NORMAL: CORRECTIONAL SERVICE OF CANADA

The Correctional Service of Canada (CSC) is committed to protecting the health and safety of staff, inmates, and the public in all of its operations, while maintaining public safety. As parts of Canada begin to ease restrictions, CSC is shaping its new normal.

PRINCIPLES

To guide the Shaping of the New Normal, in partnership with our labour partners, CSC established the following principles:

1. The **physical and mental health, safety and wellness of** CSC employees, offenders, stakeholders and the public are **paramount**. CSC will continue to make **ethical and evidence-based decisions** regarding **health practices** for staff and offenders, in **adherence with national, provincial and local public health authorities**.

2. Systemic planning and actions to prevent, manage and restore services following any COVID-19 threat will be **dynamic, adaptive, coordinated, collaborative and transparent**. The easing of restrictions and restoration of interventions, programs and services will be **proportionate** and **asymmetrical**ly implemented across Canada.

3. CSC will adopt a **phased and gradual restoration of interventions, programs and services** approach, ensuring there are appropriate measures in place to limit health and safety risks, while supporting public safety efforts. CSC will adjust restrictions as may be required by public health authorities.

4. Restoration of interventions, programs and services will be **appropriate** to the local level of the pandemic threat and **tailored** to the required response, in line with, national, provincial and territorial public health guidance. In addition, the development of local plans and activities will include **meaningful consultation** with the local Occupational Health and Safety Committee and union executives.

GOVERNANCE STRUCTURE

A robust governance structure was established to guide CSC on Shaping the New Normal.

1. The following Working Groups (WGs) have been established to develop proposals for correctional activities that may resume in the new normal as the risk of COVID-19 transmission decreases. The new normal should not be expected to resemble life prior to COVID-19. Each activity proposed will have clearly identified mitigation strategies depending on the risk levels to ensure the health and safety of staff, offenders, and members of the public. WG membership includes CSC labour partners and CSC management. All members of the working group have a voice and are responsible to

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contribute to identifying solutions. The working groups, chaired by a member of the Executive Committee, include:

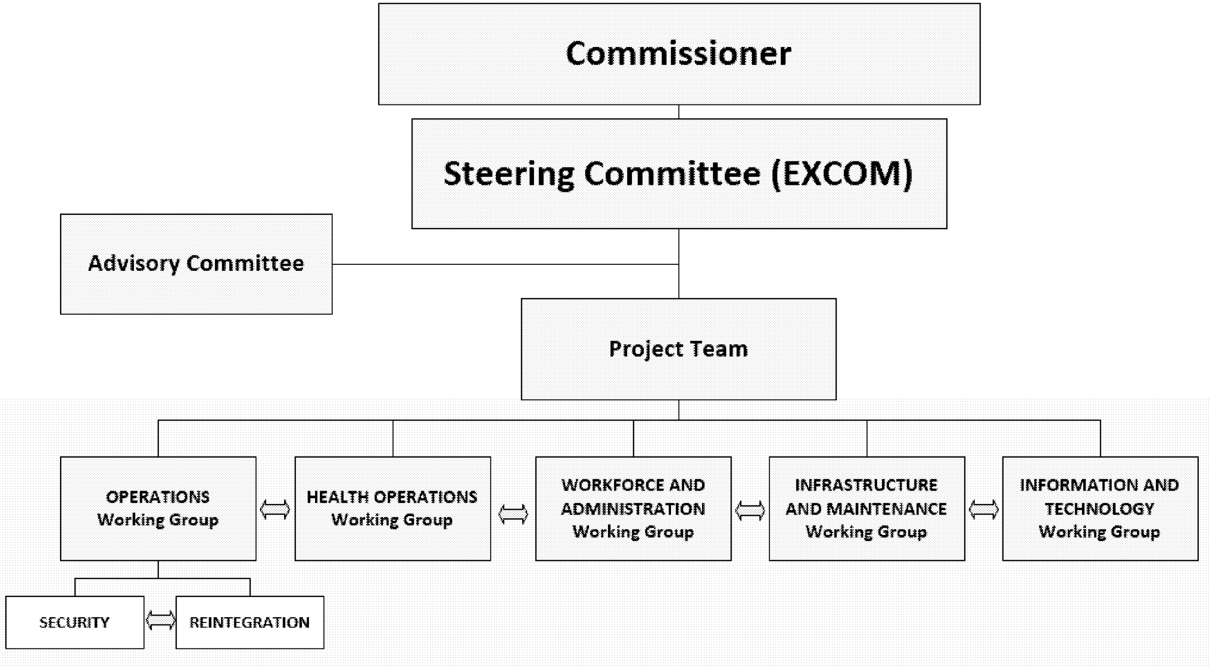
a. Operations – Security and Reintegration
b. Health Operations
c. Workforce and Administration
d. Infrastructure and Maintenance
e. Information & Technology

Working Group Chairs present updates and proposals to resume activities to the Advisory Committee.

2. The Project Team, comprised of Director Generals meets weekly to review working group progress and ensure open communication of activities amongst working groups.

3. The Advisory Committee, lead by Senior Deputy Commissioner, provides cross-functional input and non-binding strategic advice to CSC. Membership includes representatives from five of CSC's unions, Citizen's Advisory Committee National Executive, National Associations Active in Criminal Justice, National Indigenous Advisory Committee, and includes regional representation.

4. The Executive Committee Steering Committee (EXCOM SC), lead by the Senior Deputy Commissioner, provides strategic direction for shaping the new normal through deliberation and decision-making. The EXCOM SC approves the framework, actions and mitigating strategies to shape the new normal for CSC in response to the COVID-19 Pandemic, for approval by the Commissioner.



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CSC'S NATIONAL RISK MANAGEMENT FRAMEWORK

This framework provides a common language and the parameters within which to respond to the COVID-19 pandemic. The plan will identify correctional activities, risks & mitigation strategies to protect CSC staff & offenders, while respecting the law & delivering on CSC's legislated mandate. The risk management framework allows for different levels of response depending on the assessed level of risk of COVID-19 transmission, based on public health advice.

PLANNING ASSUMPTIONS

- Federal correctional institutions are considered high risk for transmission given the closed setting.
- All actions taken are to prevent the virus from entering or being transmitted within the site.
- All decisions will be guided by best available public health knowledge, practices, and epidemiological considerations.
- As communities ease restrictions, CSC needs to be mindful of the 14-day incubation period of COVID-19.

CORRECTIONAL SERVICE CANADA NATIONAL COVID-19 RISK MANAGEMENT FRAMEWORK	
LOW RISK (GREEN) – READINESS AND MONITORING – NO SUSTAINED TRANSMISSION IN CANADA OR TRANSMISSION IS LOCALIZED AND CONTAINED. DILIGENT INFECTION PREVENTION CONTROL MEASURES.	
LOW - MODERATE RISK (GREY) – HEIGHTENED VIGILANT INFECTION PREVENTION – VIRUS TRANSMISSION IN CANADA/PROVINCE AND NOT WITHIN LOCAL GEOGRAPHICAL AREA AS IDENITFIED BY LOCAL PUBLIC HEALTH AUTHORITY. MAY INCLUDE WELL DEFINED CHAINS OF TRANSMISSION E.G. TRAVEL. NO LOCAL COMMUNITY TRANSMISSION.	
MODERATE RISK (YELLOW) - LOCAL COMMUNITY TRANSMISSION OF VIRUS AS IDENTIFIED BY LOCAL PUBLIC HEALTH AUTHORITY.	
COVID-19 AT THE SITE	MODERATE - HIGH RISK (ORANGE) – COVID -19 TRANSMISSION ON SITE. TRANSMISSION IS CONTAINED IN AN IDENTIFIED ZONE.
	HIGH RISK (RED) – TRANSMISSION ON SITE PENDING INVESTGATION. TRANSMISSION SOURCE UNIDENTIFIED OR OUTBREAK IS SITE WIDE.

NOTE: AT THE SIGN OF ONE CASE OF TRANSMISSION WITHIN A SITE, THE RESPONSE/ACTION WILL MOVE TO HIGH RISK (RED) IMMEDIATELY UNTIL OUTBREAK IS CONTAINED THROUGH CONTACT TRACING AND TESTING.

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NATIONAL RISK MANAGEMENT PROTOCOL TO CHANGE COVDI-19 TRANSMISSION RISK LEVEL

The below protocol identifies the process through which CSC will change a facility's COVID-19 transmission risk level as per the National Risk Management Framework. Low, Moderate-High and High risk levels are easier to identify. Low Risk (green) – Health Services will advise when there is no sustained transmission in Canada Moderate- High Risk (Orange) & High Risk (Red) COVID-19 on site.

The below information focuses on how CSC will move from low-moderate (grey) and moderate (yellow) risk levels and implement appropriate risk mitigation strategies.

Background

- CSC Health Services Sector is monitoring public health data regarding the incidence of COVID-19 for all communities where there is a federal penitentiary or a Community Correctional Centre.

- Every week, Health Services analyzes the public health data and prepares a Community Cases Situation Report. Health Services will share the weekly report with the regions for sharing at regional and local Occupational and Health Safety Committees.

- The difference in incident cases per week per 100,000 population between health regions may suggest that some communities are at increased risk for transmission, posing greater potential for outbreaks in respective CSC Institutions and Community Correctional Centres

- A case of COVID-19 in a community does not equal community transmission. Sometimes local cases of COVID-19 may be related to imported cases (e.g. by travel) or a contained outbreak (e.g. at an industrial plant or facility), or whether they are, in fact, related to community transmission.

- **Community transmission** is when the transmission of COVID-19 is elevated, occurring between community members. Local public health authorities are unable to clearly identify the source of transmission and contain the spread.

- **Community** is defined by the geographical boundaries of the local health authority, and not necessarily the boundaries of the town/city that the site is located in.

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- If local public health authority identifies that there is evidence of uncontained elevated community transmission, CSC may want to strongly consider transitioning to Moderate Risk (Yellow) for CSC facilities in that geographic zone.

Threshold Setting

- An operational threshold of 10 incidence cases per week per 100,000 people in the local community will be used as the current threshold to trigger closer direct collaboration with local public health authorities.

- It is important to note that this threshold does not indicate that the risk level is elevated; it serves as an early warning surveillance system. This threshold will trigger asymptomatic surveillance testing and closer collaboration with local public health authorities to understand the local COVID-19 situation.

- From an operational perspective, this may mean that although sites continue to operate in the low-moderate risk (grey) category, staff should operate on a higher level of attention and alertness to ensure that all required infection prevention control measures are being followed. Local discussions with Occupational Health and Safety Committees will occur.

- Health Services will continue to engage local public health authorities and monitor for trends that indicate an increase of local community cases.

Process

1. When NHQ, Health Services has identified that there are 10 cases per 100,000 people in a local community, the Regional Director (RD) Health Services, or their delegate, will contact the local public health authority to discuss COVID-19 cases and the possibility of community transmission.

2. The RD Health Services, or their delegate, will document the date, time, and name of the local public health contact, as well as any pertinent information shared by local public health about the nature of the cases in the local community.

3. The RD Health Services will share the information with the Director General, Clinical Services and Public Health to **ensure national consistency of responding** to the public health data.

4. The Assistant Commissioner Health Services (ACHS) will notify the Regional Deputy Commissioner (RDC) that close monitoring of community transmission is underway, which

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will serve as a reminder to the Institutional Head/District Director to ensure vigilant infection prevention control measures are being strictly adhered to and enforced.

5. Based on the information provided by local public health authorities and the close monitoring by Health Services, the ACHS will notify the RDC of a change to the COVID-19 transmission risk level.

NOTE: CSC will create a table or dashboard that will be public facing on CSC's website identifying the current risk level as well as what activities will be permitted. This will easily inform inmates' family members and others entry into the site is not permitted.

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CSC'S NATIONAL RISK MANAGEMENT FRAMEWORK BY ACTIVITY

NOTE: The below framework will be continually monitored and updated as required. It is an evolving framework that will be amended based on experience, operational realities and the best available public health advice. New activities will be added as they are approved by the Shaping the New Normal Steering Committee.

	Low Risk – Green	Low-Moderate Risk - Grey Mitigation Strategies	Moderate Risk - Yellow Mitigation Strategies	Moderate-High Risk - Orange Mitigation Strategies	High Risk - Red Mitigation Strategies
UNIVERSAL INFECTION PREVENTION CONTROL (IPC) MEASURES	**NO SUSTAINED TRANSMISSION IN CANADA**	**COVID IN CANADA/PROVINCE NO LOCAL COMMUNITY TRANSMISSION**	**LOCAL COMMUNITY TRANSMISSION**	**COVID ON SITE – TRANSMISSION CONTAINED IN AN IDENTIFIED ZONE**	**COVID ON SITE – TRANSMISSION NOT CONTAINED**
General Notes		All measures in LOW RISK category continues, unless otherwise indicated	All measures in LOW-MODERATE RISK category (including LOW RISK) continue, unless otherwise indicated ☐ Quality improvement spot checks to be conducted by managers, with immediate addressing of any deficiencies	All measures in MODERATE RISK category (including LOW & LOW-MODERATE RISK) continue, unless otherwise indicated **COVID ON SITE**: Identified zones containing COVID-19 will operate as HIGH RISK; In non-COVID areas of the sites, a risk assessment will determine if moderate risk activities may continue.	
Communications		☐ Regular communication with staff, offenders and stakeholders, etc. ☐ Bilingual information materials, including signs and posters, posted throughout the site, informing staff, contractors and offenders about how to protect themselves from a contagion.			

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	Low Risk – Green	Low-Moderate Risk - Grey Mitigation Strategies	Moderate Risk - Yellow Mitigation Strategies	Moderate-High Risk - Orange Mitigation Strategies	High Risk - Red Mitigation Strategies
		☐ Staff training on Personal Protection Equipment (PPE), including donning and doffing of PPE is provided annually. ☐ Information on IPC requirements provided to contractors and other official visitors entering the site; ☐ Information or videos for visitors on IPC requirements; ☐ Inmate education on infection and prevention (cough/sneezing hygiene; handwashing; physical distancing; cleaning living area).			
Individual IPC responsibilities	☐ Stay home when sick; ☐ Hand hygiene – frequent handwashing for at least 20 seconds; ☐ Respiratory etiquette – cough into sleeve or tissue, sneeze into tissue and discard tissue into lined waste receptacle; ☐ Report any travel to area with COVID transmission to manager and consider need for 14 days self-isolation prior to return to work ☐ When off duty or outside of a federal penitentiary reserve,	☐ Self-monitor for symptoms (fever; any respiratory symptoms (such as cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat, or difficulty swallowing); or any unusual symptoms (such as chills, muscle aches, diarrhea, headache, loss of taste or smell); ☐ If at work and staff member / contractor starts to exhibit symptoms, regardless of severity; they will self-isolate and contact manager immediately; ☐ Physical distancing of 2 meters or 6 feet; If necessary, markings will be placed on the floor;	☐ Minimizing the risk of introducing COVID-19 to CSC's workplaces means minimizing to the greatest extent possible employee's contact with community members. ☐ Whenever feasible, arrangements should be made to have other household members do any necessary and essential trips outside of the household, such as, grocery shopping, visits to the pharmacy and purchasing fuel. ☐ Carpooling with colleagues is not consistent with physical distancing guidance. Staff/contractors should travel to and from work in their own vehicle or in vehicles		

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	Low Risk – Green	Low-Moderate Risk - Grey Mitigation Strategies	Moderate Risk - Yellow Mitigation Strategies	Moderate-High Risk - Orange Mitigation Strategies	High Risk - Red Mitigation Strategies
	staff/ contractors must follow public health guidance.	☐ Hand hygiene – handwashing for at least 20 seconds upon entering the site; ☐ Everyone will wear a non-medical masks at all times unless alone; ☐ CSC will provide a mask to individuals who arrive without one. ☐ Avoid touching face and/or non-medical masks, perform hand hygiene before and after if repositioning of mask is required; ☐ 14 day self isolation required if travel to area with known COVID transmission	with people from the same household.		
Organizational public health measures - requirements	☐ No alcohol based hand sanitizer in inmates' areas. ☐ Inventory and procurement of personal protective equipment, cleaning supplies, etc. is maintained.	☐ Non-touch temperature readings will be taken for all who enter a CSC site. Individuals who register a temperature of 38 degrees Celsius or higher will be required to sit at the entrance for fifteen minutes to allow for their temperature to normalize. The Correctional Manager or CCC Manager will be contacted. When fifteen minutes have passed, the individual will take a second temperature reading orally themselves using a disposable thermometer. If the second reading yields a result of	☐ Managers to regularly review procedures and expectations with employees		

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	Low Risk – Green	Low-Moderate Risk - Grey Mitigation Strategies	Moderate Risk - Yellow Mitigation Strategies	Moderate-High Risk - Orange Mitigation Strategies	High Risk - Red Mitigation Strategies
		38 degrees Celsius or above, they will not enter the site and will return home immediately, contacting local public health authorities to seek testing for COVID-19. ☐ No one other than the Officer or Commissionaire at the front entrance should touch sign in forms or pens. ☐ Formal supervised hand hygiene, using soap and water or at least 60% alcohol-based hand sanitizer (ABHS) at front entrances, pre-entry locations and strategically located through the site, including program spaces, offices, etc., respecting required physical distancing. ☐ ABHS will be controlled and supervised; ☐ Handwashing stations and hand sanitizer available throughout the site; ☐ Soap supply monitored regularly for each inmate and replenished by CSC as required. ☐ Consequences of offender non-compliance with wearing a mask may include an institutional charge as per section 40 of the Corrections and Conditional Release Act (unless exempted by a health professional).			

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	Low Risk – Green	Low-Moderate Risk - Grey Mitigation Strategies	Moderate Risk - Yellow Mitigation Strategies	Moderate-High Risk - Orange Mitigation Strategies	High Risk - Red Mitigation Strategies
		☐ Cleaning supplies and disinfectant wipes will be provide to staff/ contractors working in shared spaces, such as program rooms, etc. ☐ Increased ongoing monitoring & procurement of personal protective equipment (masks, gowns, gloves, etc.), cleaning & sanitizing supplies. ☐ In all locations, staff/ contractors and offenders will not share bathrooms. If not already in place, separate bathrooms will be identified.			
Cleaning and Disinfection	☐ Cleaning and disinfecting of all shared tools and equipment with appropriate disinfectants is mandatory, before and after use; ☐ Throughout the living units, cleaners disinfect on a daily schedule according to training standards with commercially available products (wipes, bleach, detergents and soaps, etc.), paying special attention to all high-touch surfaces, which	☐ Cleaning/ disinfecting of all tools and equipment (before and after use) is mandatory;			

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	Low Risk – Green	Low-Moderate Risk - Grey Mitigation Strategies	Moderate Risk - Yellow Mitigation Strategies	Moderate-High Risk - Orange Mitigation Strategies	High Risk - Red Mitigation Strategies
	should be cleaned throughout the day. ☐ Refer to COVID-19 cleaning and disinfectant guidance & Institutional Cleaner Guide. ☐ All cleaning is documented				
Personal Protection Equipment (PPE)		**Point of Care Risk Assessment** ☐ All staff/contractors who are required to be within 2 meters of an offender to provide care/perform other tasks must conduct a point of care assessment to determine, to the best of their ability, if the offender is experiencing COVID-19 symptoms. Non-medically trained staff/ contractors should ask the offender if they are experiencing any of the following: 1. Fever; 2. Any respiratory symptoms (such as cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat, or difficulty swallowing); or 3. Any strange symptoms (such as chills, muscle aches,			

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		diarrhea, headache, loss of taste or smell) If symptoms are present, PPE should be adjusted accordingly prior to initiating any contact and the protocol for suspected COVID-19 should be followed.			
Screening/Monitoring		☐ Supervised active screening of everyone at all site entrances; ☐ ACHS is monitoring community cases of COVID-19 across Canada.	☐ Personnel who have personal risk factors for severe disease will have risk based discussion with managers regarding the need for self isolation and impact on their ability to work ☐ Quickly identifying and isolating symptomatic individuals.		
Cohort - definition • A group of staff who are required to work the same unit or series of posts, with the goal to minimize numbers of contacts. • A group of inmates permitted to associate together and who are treated as a group. • The size of the cohort is determined at the local level in collaboration with the local Occupational Health and Safety committee, within the parameters of Health Services advice.					
Movement	☐ As per normal routine	☐ To support contact tracing and to mitigate transmission among staff/ contractors and offenders in the event of a positive case, staff rosters and inmate movement will be limited to **double cohorts**. ☐ When ACHS signals to the RDC that the threshold has been met: staff rosters and movement may be required	☐ To support contact tracing and to mitigate widespread transmission among staff/ contractors and offenders in the event of a positive case, staff rosters and inmate movement will be **single cohort** based. ☐ Non-uniformed staff/ contractors who interact with inmates will limit their in person contacts to essential interactions only		

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	Low Risk – Green	Low-Moderate Risk - Grey Mitigation Strategies	Moderate Risk - Yellow Mitigation Strategies	Moderate-High Risk - Orange Mitigation Strategies	High Risk - Red Mitigation Strategies
		to move to a single cohort during this close monitoring phase. ☐ Non-uniformed staff/ contractors who interact with inmates will limit their in person contacts to inmates on their case load ☐ No movement of staff/ contractors between security levels at clustered sites.			
Policies	☐ All areas of the work site must be decluttered and surfaces as bare as possible to support required cleaning for ongoing infection prevention control;	☐ Employees who are able to may work part of the time at the site and part of the time remotely as determined locally	☐ All employees and contractors who can work remotely, will work remotely; ☐ Critical employees who may be required to attend the site, will work remotely as much as reasonably possible;		
Engineering Controls		☐ Medical isolation spaces prepared and available ☐ A designated location(s) for PPE donning and doffing areas, complete with hand sanitizer/hand washing stations, signage (including instructions for step-wise donning and doffing), and non-touch waste and/or laundry receptacles. Ensure donning and doffing stations are separate from one another, to prevent cross-			

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		contamination. Higher risk PPE donning and doffing locations (medical staff and/or contracted cleaners) and/or the identification of contaminated versus non-contaminated zones must be identified.			
Testing	☐ CSC will test all symptomatic inmates ☐ Symptomatic staff/ contractors will be required to be tested by local public health authorities	☐ Test all symptomatic inmates or staff ☐ Introduce sentinel testing whenever community cases reach the threshold	☐ Test all symptomatic inmates or staff ☐ Asymptomatic surveillance testing of staff	☐ Testing of symptomatic inmates and staff (broadly) ☐ Outbreak testing as per the strategy	☐ Testing of symptomatic inmates and staff (broadly) ☐ Outbreak testing as per the strategy

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INSTITUTIONAL OPERATIONS	Low Risk – Green	Low-Moderate Risk Mitigation Strategies - Grey	Moderate Risk Mitigation Strategies - Yellow	Moderate-High Risk Mitigation Strategies –Orange	High Risk Mitigation Strategies – Red
Activity	**NO SUSTAINED TRANSMISSION IN CANADA**	**COVID IN CANADA/PROVINCE NO LOCAL COMMUNITY TRANSMISSION**	**LOCAL COMMUNITY TRANSMISSION**	**COVID ON SITE – TRANSMISSION CONTAINED IN AN IDENTIFIED ZONE**	**COVID ON SITE – TRANSMISSION NOT CONTAINED**
Admissions and Discharge					
New Admissions (Warrants of Committal)/ Revocations		☐ Immediately screening at intake by operations, using the COVID-19 screening form and additional screening by Health Services as part of the intake process. ☐ Medical isolation for 14 days in accordance with health services algorithms for intake and symptomatic inmates. ☐ Inmate education on infection and prevention (cough/sneezing hygiene; handwashing; physical distancing; cleaning living area). ☐ Twice-daily medical isolation wellness assessments for symptomatic offenders and once-daily medical isolation wellness assessments for asymptomatic offenders, documented in the electronic medical record. ☐ Staff/contractors working with asymptomatic offenders that are medically isolating as new admissions to the institution require only routine practices and universal masking.	☐ Follow all strategies in low-moderate risk	☐ Follow all strategies in low-moderate & moderate risk	☐ Follow all strategies in low-moderate & moderate risk
Finger printing	☐ Routine per standing order	☐ Conduct a point of care risk assessment	☐ Following 14 days of medical isolation where the inmate	☐ Fingerprinting is suspended	☐ Fingerprinting is suspended

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INSTITUTIONAL OPERATIONS	Low Risk – Green	Low-Moderate Risk Mitigation Strategies - Grey	Moderate Risk Mitigation Strategies - Yellow	Moderate-High Risk Mitigation Strategies –Orange	High Risk Mitigation Strategies – Red
		☐ Hand hygiene before and after contact ☐ Routine per standing order with appropriate IPC measures (staff – eye protection, non-medical mask, gloves). ☐ Inmate wears a mask.	remains symptom free, finger printing may be completed. ☐ Conduct a point of care risk assessment ☐ Hand hygiene before and after contact ☐ Routine per standing order with appropriate IPC measures (staff – eye protection, non-medical mask, gloves). ☐ Inmate wears a mask		
Searching personal effects	☐ Regular operations within department.	☐ Regular operations following a 72-hour quarantine period, then effects are searched.	☐ Regular operations following a 72-hour quarantine period, then effects are searched.	☐ Regular operations following a 72-hour quarantine period, then effects are searched.	☐ Regular operations following a 72-hour quarantine period, then effects are searched.
Operations					
Meal service	☐ Normal meal routine ☐	☐ No large group meal service or eating in cafeteria ☐ Food pick up at food services line by double cohort. ☐ Inmates return to unit to eat. ☐ Inmates under medical isolation will receive meals at cells. ☐ Small meal preparation – groceries will be delivered to the house	☐ No large group meal service or eating in cafeteria ☐ Food pick up at food services line by single cohort. ☐ Inmates return to unit to eat. ☐ Inmates under medical isolation will receive meals at cells. ☐ Small meal preparation – groceries will be delivered to the house.	☐ Meal service at cell level for medically isolated or quarantined inmates. ☐ Unit-based meal service for other populations. ☐ Potentially contaminated areas of the institution will use reusable food trays, must be sealed in plastic immediately after use and transported to a separate cleaning area for disinfecting	☐ Meal service at Cell Level ☐ Food trays restricted to inmate's cell / disposable food trays and utensils will be used ☐ Reusable food trays, must be sealed in plastic immediately after use and transported to a separate cleaning area for disinfecting
Inmate Movement	☐ Routine per standing order	☐ Double cohort	☐ Single cohort	☐ Unit based	☐ Restricted to the Unit

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INSTITUTIONAL OPERATIONS	Low Risk – Green	Low-Moderate Risk Mitigation Strategies - Grey	Moderate Risk Mitigation Strategies - Yellow	Moderate-High Risk Mitigation Strategies –Orange	High Risk Mitigation Strategies – Red
Canteen	☐ Inmates can go to canteen to pick up items	☐ Inmates can go to canteen to pick up items – by cohort	☐ Canteen delivered to unit.	☐ Canteen delivered to cell	☐ Canteen delivered to cell.
Searching inmates	☐ Normal routine per post and standing orders/ institutional search plan	☐ Routine searches per post and standing orders/institutional search plan with established IPC measures (staff mask and gloves) ☐ Inmate will wear mask	☐ Routine searches per post and standing orders/ institutional search plan with established IPC measures (staff mask, gloves and eye protection) ☐ Inmate will wear mask	☐ Reasonable grounds searches	☐ Reasonable grounds searches
Searching Cells	☐ Normal routine per post and standing orders/ institutional search plan	☐ Routine searches per post and standing orders/institutional search plan with established IPC measures (staff mask and gloves)	☐ Routine searches per post and standing orders/ institutional search plan with established IPC measures (staff mask and gloves)	☐ Reasonable grounds or exceptional searches	☐ Reasonable grounds or exceptional searches
Control Cleaning	☐	☐ Control cleaning by CSC employees or contractors	☐ Control cleaning by CSC employees or contractors	☐ Control cleaning by CSC employees or contractors	☐ Control cleaning by CSC employees or contractors
Inmate Work					
Industry	☐ Routine per standing order	☐ Routine per standing order with appropriate IPC measures	☐ Critical industry operations remains open with appropriate IPC measures	☐ Critical industry operations remains open with appropriate IPC measures operated by staff. Offender involvement may be added only if offenders are not from within (and have no contact with others from) identified zone and following local site consultation with senior management, local unions and occupational health and safety committee.	☐ Critical industry operations remains open with appropriate IPC measures operated by staff only

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INSTITUTIONAL OPERATIONS	Low Risk – Green	Low-Moderate Risk Mitigation Strategies - Grey	Moderate Risk Mitigation Strategies - Yellow	Moderate-High Risk Mitigation Strategies –Orange	High Risk Mitigation Strategies – Red
Range cleaning	☐ Routine per standing order	☐ Routine per standing order with appropriate IPC measures	☐ Inmate cleaners for range and common areas as per national standards	☐ Inmate cleaners for range and common areas at unit level as per national standards	☐ Cleaning completed by CSC employees or contractors
Snow removal/ maintenance	☐ Routine per standing order	☐ Routine per standing order with appropriate IPC measures	☐ Snow removal/maintenance by inmates with appropriate IPC measures ☐ Any equipment, including shovels, tractors, lawn mowers, etc. will be disinfected before and after use and will not be shared	☐ In the event of an emergency, local discussions will occur to consider if snow removal/maintenance may be completed by inmates with appropriate IPC measures. ☐ Any equipment, including shovels, tractors, lawn mowers, etc. will be disinfected before and after use and will not be shared	☐ Snow removal/ maintenance completed by CSC employees or contractors ☐ In the event of an emergency, local discussions will occur to consider if snow removal/maintenance may be completed by inmates with appropriate IPC measures. ☐ Any equipment, including shovels, tractors, lawn mowers, etc. will be disinfected before and after use and will not be shared
Perimeter Work Clearance	☐ Routine per standing order	☐ Routine per standing order with appropriate IPC measures ☐ Active screening before leaving and upon return to the site	☐ Suspended	☐ Suspended	☐ Suspended
Recreation					
Hobby Craft	☐ Regular routine	☐ Small group activities allowed ☐ No sharing of materials ☐ Limited number of offenders in the hobby rooms at the same time to allow for physical distancing	☐ No small group activities allowed ☐ Increased in-cell activities ☐ Provide materials for in-cell hobby and crafts, as feasible ☐ Provide materials from the Pro-Social Hobbies Module of the	☐ Outside of cell activities temporarily on hold ☐ Provide materials for in-cell hobby and crafts, as feasible ☐ Provide materials from the Pro-Social Hobbies Module	

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INSTITUTIONAL OPERATIONS	Low Risk – Green	Low-Moderate Risk Mitigation Strategies - Grey	Moderate Risk Mitigation Strategies - Yellow	Moderate-High Risk Mitigation Strategies –Orange	High Risk Mitigation Strategies – Red
			SIU Social Program for in-cell activities ☐ Limited number of offenders in the hobby rooms at the same time to allow for physical distancing	of the SIU Social Program for in-cell activities	
Library	☐ Regular routine	☐ Maintain strict access protocols to ensure maximum access to learning, legal and leisure opportunities for offenders; ☐ Chairs to be placed 3 meters apart; ☐ Number of inmates accessing library is limited to size of space and ability to physically distance; ☐ All materials are to be disinfected upon return ☐ Explore and/or maintain the option of audiobook downloads	☐ Prioritize access to computers and legal resources for case preparation, as and when needed; ☐ Book cart could be made available to make reading resources available to offenders, to be distributed by inmate library workers or inmate volunteers; ☐ If not possible, a rotation schedule will be established for inmate library workers/inmate volunteers/range representatives to return, renew, or take out books for inmates. ☐ All materials are to be disinfected upon return	☐ Access to computers and legal resources for case preparation upon request ☐ Library services temporarily on hold, some requests for books may be responded to on a case-by-case basis. ☐ Inmate committees or inmate library workers may provide access to magazines and/or newspapers, if authorized by the site.	☐ Library closed until outbreak is contained
Leisure and social activities, including ethno cultural services	☐ Regular routine ☐	☐ Program facilitator activities: combination of on site and off site, per institutional routine ☐ SPOs will inform offenders of measures prior to any activity. ☐ IPC Measures posters will be posted in hobby/crafts rooms, gym, etc.	☐ Individual in-person activities, as feasible ☐ Increased in-cell social and leisure activities ☐ Staff to work from home unless required to be on-site	☐ No in-person social or leisure activities in contained COVID areas; Increased in-cell social and leisure activities	☐ No in-person social or leisure activities

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INSTITUTIONAL OPERATIONS	Low Risk – Green	Low-Moderate Risk Mitigation Strategies - Grey	Moderate Risk Mitigation Strategies - Yellow	Moderate-High Risk Mitigation Strategies –Orange	High Risk Mitigation Strategies – Red
Gym	☐ Gymnasium open for scheduled recreation	☐ Gymnasium open for scheduled recreation – double cohort, ensuring continuation of physical distancing ☐ Gym equipment may be used and will be disinfected before and after each use. ☐ Shared surfaces (e.g. chairs, tables, door handles, etc.) will be cleaned between cohorts. All cleaning will be documented. ☐ SPOs will engage individual and/or small group activities that do not require sharing materials	☐ Gymnasium open for scheduled recreation time – single cohort, ensuring continuation of physical distancing; ☐ Shared surfaces (e.g. chairs, tables, door handles, etc.) will be cleaned between cohorts ☐ No equipment, including weights, can be used/shared ☐ Increased in-cell activities ☐ SPOs will provide materials from the Physical Wellness Module of the SIU Social Program for in-cell exercise	☐ Gymnasium closed ☐ SPOs will provide materials from the Physical Wellness Module of the SIU Social Program for in-cell exercise	☐ Gymnasium closed ☐ SPOs will provide materials from the Physical Wellness Module of the SIU Social Program for in-cell exercise
Yard	☐ Yard open for scheduled recreation	☐ Yard open for scheduled recreation – double cohort	☐ Yard open for scheduled recreation – single cohort	☐ Yard may be closed for recreation. Movement plan determined locally with the involvement of Health Services and local Public Health Authorities.	☐ Yard may be closed for recreation. Movement plan determined locally with the involvement of Health Services and local Public Health Authorities.
Gardens	☐ Routine per standing order	☐ Inmate access to gardens; ☐ No more than double cohort ☐ Physical distancing and masks required ☐	☐ Inmate access to gardens; ☐ No more than single cohort ☐ Physical distancing and masks required	☐ No access	☐ No access
Temporary Absences/Work Releases					
Escorted Temporary Absence - Medical	☐ Routine per standing order	☐ When transporting inmate, with COVID-like symptoms: 4. inmate will wear medical/procedural mask	☐ When transporting inmate, with COVID-like symptoms: 1. inmate will wear medical/procedural mask	☐ When transporting inmate: 1. inmate will wear medical/ procedural mask	☐ When transporting inmate: 1. inmate will wear medical/ procedural mask

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INSTITUTIONAL OPERATIONS	Low Risk – Green	Low-Moderate Risk Mitigation Strategies - Grey	Moderate Risk Mitigation Strategies - Yellow	Moderate-High Risk Mitigation Strategies –Orange	High Risk Mitigation Strategies – Red
		5. Officer will wear gown, gloves, eye protection and mask 6. Vehicle will be disinfected before and after use ☐ Transporting an inmate without COVID-like symptoms – both staff and inmates to wear non-medical mask ☐ When an inmate returns to an institution from an external health care setting, refer to Patient Journey: COVID-19 Return from Hospitalization algorithm	2. Officer will wear gown, gloves, eye protection and mask 3. Vehicle will be disinfected before and after use ☐ Transporting an inmate without COVID-like symptoms, when medically necessary,– both staff and inmates to wear non-medical mask, officer to wear eye protection ☐ When an inmate returns to an institution from an external health care setting, refer to Patient Journey: COVID-19 Return from Hospitalization algorithm	2. Officer will wear gown, gloves, eye protection and mask 3. Vehicle will be disinfected before and after use ☐ When an inmate returns to an institution from an external health care setting, refer to Patient Journey: COVID-19 Return from Hospitalization algorithm	2. Officer will wear gown, gloves, eye protection and mask 3. Vehicle will be disinfected after use ☐ When an inmate returns to an institution from an external health care setting, refer to Patient Journey: COVID-19 Return from Hospitalization algorithm
Escorted Temporary Absence - security escort (excludes medical)	☐ Routine per standing order	☐ Routine per standing order with appropriate IPC measures ☐ Active screening before leaving and upon return to the site	☐ Suspended	☐ Suspended	☐ Suspended
Non security escort - ETA	☐ Routine per standing order	☐ Routine per standing order with appropriate IPC measures; ☐ Active screening before leaving and upon return to the site	☐ Suspended	☐ Suspended	☐ Suspended
Unescorted Temporary Absences/Work Releases	☐ Routine per standing order	☐ Routine per standing order with appropriate IPC measures ☐ Active screening before leaving and upon return to the site	☐ Suspended	☐ Suspended	☐ Suspended

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REINTEGRATION OPERATIONS	Low Risk – Green	Low-Moderate Risk Mitigation Strategies - Grey	Moderate Risk Mitigation Strategies - Yellow	Moderate-High Risk Mitigation Strategies –Orange	High Risk Mitigation Strategies – Red
Correctional Programs and Structured Social Programs					
Program Planning	☐ Prioritization of programs (proximity to release or scheduled hearing, Structured Intervention Unit delivery)	☐ Prioritization of programs (proximity to release or scheduled hearing, Structured Intervention Unit delivery) ☐ Offenders in Structured Intervention Unit could be assigned to participate in a program outside of the unit, per the Threat Risk Assessment (TRA)	☐ Prioritization of programs (proximity to release or scheduled hearing, Structured Intervention Unit delivery)	☐ Same as Moderate Risk	☐ Same as Moderate Risk
Program Facilitators		☐ Program facilitator activities combination of on site and off site per institutional routine. Off-site work for program tasks, e.g., session prep, post session work, report writing, etc. available as an option for employees			
Office Space		☐ Only offices that allow for a minimum of 3 meters between desks may be shared ☐ Office door to be kept open when possible for air circulation ☐ If different staff are using an office space at different times – the office will be disinfected between uses	☐ No sharing of office space		
Program Space		☐ Chairs to be placed 3 meters apart ☐ Visual markings on the floor to ensure physical distancing ☐ All spaces to be disinfected between program sessions according to national standards ☐ All cleaning will be documented			

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REINTEGRATION OPERATIONS	**Low Risk – Green**	**Low-Moderate Risk Mitigation Strategies - Grey**	**Moderate Risk Mitigation Strategies - Yellow**	**Moderate-High Risk Mitigation Strategies –Orange**	**High Risk Mitigation Strategies – Red**
Program Delivery		☐ At the first group session, when reviewing rules, review necessity to use PPE and consequences of non-compliance. Consequences of non-compliance may include suspension from programs and an institutional charge as per section 40 of the Corrections and Conditional Release Act. ☐ Group materials printed 3 days in advance before providing to offenders to allow for adequate time to “quarantine” paper ☐ Group materials provided to offenders (workbook comprised of all handouts and some content); ☐ Items will be not be passed between participants; ☐ Modifications will be made to program content as required to respect all public health measures ☐ Everyone is required to remain in their seat throughout the program to respect physical distancing, including during role plays ☐ Session length may be limited to between 1 and 2.5 hours ☐ In class offender worksheet completion to be made homework assignment ☐ High intensity groups – delivered by one facilitator with reduced number of participant	☐ No in person group Programs ☐ Individual program delivery, in person or using alternate means ☐ Increased homework exercises to facilitate independent learning, as feasible ☐ Program delivery using telephone or video - pre and post program session, individual and make up sessions, Motivational Modules sessions, case conferences ☐ Staff work from home unless critical to be onsite ☐ Off site work for program tasks, e.g., session prep, post session work, report writing	☐ Following direction of public health authorities, some of the measures in yellow may be undertaken ☐ Alternative Correctional program delivery could continue if in compliance with direction from local public health	☐ No in person programs or individual sessions

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		Note: local discussions will occur between manager and employees who are immunocompromised regarding alternative program delivery as required			
Group Size		☐ Limited by size of space – allowing for 3 meters distance between chairs ☐ Maximum 5 participants			
Spiritual/Cultural Advisors					
Spiritual/ cultural advisors Individual & group activities **NOTE: Elder assisted hearings and Cultural Ceremonies will be addressed later**	☐ Group meetings and group services permitted ☐ Longer term - leveraging technology for unique Elder and Chaplaincy services.	☐ Limited number of Elders/Chaplains based on site-specific service delivery plans with modified delivery options. ☐ May resume group meetings, programs and services with physical distancing and masks. ☐ Individual meetings (with physical distancing) ☐ Virtual interventions – phone or videoconference ☐ All common touch surfaces and tables will be disinfected before and after use.	☐ Limit site-based and tradition-specific Elders and Chaplains from entering sites, except for urgent or critical needs. ☐ Individual in person meetings to provide essential support in some cases following required IPC measures ☐ If required, alternate workspace to be provided to ensure physical distancing (e.g. cultural/spiritual/religious intervention held in cafeteria rather than cultural centre/chapel ☐ Virtual interventions – phone or videoconference ☐ When available, Lexan barriers may be used	☐ Virtual interventions – phone or videoconference	☐ Virtual interventions – phone or videoconference

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REINTEGRATION OPERATIONS	Low Risk – Green	Low-Moderate Risk Mitigation Strategies - Grey	Moderate Risk Mitigation Strategies - Yellow	Moderate-High Risk Mitigation Strategies –Orange	High Risk Mitigation Strategies – Red
			Note: Elders, chaplains and other cultural/spiritual advisors who are subject to community public health measures requiring self-isolation should not enter a CSC facility and conduct their work virtually.		

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STAFF	Low Risk – Green	Low-Moderate Risk Mitigation Strategies - Grey	Moderate Risk Mitigation Strategies - Yellow	Moderate-High Risk Mitigation Strategies –Orange	High Risk Mitigation Strategies – Red
Staff Gyms	☐ Gymnasium open	☐ Gymnasium open – double cohort, ensuring continuation of physical distancing ☐ Gym equipment may be used and will be disinfected before and after each use. ☐ Shared surfaces (e.g. chairs, tables, door handles, etc.) will be cleaned between cohorts. All cleaning will be documented.	☐ Gymnasium open – single cohort, ensuring continuation of physical distancing; ☐ Shared surfaces (e.g. chairs, tables, door handles, etc.) will be cleaned between cohorts ☐ No equipment, including weights, can be used/shared	☐ Gymnasium closed	☐ Gymnasium closed

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CHANGING LIVES. PROTECTING CANADIANS.

Clinical Management of Patients with COVID-19

GUIDANCE DOCUMENT FOR HEALTHCARE PROFESSIONALS

UPDATED JULY 3, 2020

Created: April 8, 2020

Next Review: September 2020

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Document History

Document Date	Document Sections	Description of Revisions
April 9, 2020	Document was created	The document was approved by the National Medical Advisory Committee (NMAC) at the April 5, 2020 meeting.
May 1, 2020	Minor changes throughout the document were made. Other main sections included changes to the "Clinical Presentation/Symptoms", the addition of "Best Practices for Nasopharyngeal Swabs".	The document was reviewed and approved by NMAC at the April 30, 2020 meeting.
July 3, 2020	Added a description on frail older adults and those who are immunosuppressed, added spiritual care to Goals of Care, updated dietary recommendations.	The document was reviewed and approved by NMAC at the June 4, 2020 meeting. No changes were recommended at the National Medical Advisory Committee (NMAC) meeting, June 25, 2020.
September 2020		Next Review

Accountability

This policy was initially reviewed and approved by the National Medical Advisory Committee (NMAC) on April 5, 2020, and will be reviewed at least every 30 days by NMAC to ensure it remains consistent with the risks posed by the COVID-19 pandemic.

Introduction

COVID-19 is a respiratory tract infection caused by a newly emergent coronavirus (SARS-CoV-2) that was first recognized in Wuhan, China, in December 2019. Genetic sequencing of the virus suggests that it is closely linked to the SARS virus.

Most people with COVID-19 develop only mild or uncomplicated illness (81%), approximately 14% develop severe disease that requires hospitalization and oxygen support and approximately 5% require intensive care unit support.

Those with co-morbidities, who are immunocompromised or are older, are at an increased risk for severe illness and may decompensate or deteriorate quickly once mild symptoms are noted. The median day for clinical deterioration was approximately 8 to 9 days after symptom onset.

Note: This document is intended as a guidance tool for the management of patients with COVID-19. Clinical judgement continues to paramount in the application of these recommendations. Please be aware that the information continues to evolve in this area and all efforts will be made to update the information as it becomes available.

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Prevention Strategies/Measures

- **Physical distancing** where possible minimum 6 feet (2 meters) apart.
- **Frequent hand hygiene** with soap and water or if not available, alcohol based hand rub for a minimum of 20 seconds.
- **Frequent cleaning and disinfecting** of frequently touched objects and surface.
- **Prompt identification and isolation** of those with symptoms.
- **Practice respiratory hygiene** (cover mouth and nose with tissue when coughing or sneezing or cough into the bend of your arm, discard tissue immediately in a covered bin, and perform hand hygiene).

Clinical Presentations / Symptoms

Clinical Presentations		
Symptoms	n=	7 239
Cough	5 411	(75%)
Headache	4 157	(57%)
Weakness	4 115	(57%)
Pre-Existing Conditions	n=	7 015
Respiratory disease	841	(12%)
Cardiac	795	(11%)
Diabetes	617	(9%)
Other	1 421	(20%)
Complications	n=	3 644
Pneumonia	445	(12%)
Dyspnea	286	(8%)
Abnormal lung auscultation	251	(7%)
Other	355	(10%)

Clinical presentation summary of COVID-19 cases reported in Canada, retrieved from the COVID 19 Daily Epidemiology Update, PHAC, April 20, 2020.

Epidemiological summary of COVID-19 cases in Canada

Frail older adults and those who are immunosuppressed can present with atypical symptoms. Fever, cough and dyspnea may be absent despite respiratory disease. In frail older adults, atypical symptoms may include milder symptoms, delirium or acute functional decline, little or no temperature elevation, mild hypoxia (O2 sat<90%) without respiratory symptoms. Patients on immunosuppressive therapies may not display normal, high spiking fevers, and their white blood cell counts may not be as high. (Reference: COVID-19 Clinical Corner: Treatment Considerations for Specific Patient Populations, Issue 3).

Classification of Severity of Disease

Mild Illness: Ambulatory COVID-19 patients, estimated mortality <1%: These are patients who would normally be managed outside of hospital, and do not require supplemental oxygen, intravenous fluids, or other physiologic support.

Symptoms of mildly ill patients include:

- Uncomplicated upper respiratory tract viral infection may have non-specific symptoms such as fever, fatigue, cough (with or without sputum production), anorexia, malaise, muscle pain, sore throat, nasal congestion, or headache.
- Rarely, may also present with diarrhea, nausea, and vomiting.

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- Older and/or immunosuppressed patients may present with atypical symptoms.

Moderate Illness: COVID-19 Treatment Unit patients, estimated mortality <5%: These are patients who would normally be managed on a hospital medical/general ward. This could include low-flow supplemental oxygen (e.g., 1-5 L/min via nasal prongs)

Pneumonia can present as mild with no need for supplemental oxygen. However, pneumonia can be severe and can present as:

- Prolonged fever
- Respiratory rate >25 breaths/minute
- SpO_2 ≤93% on room air
- Tachycardia
- Temperature >39

Severe Illness: These patients require immediate transfer to outside hospital. These patients will have symptoms of severe respiratory distress which include:

- Respiratory rate >30 breaths/minute
- SpO_2 ≤93% on 5 litres oxygen
- Heartrate >130 bpm
- Signs of dyspnea or increased work of breathing (e.g. grunting, nasal flaring, wheezing)

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Investigations of Suspected Cases of COVID-19

Initiate droplet contact precautions as per CSC Infection Prevention and Control Guidelines.

Mildly ill COVID-19 Patient:

These patients would not normally require any investigation but each patient should have a nasopharyngeal (NP) swab for COVID-19 and if requested by the physician, influenza.

Moderately ill COVID-19 Patient:

These patients would be admitted to the COVID Treatment Unit:

1) Initiate specimen collections for laboratory diagnosis;
2) NP Swab if not previously collected for both COVID-19 and Influenza;
3) Initiate Serology Specimens collection :

• CRP • CK • ALP • AST / ALT • LDH • Cr • eGFR • Lactate • Electrolytes	• CBC	• PT • PTT • INR • D-Dimer

4) Chest X-ray (portable, if possible)
5) ECG

Best Practices for Nasopharyngeal Swabs

Risk of transmission while collecting an NP swab from a patient can be reduced by placing a procedural mask over the patient's mouth. This can help contain coughing and sneezing. Persons in the room during the procedure should, ideally, be limited to the patient and the person obtaining the specimen. Proper PPE should be worn.

Persons performing the testing should stand to the side of the patient, not directly in front of them, and should move away from the patient (to more than 2 meters away) when the procedure is complete.

Patients should return mask to proper position (covering mouth and nose) after the procedure is complete. Hand hygiene should be performed by all persons.

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Management/Treatment COVID-19 (within CSC)

Mildly ill COVID-19 Patient:

These are patients who if in the community would stay at home. They require simple supported care and monitoring. Please see nursing care for patient with mild COVID-19 (Appendix A).

Moderately ill COVID-19 Patient:

These are patients who will be managed in the COVID Treatment Unit. They will require close monitoring and nursing care. These patients will be cared for by a clinical team including a primary care physician, nurse, pharmacist and other health disciplines as well have access to an ID physician for consultation.

- **Nursing**: See nursing care for patient with moderate COVID-19 (Appendix B) ;
- **Fever**: Acetaminophen 500 mg PO/PR every 4 hours (as needed) ;
- **Antiviral Therapy**:
    - Antiviral therapies are not yet proven effective for treatment of suspected or confirmed COVID-19.
- **Antibiotics**:
    - If a superimposed bacterial pneumonia is considered to be present, this should be regarded as a community acquired pneumonia.
    - Before therapy is commenced if possible an ID physician should be consulted. Antibiotic therapy would be provided based on guideline for adult outpatient community acquired pneumonia (CAP). (See Appendix C) http://thehub/En/aboutcsc/sectors/health-services/pharmacy/Pages/default.aspx
- **Immunocompromised Patient**, consideration:
    - Recommend to consult ID Physician for **all** immunocompromised patients, for example (e.g., hematological malignancies, transplantation, immunosuppressive agents, etc.)

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Monitoring/Follow-up

Mildly ill COVID-19 Patient:

- See nursing care for patients with mild COVID-19. (Appendix A)

Moderately ill COVID-19 Patient:

- See nursing care for patients with moderate COVID-19 (See Appendix B);
- Monitor for signs of symptomatic improvement;
- Close monitoring emphasized for patients aged 50 years and above with underlying comorbidities that may increase their risk of disease progression including:
    - Cardiovascular disease, cerebrovascular disease, chronic respiratory diseases, chronic kidney disease, chronic liver disease, diabetes, hypertension, cancer, immunocompromising conditions.
- Pregnant Women, consultation with obstetrician and ID Physician;
- The National Early Warning Score (NEWS) 2 aggregate scoring system may be helpful when monitoring for clinical deterioration that would warrant transfer to a higher level of care. (See Appendix D, E & F).

Additional Points for Consideration, Mild & Moderate

- Avoid nebulized medications ;
- Patients with inflammatory conditions on stable doses of NSAIDs could remain on them unless evidence changes (Ref #1 below) ;
- ACE inhibitors and Angiotensin Receptor Blockers – patients should be maintained on their therapy in the absence of clinical data suggesting risk, to avoid decompensation of cardiac disease (Ref #1 below) ;
- Use of ORAL corticosteroids is not recommended in patients with COVID-19. Inhaled corticosteroids are considered safe to use in those who have had them previously prescribed. There is no clinical evidence to support or deny the continued use of oral steroids in patients who have had them previously prescribed, it is known, however, that oral corticosteroids can increase the incidence of some respiratory infections, Consult with healthcare provider and pharmacy with regards to all corticosteroid use.

1. Reference: The COVID-19 Antimicrobial Management Working Group, Alberta Health Services. Recommendations for Antimicrobial Management of Adult Hospitalized Patients with COVID-19. https://www.google.ca/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKEwiCkp0oMfoAhUHGuwKHdXYBzcQFjAAegQIARAB&url=https%3A%2F%2Fwww.albertahealthservices.ca%2Fassets%2Finfo%2Fppih%2Fif-ppih-covid-19-recommendations.pdf&usg=AOvVaw3eAEVUtUhn4cXRRBrPG7wk

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Plan of Care

Treatment plan:

- All patients with suspected or confirmed COVID-19 should have a plan of care documented in the Electronic Medical Record.

Dietary Advice:

- Dietary recommendations during a COVID-19 pandemic and specifically for a patient with COVID-19 are provided in appendices F and G respectively.

Goals of Care:

- For each patient in the COVID-19 Treatment Unit or moderate illness, the clinical team should discuss goals of care up to and including specific patient wishes about end of life care (See Appendix I – Guidance on Staff Communication and Engagement with Patients about COVID-19).
- Spiritual care should be considered as an essential service in supporting patients with COVID-19.

End of Life Care:

- When providing end of life care, attention should be given to non-pharmacological symptom management as well as medications for specific symptoms. With the patient's permission, family and friends should be updated regularly on the patient's condition.
- See CSC 's Palliative Care Guidelines.
- See Chart in Appendix K - End-of-life care in the emergency department for the patient imminently dying of a highly transmissible acute respiratory infection (such as COVID-19).

Communication with Community Hospital:

- Agreement should be reached with the community hospital on the clinical guidelines for transfer of care of a patient with COVID-19. The protocol to follow for transfer to hospital should be known by the clinical team and operations.

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Promoting Mental Health

COVID-19: Promoting Mental Health and a Sense of Purpose and Meaning

Everyone is potentially vulnerable to the deleterious effects of stress and social isolation during a pandemic, and those with pre-existing mental or physical illness, multiple stressors and limited social supports even more so. The role of ongoing provision of mental health, spiritual and cultural services during such times cannot be overemphasized, and the role of health and mental health professionals, chaplains and Indigenous Elders is critical.

It is important for mental health services to identify and prioritize high risk or vulnerable patients for assessment and follow up. This includes prioritizing new referrals and patients already known to the service. Factors to consider in prioritizing cases include: those at increased risk for suicide or serious self-harm, on enhanced observation, acutely unstable and/or at risk of serious mental or physical deterioration (e.g. those with considerable or higher needs on the *Mental Health Needs Scale*). This would also include prioritizing those on medical isolation whose daily health visits should include inquiring as to how they are coping, their emotional well being, if they are having any suicidal urges and if they would like to see mental health staff, a chaplain and/or Elder. It can also involve asking people in medical isolation if there are any messages they would like relayed to significant others, and conversations where relevant around end of life issues and wishes. Virtual sessions using telephone or videoconferencing should be encouraged when possible for sessions with mental health staff, chaplains and Elders while social distancing measures remain in effect, otherwise a two metre distance should be respected.

It is important to allow people an opportunity to talk about their fears, and take the time to educate them about COVID-19 and the measures being taken. It is also important to focus on things they can control, including things they can do to lessen the chance of transmission, developing a schedule/routine, finding diversionary activities (e.g. Puzzles, drawing, music, TV, exercise, letters, journaling, reading, studying, etc.), and promoting spiritual and cultural practises as appropriate (e.g. readings, meditation, prayer). Mental health visits should involve review of relevant symptoms, including suicidal or self-harm urges, and medication, including for adherence and drug use, with adjustments to the treatment plan as indicated. Reframing distressing emotions (e.g. fear as indicative of caring for themselves and others) and teaching other stress/emotion regulation management approaches is also encouraged.

*For more details on strategies to promote stress management, resilience and mental health, please see COVID-19 Clinical Corner, Issue #2, March 27, 2020. (See Appendix J).

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Appendix A: Nursing Care and Management of a Patient with Mild COVID 19 Symptoms

This document outlines the care plan when providing care for a patient experiencing **mild COVID 19 symptoms** - fever, chills, cough, fatigue, aches and pains, congestion, runny nose, diarrhea and sore throat.

Ensure you practice good handwashing and wear appropriate PPE.

Monitor and record Vital Signs BID, assess for changes, abnormal results or worsening of symptoms

- temperature
- heart rate
- respiratory rate
- blood pressure
- SpO2

Assess general appearance

When assessing respiratory status specifically assess for:

- SOB, at rest, when speaking or with exertion
- persistent pain or pressure in the chest
- bluish lips or face

Nutrition and hydration :

- Monitor nutrition and hydration (Is the patient eating and drinking well? Are they voiding & going to the bathroom regularly?)
- Monitor patient's own use of over the counter medications (i.e. Tylenol for fever and prescribed medications)

If you assess any of the following:

- SaO2 <95 on Room Air
- Increased work of breathing as assessed above
- increased respiratory rate
- increased heart rate > 110 bpm

  OR
- Any abnormal vital signs or worsening of any symptoms

Notify the physician immediately.

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Appendix B: Nursing Care and Management of a patient with Moderate COVID 19 Symptoms

This document outlines the care plan for a patient experiencing **moderate COVID 19 symptoms** - fever, chills, cough, fatigue, aches and pains, congestion, and may have chest tightness or pain, feeling SOB, persistent fever, poor fluid intake.

Ensure you practice good handwashing and wear appropriate PPE.

Monitor and record **Vital Signs q4h**, assess for changes, abnormal results or worsening of symptoms:

- temperature
- heart rate
- respiratory rate
- blood pressure
- SpO2
- auscultation of the chest at least once daily

Initiate oxygen therapy to maintain SpO2 >93%:

- Start with 2 L/min by nasal cannula or mask and titrate to a max of 5 L/min.

Complete a general assessment including mental health:

- Assess for new confusion or drowsiness

When assessing respiratory status specifically assess for:

- SOB, at rest, when speaking or with exertion
- Persistent pain or pressure in the chest
- Bluish lips or face

Nutrition and hydration:

- Monitor nutritional status (Are they eating and drinking sufficiently? Record fluid intake and output and monitor bowel functioning).

Pharmacist to review medications on admission to the unit.

If you assess any of the following:

- respiratory rate > 25/min
- SpO2 <93 on NP 5L/min
- increased heart rate > 130 bpm
- increased work of breathing as assessed above
- change in orientation, confusion (for example, GCS <13)

  OR
- a NEWS 2 score of ≥5 (see Appendix D, E, and F)

Notify the physician immediately. Consider emergent transfer to outside hospital.

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Appendix C: Community acquired pneumonia (CAP)

Adult outpatients: The CRB-65 (please see in notes/references) does not require any blood work & is used easily in an office setting to identify patients who may require hospital admission. Recommended to check pneumococcal vaccine status when patients are diagnosed with CAP.

<table>
<tr><th>Infection</th><th>Regimen</th><th>Usual Duration</th><th>Notes/References</th></tr>
<tr><td>CAP, mild to moderate OUTPATIENT without comorbidity/ modifying factors

Check pneumococcal vaccine status</td><td>1st line: Amoxicillin 1 g TID
2nd line: doxycycline 100 mg BID ;
Azithromycin 500 mg daily on first day then 250 mg daily x 4 days or 500 mg daily x 3 days;
Clarithromycin 500 mg BID</td><td rowspan="3">5-14 days
Depends on various factors such as clinical presentation, comorbidities, age, and drug selected. Patients should be treated for a minimum of 5 days, be afebrile for 48-72 hours, and otherwise clinically stable before discontinuing therapy.
Exception: azithromycin</td><td rowspan="3">Review antibiotics prescribed for any type of infection in the previous 3 months; if significant exposure to particular antibiotic class, consider selecting an alternate class.

Comorbidity/modifying factors: hospitalization in the past 3 months and/or chronic heart, lung, liver or renal disease, diabetes mellitus, alcoholism, malignancies, asplenia, immunosuppression, age>65 years

Consider using a macrolide in patients where atypical organisms are suspected (e.g., more severe illness, positive urine antigen test, or during summer months for Legionella) or in the case of severe penicillin allergy.

** In regions with a high rate (>25%) of macrolide resistant S. pneumoniae, consider use of alternative agents, including those patients without comorbidities.

Fluoroquinolones (FQ) should be reserved for treatment failures, comorbidities with recent antibiotic use, allergies or documented infections with highly drug-resistant pneumococci or Legionella due to concerns over rapid emergence of FQ-resistant pneumococci and C. difficile-associated disease.

<table>
<tr><th colspan="3">CRB-65</th></tr>
<tr><th colspan="2">Criteria</th><th>Points</th></tr>
<tr><td colspan="2">Confusion: new onset based on a specific mental test, or disorientation to person, place or time</td><td>1</td></tr>
<tr><td colspan="2">Respiratory rate ≥30 breaths/minute</td><td>1</td></tr>
<tr><td colspan="2">Low Blood pressure: SBP <90mmHg or DBP ≤60mmHg</td><td>1</td></tr>
<tr><td colspan="2">Age ≥ 65 years</td><td>1</td></tr>
<tr><th>Score</th><th>Risk of Mortality</th><th>Suggested Management</th></tr>
<tr><td>0</td><td>< 2%</td><td>• Outpatient</td></tr>
<tr><td>1-2</td><td>~9%</td><td>• Consider hospital admission</td></tr>
<tr><td>≥ 3</td><td>>19%</td><td>• Hospital admission</td></tr>
</table>
If a recent urea is available, may use CURB-65 where BUN >7mmol/L = 1 point.</td></tr>
<tr><td>CAP, mild to moderate OUTPATIENT with comorbidity/ modifying factors

Check pneumococcal vaccine status</td><td>1st line: Any one of the beta-lactam agents in COLUMN A plus one of the agents listed on COLUMN B
<table>
<tr><th>COLUMN A</th><th>COLUMN B</th></tr>
<tr><td>Amoxicillin-clavulanate 875mg BID</td><td>Doxycycline 100 mg BID</td></tr>
<tr><td>Cefuroxime axetil 500 mg BID</td><td>Azithromycin 500 mg daily on first day then 250 mg daily x 4 days</td></tr>
<tr><td>Cefprozil 500 mg BID</td><td>Clarithromycin 500 mg BID</td></tr>
</table>
2nd line/if beta-lactam allergic: Levofloxacin 750 mg once daily x 5 days; Moxifloxacin 400 mg once daily x 5 days</td></tr>
<tr><td>CAP, mild to moderate OUTPATIENT with comorbidity/modifying factors – suspected aspiration[a]

Check pneumococcal vaccine status</td><td>1st line: Amoxicillin-clavulanate 875 mg BID;
Clindamycin 300 to 450 mg QID</td></tr>
</table>

[a] *Anaerobic coverage is indicated in the classic aspiration pleuropulmonary syndrome in patients with a history of loss of consciousness because of alcohol/drug overdose or after seizures in patients with concomitant gingival disease or esophageal motility disorders. Consider aspiration pneumonia in patients with difficulties swallowing who show clinical signs of a lower respiratory tract infection*

CAP = Community-acquired pneumonia

Adapted from: Anti-infective Review Panel. Anti-infective guidelines for community-acquired infections. Toronto: MUMS Health Clearinghouse; 2019; *Rx Files Antibiotics and Common Infections. Stewardship, Effectiveness, Safety and Clinical Pearls. October 2016.*

Resources:

1. Rx Files. Antibiotics and Common Infections. Stewardship, Effectiveness, Safety and Clinical Pearls. October 2016. Available from: https://www.rxfiles.ca/rxfiles/uploads/documents/ABX-Newsletter-2016-COMPLETE.pdf. Accessed on February 20, 2019.
2. Toronto Central Local Health Integration Network. Management of Community-Acquired Pneumonia in Adults. Available from: https://www.antimicrobialstewardship.com/community-acquired-pneumonia. Accessed on February 20, 2019.
3. Metlay JP, Waterer GW, Long AC et al. Diagnosis and Treatment of Adults with Community-Acquired Pneumonia. An official clinical practice guideline of the American Thoracic Society and Infectious Diseases Society of America. Retrieved from: https://www.atsjournals.org/doi/pdf/10.1164/rccm.201908-1581S

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Appendix D: National Early Warning Score (NEWS) 2 - Chart 1

Chart 1: The NEWS scoring system

Physiological parameter	Score						
	3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

Reproduced by: Royal College of Physicians. *National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS*. Updated report of a working party. London: RCP, 2017.

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Appendix E: National Early Warning Score (NEWS) 2 - Chart 2

Chart 2: NEWS thresholds and triggers

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low–medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.
**The response team must also include staff with critical care skills, including airway management.

Reproduced by: Royal College of Physicians. *National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS*. Updated report of a working party. London: RCP, 2017

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Appendix F: National Early Warning Score (NEWS) 2 - Chart 4

Chart 4: Clinical response to the NEWS trigger thresholds

NEW score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• Continue routine NEWS monitoring
Total 1–4	Minimum 4–6 hourly	• Inform registered nurse, who must assess the patient • Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required
3 in single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
Total 5 or more Urgent response threshold	Minimum 1 hourly	• Registered nurse to immediately inform the medical team caring for the patient • Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients • Provide clinical care in an environment with monitoring facilities
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level • Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills • Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency unit or ICU • Clinical care in an environment with monitoring facilities

Reproduced by: Royal College of Physicians. *National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS*. Updated report of a working party. London: RCP, 2017

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Appendix G: Dietary Recommendations during COVID-19

Maintaining a healthy balanced diet will help to support a patient's resistance to the virus.

Meals

- Encourage patients to eat 3 meals per day;
- Encourage patients to try to eat as much as they can at each meal;
- If a patient has a low appetite, encourage them to eat more frequently (in between meals);
- Encourage patients to choose fruits and vegetables rich in colour (dark green, orange, red, etc.) to increase intake of antioxidants and other nutrients that support immune function.

Fluids

- Water is naturally part of many foods like vegetables and fruit; milk products; hot and cold beverages as well as soup;
- Encourage patients to drink cold or warm liquids according to their preference;
- Encourage patients to drink often, with meals and in between meals.

Other tips

- Encourage patients to get plenty of rest (at least 7 to 9 hours every night)
- If a patient is age 60 years or older, consider whether it would be helpful if they took a multivitamin.

A patient cannot "boost" their immune system through diet, and no specific food or supplement will prevent the patient catching COVID-19/Coronavirus. Remind the patient to good hygiene practice remains the best means of avoiding infection.

As no one food or supplement can prevent illness, remind the patient to eat a variety of foods to maintain a healthy balanced diet.

If a patient indicates their appetite is poor and/or they have lost weight, please contact the Regional Dietitian for advice.

Caution: If a patient has specific nutrition needs, it is important that they continue to follow the dietary recommendations made by the dietitian / doctor. If a patient has any dietary concerns, please request a consultation with the regional dietitian for advice.

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Appendix H: Dietary Recommendations for a patient with COVID-19 - Confirmed or Suspected

Drink often

It is important that a patient drink often because fever makes a person sweat. This causes a person to lose water and electrolytes.

Water is naturally part of many foods like vegetables and fruit; milk products; hot and cold beverages as well as soup.

Encourage the patient to drink cold or warm liquids according to their preference.

Monitor for signs of dehydration:

- Extreme thirst, dry mouth and tongue, infrequent urination or very dark urine, feelings of dizziness, confusion or headaches.
- Encourage patients to report any concerning symptoms to Health Services

Sore throat

Hard candies or pastilles, preferably without sugar, can also be used to soothe a sore throat.

Fatigue affecting oral intake

It is important that to encourage the patient to eat and drink regularly even if you have a low appetite.

Encourage patients to eat fruits and vegetables rich in colour (dark green, orange, red, etc.) to increase intake of antioxidants and other nutrients that support their body's immune function.

Encourage patients to try to eat as much as they can at each meal;

If a patient's appetite is poor and they are having trouble eating, consult the Regional Dietitian for advice.

GI complaints (nausea, vomiting, diarrhea or severe abdominal pain) that may affect oral intake

It is important that the patient eat and drink, even if they are not feeling well.

If their appetite is poor and they are having trouble eating, speak with the Regional Dietitian for advice.

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Appendix I: Guidance on Staff Communication & Engagement with Patients about COVID-19, April 20, 2020

Communication tips

The purpose of these Communication Tips is to help support Healthcare Staff in conversations with patients diagnosed with COVID-19.

As Healthcare Professionals, you are playing a critical role in identifying, reporting and managing cases of COVID-19 within CSC's Institutions.

As there is currently no cure for this virus, infection can sometimes lead to death especially for those most vulnerable (those aged 65 and older; those with compromised immune systems; and those with underlying medical conditions such as, but not limited to, diabetes, heart disease and asthma).

These are unprecedented times and while most of those who contract COVID-19 will recover, it is important to remind all patients to:

- focus on staying healthy;
- practice physical distancing as much as possible;
- wash hands frequently; and,
- follow their current treatment plans.

Acknowledge fears and feelings of uncertainty

Given the potential seriousness of the diagnosis, patients may show signs of anxiety and uncertainty. Some may verbalize their fears and express anxiety about what kind of care they will receive.

- It is important to acknowledge their fears and take the time to talk about their concerns.
- Asking what they are worried about in particular may open the dialogue.
- They may ask how they contracted the virus. Did they infect others?
- Some may be worried about their family and friends and ask if they can connect with them; some may seek spiritual care and guidance for comfort.
- All efforts should be made to reassure patients they will receive the appropriate medical care and that most with the virus will recover.
- In addition, it is important that patients understand the importance of staying as healthy as possible and to follow treatment recommendations for existing conditions.

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Discuss goals of care

When a patient is diagnosed with COVID-19, it will be important to explain the kinds of care they will receive and assure them they will be included in all care planning decisions.

- Discuss the range of outcomes, noting that most people infected with COVID -19 virus have mild symptoms and recover. For example about 80% of patients have mild to moderate symptoms. Older persons and those with underlying conditions (hypertension, diabetes, cardiovascular disease etc.) are at higher risk for more severe disease. Therefore, it is important to carefully follow treatment recommendations for existing conditions to stay as healthy as possible.
- Assure the patient they will receive the care they need, including comfort care to avoid distress or discomfort.
- While there may be hope for a patient's full recovery, this is an opportunity to ask the patient whether they have an advanced care plan, should their condition deteriorate.
- Inquire as to whether or not they have completed a DNR.
- Have they identified a substitute decision maker?
- If no advance care planning is in place, initiate the conversation and document the patient's wishes.
- Ask if they have any wishes or messages for loved ones and assure them, you will do your best, within your power, to convey those messages.

Be honest, direct and empathic

- It is important to be honest, direct and empathetic when talking with a patient who has been diagnosed with COVID-19.
- Start the conversation early while the patient is well enough and has the energy for the discussion.
- As some patients may have limited literacy skills, it is important that the information shared, be in words the patient understands so they are better able to participate in discussions about their future care.
- You may also wish to take the time to explain the extra precautions Healthcare Staff are taking (i.e. face masks, gloves, etc.) to avoid the spread of the virus.

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Take a moment to prepare yourself for the conversation

- You may be very familiar with the patient as you may have been providing healthcare to them for many years, especially those with underlying chronic conditions. They will be looking to you for reassurance that they are being kept as safe as possible.
- Given that the information on COVID -19 is evolving daily, provide a response based on the most current messaging from Public Health.
- Some discussions will not be easy. Take a moment, to gather your thoughts.

This is a difficult time in healthcare especially for those providing care in challenging environments such as correctional institutions. We recognize that as you come to work every day in CSC, you may also be worried about family and friends at home. We thank you for your professionalism, dedication and service.

CSC Health Services, April 20, 2020

Sources:

- *Coronavirus disease (COVID-19): For health professionals; Canada.ca/coronavirus. Government of Canada website.*
- *Tips to Make the Most Difficult Conversations Easier, ACP Hospitalist; Hospital Medicine, May 2014.*
- *Dying Well in Custody Charter- Self- Assessment Tool; A National Framework for Local Action, April 2018. EndofLifeCareAmbitions.org.uk/tag/prison*
- *COVID Communication Skills, A Playbook of Vital Talk Tips; Vital Talk 2020 website.*
- *What Recovery from COVID-19 Looks Like, Public Health, Scientific American; April 11, 2020.*

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Appendix J: COVID-19 Clinical Corner, Issue #2, March 27, 2020

What are the potential effects of stress?

These are unprecedented stressful times, and stress is unavoidable for all of us and those we care for. Stress occurs when our mind perceives a threat, real or imagined, and it can have both positive and negative effects. With acute danger, stress can mobilize us to act to protect ourselves from imminent threat (e.g. fight, flight or freeze response). When the stress is imperceptible or chronic, it can still motivate us into action, but it can also be more prone to have deleterious effects – cognitive, emotional, physical and behavioural. These may include:

Cognitive:

- difficulty concentrating or thinking
- memory problems
- negativity or lack of self-confidence
- constant worrying
- difficulty making decisions

Emotional:

- moodiness or irritability
- anxiety or nervousness
- depression, sadness or guilt
- low morale, hopelessness or helplessness
- feeling agitated or unable to relax

Physical:

- headaches
- muscle tension or other physical pain or discomfort
- stomach problems, nausea, diarrhea or vomiting
- loss of appetite or sex drive
- rapid heart rate, high blood pressure
- insomnia
- fatigue

Behavioural:

- changes in appetite or sleep patterns
- social withdrawal
- nervous habits such as nail biting, teeth grinding or foot
- tapping
- increased use of caffeine, alcohol, drugs or cigarettes
- neglect of family or work responsibilities
- decline in performance or productivity.

Who is most vulnerable to the deleterious effects of stress?

All of us are vulnerable to the deleterious effects of stress, but some of us are more vulnerable than others. Factors that may make a person more vulnerable include:

- limited social support
- multiple stressors
- uncertainty
- pre-existing mental or physical illness
- difficulty regulating or balancing emotions
- lack self-confidence
- sense of helplessness or powerlessness

What can we do to manage stress during a crisis?

Know that stress is normal under these extraordinary circumstances, but we can all play a role to manage our stress so it can more likely be channelled constructively to promote mental health – our own mental health and that of our family, friends, co-workers and patients. In order to do this, a key to keep in mind is to stay focussed on what is in our control vs what isn't, that is to live by the Serenity Prayer:

Grant me the serenity to accept the things I cannot change, the courage to change the things I can and the wisdom to know the difference.

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What is in our control are our actions and words, not our automatic thoughts, feelings and urges, nor the actions, words thoughts or feelings of others. When we focus on what's in our control, we can then feel empowered and be more effective to influence some of these other things in a positive direction.

What we can do for our own health?

First and foremost, it is essential that we look after ourselves if we are going to be of help to others. We can do this by following any and all precautions and advice from public heath authorities to stay healthy, minimize our risk of contracting COVID-19 or spreading the disease. Prioritizing our own health will not only improve our own safety but also the safety and health of others. It will also improve our resilience, lessen our anxiety and allow us to better support and care for others (see Keep Informed under Resources for links to various public health agencies).

What can we do for our own mental health?

In addition to protecting our physical health, we can do additional things to promote our mental health and resilience. These include:

- **Connect with others:** It has become more important than ever to stay connected during this time of physical social distancing and isolation. Understanding, compassion and kindness go a long way to mitigating one another's stress. Reach out to family, friends, coworkers or your social or spiritual community, and support one another without judgement. Use the telephone, social media and messenger apps. Don't be afraid to tell others how you are feeling, and don't be afraid to ask for help, including professional help if you are really struggling.
- **Take time for yourself**: Set aside 20-30 minutes at least once and preferably twice a day to care for yourself. Do some mindful breathing, meditate, stretch, or take a warm bath. Do some activities you usually enjoy – listen to music, watch a movie, play games, or go for a walk. Be patient with yourself, and know that your stress can be channeled to keep yourself safe and to help others.
- **Honour and respect your feelings**: Know that stress and distress are normal at this difficult time, and are a testament to caring for yourself and for others. Be patient with yourself. Avoid blaming yourself if something unfortunate happens. Know that guilt is commonplace, and is not indicative of having done something wrong, but rather is a testament to wishing things were different. And if you did make a mistake, forgive yourself and allow it to promote learning. Talk to select others about your feelings, and consider journaling or using some other art form to express your feelings to avoid things from building up.
- **Live with intention by actively managing your own wellbeing**: Maintain routines where possible: eat regular nutritious meals, drink plenty of fluids, stay physically active and allow adequate time for sleep. Continue with any treatment for pre-existing physical or mental health conditions. Make a list of priorities and try to focus on one thing at a time.
- **Be grateful for good things**: Make it a point to take special note of those people and things in the world that you are grateful for. If it helps, you can write these down in a journal, say them out loud before a meal or post one thing each day on a gratitude tree. You can also invite others in your home or place of work to do same to build a small community of awareness of what there is to be grateful for.
- **Practise good sleep hygiene**: Go to bed and wake up at a regular time and allow

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yourself enough sleep to be rested (8 hours for most of us); avoid sleeping in and curtail time in bed during the day and if you must take a nap, limit these to no more than 20-30 minutes; exercise daily, but not right before bed; avoid caffeine within 6 hours of bedtime; have a wind down pre-bedtime ritual (e.g. light reading, music, a light bedtime snack but avoid excess fluids before going to bed); insulate your room from excess light or noise; make sure you have comfortable pillows, set a comfortable temperature on the thermostat; void before retiring; and only use a sleep aid if these other things don't work (consult with your doctor as to which one).

- **Stay informed while managing exposure to media:** News is everywhere 24 hours a day. Too much exposure in such uncertain times can increase our fear and anxiety. To minimize its potential adverse impact, we can read, watch or listen to the news at a specific time each day to receive the updates we need while avoiding being inundated with sensationalistic stories. Use only reputable/reliable sources like the local, provincial or national agency of public health, the CDC or WHO.
- **Help others**: Helping others contributes to our own mental health by giving us a sense of purpose, meaning, value and self-worth (see below for how).

What can we do to help others?

Whether it's at home or at work, there is lot's we can do to help others, most of all by being a role model ourselves. Be aware that even small gestures can go a long way: a kind word, gentle encouragement, respecting social distancing, disinfecting a surface, or offering soap or a hand sanitizer. Be aware too that we help others by respecting those in need of physical isolation such as the elderly, sick or other people at increased risk, but do reach out to them to offer social support with a text message, phone call or facetime. Reach out to those known to be vulnerable to stress or who are struggling (e.g. those with mental illness or who are socially isolated). Ask others what they need, and offer support while respecting all precautions. Offer those in isolation to deliver food, medicine or other essentials leaving these 6 meters outside their door. And offer your kindness, patience and social support.

At home or at work, we can work with others to designate chairs, work stations, dishes, utensils, computers, telephones and bathrooms for use by a specific person, and assign particular responsibilities to those who are able (e.g. to disinfect high touch surfaces, clean the dishes, take out the garbage, prepare meals, do essential shopping). We can help by respecting any direction to work from or stay at home, and all directions in the work place to stay safe (social distancing, handwashing, use of PPE when indicated).

With our family, friends, co-workers and patients, we can also help by educating them about stress, and reminding them of the message of the serenity prayer to focus on those things that are in their control, such as the things listed in this Clinical Corner, to look after themselves and others.

You can also contact Employee Assistance Services at 1-800-268-7708, which is a 24/7 number. The TTY number is 1-800-567-5803.

Please send any other clinical questions, suggestions or resources related to COVID-19 to the following email account: GEN-NHQ Pharmacy

*Information presented in this Clinical Corner has been sourced from the websites of the Public Health Agency of Canada, Canadian Mental Health Association, Centers for Disease Control and World Health Organization
*See the following page for resources on keeping informed and managing stress

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Resources:

Keep informed:

Public Health Agency of Canada (1 844-280-5020)
https://www.canada.ca/en/publichealth/services/diseases/coronavirus-disease-covid-19.html

Newfoundland and Labrador (811)
https://www.gov.nl.ca/covid-19/

Prince Edward Island (811)
https://www.princeedwardisland.ca/en/topic/covid-19

Nova Scotia (811)
https://novascotia.ca/coronavirus/

New Brunswick (811)
https://www2.gnb.ca/content/gnb/en/departments/ocmoh/cdc/content/respiratory_diseases/coronavirus.html

Quebec (1 877 644-4545)
https://www.inspq.qc.ca/

Ontario (1 866 797-0000)
https://www.publichealthontario.ca/

Manitoba (1 888 315-9257)
https://www.gov.mb.ca/health/publichealth/index.html

Saskatchewan (811)
https://www.saskatchewan.ca/residents/health/~/link.aspx?_id=6C6BF971659346E0B8E9DE4AE3B2AFF9&_z=z

Alberta (811)
https://www.alberta.ca/coronavirus-info-for-albertans.aspx

British Columbia (811)
http://www.bccdc.ca/health-info/diseases-conditions/covid-19

Nunavut (1 877 975-5772)
https://gov.nu.ca/health/information/covid-19-novel-coronavirus

Northwest Territories (911)
https://www.hss.gov.nt.ca/en/services/coronavirus-diseasecovid-19

Yukon (811)
https://yukon.ca/en/health-and-wellness/health-concernsdiseases-and-conditions/find-information-about-coronaviruscovid

Centers for Disease Control
https://www.cdc.gov/coronavirus/2019-nCoV/index.html

World Health Organization
https://www.who.int/emergencies/diseases/novel-coronavirus-2019

Stress and how to manage it:

Canadian Mental Health Association
https://cmha.ca/documents/stress

Heart and Stroke Canada
https://www.heartandstroke.ca/get-healthy/reducestress/manage-your-stress

My Health Alberta
https://myhealth.alberta.ca/youth-addiction-mentalhealth/stress/stress-self-care-resources

Healthlink BC
https://www.healthlinkbc.ca/health-topics/rlxsk

WebMD
https://www.webmd.com/balance/guide/tips-to-control-stress#1

Mayo Clinic
https://www.mayoclinic.org/tests-procedures/meditation/indepth/meditation/art-20045858

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Positive Psychology
https://positivepsychology.com/stress-management-techniquestips-burn-out/

Centre for Addiction and Mental health
https://www.camh.ca/en/health-info/mental-health-and-covid-19

Finding Help
https://www.ementalhealth.ca/

Guided relaxation and anti-stress meditations:

English

https://www.youtube.com/watch?v=OS_iqfGjL78

https://www.youtube.com/watch?v=_DTmGtznab4

https://www.youtube.com/watch?v=YFSc7Ck0Ao0

https://www.youtube.com/watch?v=MIr3RsUWrdo

https://www.youtube.com/watch?v=CdbzDMSGsyg

Français

https://www.youtube.com/watch?v=DczdzpTrMFQ

https://www.youtube.com/watch?v=zCxHCJLSvrw

https://www.youtube.com/watch?v=jCdhiqhYWfM

https://www.youtube.com/watch?v=Z9cZbUlaO1g

https://www.youtube.com/watch?v=fTvbiw-u_O8

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Appendix K: End-of-Life Care in the ED

End-of-Life Care in the ED for the patient imminently dying of a highly transmissible acute respiratory infection (like COVID19)

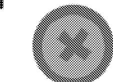
For all patients

- Document discussion around GOC and update category status
- Consider involving spiritual care or palliative care. Ensure COVID status is documented
- Place the patient in a private room with appropriate droplet/contact precautions
- Encourage telephone or video conferencing to minimize visitors
- Ensure my visitors are following appropriate PPE procedures

Non-pharmacological symptom management

- Frequent symptom assessment using validated tools for signs of distress
- Frequent patient repositioning
- Eye and mouth care (avoid deep suctioning)
- Emotional support to patient and and family
- Consider discontinuing any therapy or monitoring not contributing to patient comfort

Avoid the use of



- Fan
- Oxygen > 6 L/minute
- High flow nasal cannula oxygen
- BiPAP or CPAP
- ALL nebulized treatments

During withdrawal of life-sustaining therapy, do not extubate the patient in the ED, but decrease ventilatory support and ensure comfort throughout.

Pharmacological symptom management

Airway Secretions

- Glycopyrrolate 0.4mg subcut/IV q4h prn OR
- Scopolamine 0.4mg subcut/IV q4h prn (more sedating, may have a benefit with agitation)

Agitation/Delirium

- Haloperidol 0.5-lmg subcut/IV q2h prn
- 2nd line: Midazolam 0.5mg subcut/IV q30min prn
- Refractory: consider adding methotrimeprazine 12.5-25mg subcut/IV q4h prn

Pain

If opioid naive:
- Morphine 2.5-5 mg subcut/IV q2h prn OR
- Hydromorphone 0.5-lmg subcut/IV q2h prn

If opioid-tolerant, refer to opioid equi-analgesia and conversion tables

Dyspnea

If opioid-naive, low-dose morphine is the medication of choice:
- Morphine 1-2.5mg subcut/IV q30min prn
- or Hydromorphone 0.25-0.5mg subcut/IV q30min prn
- or Fentanyl 12.5-50mcg subcut/IV q15min prn

If opioid tolerant, give breakthrough doses to effect:
- Breakthrough dose = 10% of total daily dose of subcut/IV opioid in 24 hours

---

Second line: Midazolam 0.5-lmg subcut/IV q30min prn

For severe respiratory distress, consider Ketamine in dissociative dosing as a temporizing measure:
- Ketamine 1-2mg mg/kg IV or 4 mg/kg IM

Nausea

- Haloperidol 0.5-lmg subcut/IV q4h prn OR
- Ondansetron 4mg subcut/IV q6h prn

Fever

- Acetaminophen 650mg po/pr q4h prn

Infographic created by Dr. Shahbaz Syed, Department of Emergency Medicine, University of Ottawa
Hendin A., La Riviere CG., Williscroft OM., O'Connor E., Hughes J., Fischer, LM. End-of-life care in the Emergency Department for the patient imminently dying of a highly transmissible acute respiratory infection (such as COVID-19). CJEM. March 2020.

Image: EM Ottawa - https://emottawablog.com/2020/03/end-of-life-care-in-the-ed-related-to-covid-19/

Article: « End-of-life care in the emergency department for the patient imminently dying of a highly transmissible acute respiratory infection (such as COVID-19) ». Hendin, A., La Rivière, C., Williscroft, D., O'Connor, E., Hughes, J., & Fischer, L. (2020). CJEM, 1-4. doi:10.1017/cem.2020.352

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Additional Resources

1. Clinical Management of Patients with Moderate to Severe COVID-19 - Interim Guidance, Retrieved April 2, 2020, Public Health Agency of Canada. This guidance document has been endorsed by: Canadian Critical Care Society and Association of Medical Microbiology and Infectious Disease (AMMI) Canada. https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/clinical-management-covid-19.html#1
2. Infection prevention and control for coronavirus disease (COVID-19): Interim guidance for acute healthcare settings https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/interim-guidance-acute-healthcare-settings.html
3. BMJ Best Practice. Coronavirus disease 2019 (COVID-19) Best Practice Clinical Guidelines. Retrieved March 24, 2020, from https://bestpractice.bmj.com/topics/en-gb/3000168
4. Centers for disease Control and Prevention. Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19). Retrieved April 3, 2020, from https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
5. Public Health Agency of Canada. (2020, March 23). Government of Canada. Retrieved March 24, 2020, from https://www.canada.ca/en/public-health/services/publications/diseases-conditions/cleaning-disinfecting-public-spaces.html
6. World Health Organization. (2020, March 13). Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected. Retrieved March 24, 2020, from https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected
7. ICD-10-CA Coding Direction for Confirmed COVID-19 Cases - https://www.cihi.ca/en/bulletin/icd-10-ca-coding-direction-for-confirmed-covid-19-cases

- As direction from the World Health Organization (WHO), when there is documentation of a confirmed case of COVID-19, assign *U07.1* Emergency use of U07.1.
- Note: Do not assign U07.1 when COVID-19 is only suspected.

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COVID-19 Update: Guidance on the Use of Non-Medical Masks and Personal Protective Equipment

JUNE 3, 2020

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Document History

Revision Date	Document Section	Description of Revisions
April 8, 2020		Document was created.
May 1, 2020	Throughout document.	Updated to reflect Public Health Agency of Canada recommendations on all-shift masking, as well as further guidance issued on PPE for nasopharyngeal swab collection, disposal of used PPE, working in COVID-19 Transitional Units or contaminated zones, and performing seal checks on KN95 Masks.
May 13, 2020	Appendix B.	Updated to ensure consistency with BC CDC's advice on reusing face shields.
	Throughout document.	Minor editorial changes, such as grammar.
June 3, 2020	Throughout document.	The title of the document has been updated to include non-medical masks. The guidance has been updated to reflect that this guidance applies to institutions and CCCs. In addition, considerations are given for the use of PPE in the following scenarios: offenders cohorted in zones (including PPE reuse in each zone), transfers to and from outside hospital, staff working with medically isolated new admissions, and brief contacts with asymptomatic offenders. Appendix F is new and provides an overview of all the PPE scenarios detailed in the document.

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COVID-19 Update: Guidance on the Use of Non-Medical Masks and Personal Protective Equipment

Preamble

CSC has taken an active approach to the prevention and containment of COVID-19 over the last several weeks and will continue to introduce additional measures as new evidence emerges and best practices are identified.

In the absence of effective drugs or a vaccine, continued vigilance in the implementation of infection prevention and control measures is essential. The following guidance document outlines the use of medical and non-medical masks for universal masking requirements for all staff, as well as the recommended PPE for a variety of scenarios. This document applies to both institutions and Community Correctional Centres (CCCs).

The body of knowledge around COVID-19 is rapidly evolving and public health advice can change as more is learned about the virus. That said, the fundamentals of infection prevention remain the same. We know that the following measures are effective and must continue to be consistently implemented:

- Physical distancing (2 metres or more), whenever feasible;
- Frequent hand washing;
- Covering cough/sneezes with a tissue then properly disposing of the tissue or coughing/sneezing into the bend of the arm;
- Quickly identifying and isolating symptomatic individuals; and
- Enhanced cleaning with a focus on high touch surfaces.

In addition, CSC is implementing further interim measures, in accordance with Public Health Agency of Canada direction, including:

- Implementing **masking** for the full duration of shifts for all staff/contractors in all institutions;
- Implementing **masking and eye protection** for the full duration of shifts for all staff/contractors in institutions with an active COVID-19 outbreak, where an outbreak is defined as one or more confirmed COVID-19 case(s).

NHQ Health Services staff are working closely with provincial and federal public health authorities to help guide decisions about PPE.

Virus Transmission – Key Findings

Current evidence continues to indicate that droplet and contact precautions are appropriate for the routine care (within 2 metres) of COVID-19 symptomatic or confirmed individuals.

Airborne precautions should be used when aerosol generating procedures are planned or anticipated (i.e. CPAP machine, drilling by the dentist, and CPR) with COVID-19 symptomatic or confirmed individuals.

An emerging body of evidence also suggests that asymptomatic and pre-symptomatic individuals may be responsible for some transmission of COVID-19. This has led to the implementation of **masks for all**

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staff/contractors, in all CSC institutions, at all times. Staff are required to wear their masks at all times unless they are in a closed space by themselves or if there is a physical barrier between themselves and others. The intent of this masking approach is to protect staff and offenders from individuals who may unknowingly have COVID-19 and be shedding the virus. In the closed environment of a correctional setting, COVID-19 is likely introduced via the community. With the suspension of visitors and programs due to COVID-19, employees are an important potential source of introduction and spread of the virus. It is for this reason that staff/contractors are being prioritized for mask distribution for asymptomatic use, as a method of source control (preventing the worker from spreading the illness to others). As masks have become more accessible, CSC is also extending mask distribution to asymptomatic offenders. Priority is being given to asymptomatic offenders at institutions with active COVID-19 outbreaks, and non-outbreak sites will distribute masks to asymptomatic offenders wherever possible, prioritizing non-medical masks and taking into account the local PPE supply.

In institutions with an active COVID-19 outbreak, CSC is implementing the use of **masks and eye protection for all staff/contractors, at all times.** Asymptomatic offenders at outbreak sites are distributed medical/procedural masks for their own protection, and staff/contractors must instruct offenders on how to wear masks properly (including proper hand hygiene when placing the mask and removing it). In outbreak sites, non-medical masks may only be considered for use in designated non-contaminated areas, in sites that have established distinct contaminated and non-contaminated zones.

Guiding Ethical Principles in Pandemics

Public health pandemics such as COVID-19 have the potential to overwhelm any jurisdiction's available human and material resources. While all decisions need to be grounded in the best available scientific literature, leaders and decision-makers must also include key ethical considerations in their decision-making processes.

An overview of the relevant ethical considerations with respect to the deployment of PPE in response to COVID-19 are attached in Annex A.

Point of Care Assessments

All staff must work proactively to identify suspect or confirmed cases of COVID-19 among offenders. All staff/contractors who are required to be within 2 metres of an offender to provide care/perform other tasks must conduct a point of care assessment to determine, to the best of their ability, if the offender is experiencing COVID-19 symptoms. Non-medically trained staff should ask the offender if they are experiencing any of the following:

- Fever;
- Any respiratory symptoms (such as cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat, or difficulty swallowing); or
- Any strange symptoms (such as chills, muscle aches, diarrhea, headache, loss of taste or smell).

Medically trained staff/contractors should follow their clinical training to determine if an offender is symptomatic prior to providing care that requires they be within 2 metres of the offender. If symptoms are present, PPE should be adjusted accordingly prior to initiating any contact and the protocol for suspected COVID-19 should be followed.

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Universal Masking at All Sites and Universal Masking and Eye Protection at Outbreak Sites

Taking into consideration infection and prevention principles and recognizing that supply chains are struggling to keep up with global demands, the following guidance serves to provide the greatest degree of effective protection for staff/contractors and offenders. In addition to the guidance below, additional measures, including PPE, may be implemented on a case by case basis in the event of an outbreak.

Universal Masking for All Asymptomatic Staff/Contractors at All Sites & Universal Masking and Eye Protection for All Staff/Contractors at Outbreak Sites

As an interim measure to contain the transmission of COVID-19, all staff/contractors are required to wear masks for the full duration of their shift, across all CSC institutions. Staff are required to wear their masks at all times unless they are by themselves (e.g. in an office, corridor, empty room, outdoors) or if there is a physical barrier between themselves and others. In non-outbreak sites, non-medical masks should be worn for universal masking as much as possible in order to preserve medical/procedural masks for higher risk activities.

For any sites with an active COVID-19 outbreak, medical/procedural masks and eye protection are to be worn by all staff/contractors for the full duration of their shifts. The use of non-medical masks may only be considered in sites with established distinct contaminated and non-contaminated zones; where the non-contaminated zones may use non-medical masks.

The following are best practices when implementing universal masking and eye protection measures:

- Masks are not a replacement for physician distancing – staff/contractors must continue to maintain at least two metres of separation from offenders and other staff, whenever possible, even when following universal masking measures.
- Given resource supply limitations, a single mask may be worn for an extended period of time (e.g. donned at the beginning of the shift and continued to be worn throughout the shift) as long as it is not visibly soiled, damp, damaged, or difficult to breathe through. All staff should make efforts to maximize the longevity of each mask. See Annex C for guidelines on the extended use/reuse of masks.
- Masks are to be donned when entering the institution and removed only when eating (note: physical distancing is imperative when masks are removed for eating) or when leaving the institution at the end of the shift. In outbreak sites, the same guidance applies to the use of both masks and eye protection.
- Proper hand hygiene is imperative, including before and after removing the mask. Avoid touching and manipulating the mask (if it is necessary to readjust, hand hygiene should be performed before and after adjusting the mask). Masks should not be dangled under the chin, around the neck, or placed on top of the head.
- All staff/contractors must be trained and monitored for compliance with donning, doffing, and wearing masks – and eye protection at outbreak sites – for the duration of their shift, as well as properly assessing the need for additional PPE (as per the guidance for COVID-19 positive and symptomatic offenders below).

Institutional Heads will establish a process to track and regularly monitor PPE training, the issuing of masks and eye protection, as well as the proper use of PPE (including appropriate donning, doffing, and wearing of mask and eye protection), in collaboration with Health Services.

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PPE Requirements by Zone and/or by Offender COVID-19 Status

In order to mitigate the spread of COVID-19 throughout the institution, separate zones should be established to accommodate the cohorting of offenders in the case of an outbreak. CSC recommends cohorting offenders for medical isolation in the following zones:

- Offenders who are identified as COVID-19 positive
- Offenders who are symptomatic and/or awaiting test results
- Offenders identified as close contacts of a COVID-19 positive case

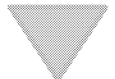
PPE Requirements: Offenders Diagnosed with COVID-19 // Zone: COVID-19 Positive

Staff/contractors within 2 metres of offender	Staff/contractors within two metres of offender on CPAP or undergoing dental work[1]	Offender (when out of cell)
Gloves Medical/Procedural Mask Face Shield (preferred)/Eye Goggles Gown	Gloves N95 Mask Face Shield (preferred)/Eye Goggles Gown	Medical/Procedural Mask

Notes

1. In order to preserve PPE supplies, staff/contractors should make efforts to provide care to more than one COVID-19 positive offender at a time in order to reduce the number of times staff/contractors are required to don and doff new PPE. Staff/contractors only need to change PPE when it becomes damaged or soiled.
2. Gloves are the only PPE that should be changed after contact with an offender and before initiating contact with a different offender. Hand hygiene should be performed before donning new gloves and gloves should cover the wrist/cuff of the gown.
3. Face Shields/goggles may be individually issued and reused if the face shield/eye goggles are in good repair and disinfected by the user (see Annex B).
4. Gowns, if cloth, are to be stored and laundered for reuse.
5. Gloves and masks should be safely disposed of after use.

PPE Reuse in This Zone



Change Gloves Between Each Offender, Reuse All Other PPE Unless Soiled/Damaged

In zones dedicated to COVID-19 positive offenders, the same PPE can be worn as long as the staff/contractor stays within the unit or zone. The entirety of these areas are considered contaminated, and as such, while in this zone, gowns, masks, and eye protection only need to be changed if they become soiled or damaged. Gloves should be changed and hand hygiene should be performed after contact with an offender (or their environment) and before initiating contact with a different offender.

[1] Only dental work that requires the use of a high-speed drill is considered an aerosol-generating procedure; however, given that it may be hard to predict in advance which procedures will require drilling, CSC recommends treating every dental case having the potential to become an aerosol-generating procedure, requiring N95 masks. Refer to CSC's COVID-19: Guidance for Dental Services for the most up to date and additional information.

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Before leaving these contaminated units or zones, staff must doff PPE, as well as perform hand hygiene, replace their mask, and replace or repurpose their eye protection (as per Annex B). The goal is to prevent transmission of the virus from contaminated zones to areas of the site that are free from contamination. Donning and doffing should take place in designated areas – these areas should include: a hand washing station equipped with alcohol-based hand rub and/or soap and water; no-touch receptacles for the disposal of gloves and non-reusable face shields and gowns; and no-touch laundry hampers (ideally lined with plastic liners) for reusable gowns. See the section on Donning and Doffing for more information.

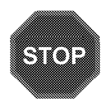
PPE Requirements: Offenders with Symptoms of COVID-19 // Zone: Symptomatic and/or Awaiting Test Result

Staff/contractors within 2 metres of offender	Staff/contractors within two metres of offender on CPAP or undergoing dental work[1]	Offender (when out of cell)
Gloves Medical/Procedural Mask Face Shield (preferred)/Eye Goggles Gown	Gloves N95 Mask Face Shield (preferred)/Eye Goggles Gown	Medical/Procedural Mask

Notes

1. **New PPE must be donned for each offender in this group** (see below for PPE Reuse in the Zone). Staff/contractors must doff PPE after providing care/performing other tasks within two metres for an offender with symptoms of COVID-19.
2. Face Shields/goggles may be individually issued and reused if the face shield/eye goggles are in good repair and disinfected by the user (see Annex B). They should be replaced or reprocessed between contact with different offenders.
3. Gowns, if cloth, are to be stored and laundered for reuse.
4. Gloves and masks should be safely disposed of after use.

PPE Reuse in this Zone



Change PPE Between Each Offender

In zones dedicated to symptomatic, but not confirmed positive COVID-19 offenders, **PPE must be changed after contact with an offender (or their environment) and before initiating contact with a different offender.** This is important in mitigating the spread of COVID-19 between offenders that are symptomatic with COVID-19 (but not yet confirmed by a positive test result), and those who are symptomatic, but whose symptoms are attributable to another infectious agent.

Before leaving this zone, staff must doff PPE, as well as perform hand hygiene, replace their mask, and replace or repurpose their eye protection (as per Annex B). The goal is to prevent transmission of the virus from contaminated zones to areas of the site that are free from contamination. Donning and doffing should take place in designated areas – these areas should include: a hand washing station equipped with alcohol-based hand rub and/or soap and water; no-touch receptacles for the disposal of gloves and non-reusable face shields and gowns; and no-touch laundry hampers (ideally

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lined with plastic liners) for reusable gowns. See the section on Donning and Doffing for more information.

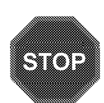
PPE Requirements: Close Contacts of a COVID-19 Case // Zone: Close Contacts

Staff/contractors within 2 metres of offender	Staff/contractors within two metres of offender on CPAP or undergoing dental work[1]	Offender (when out of cell)
Gloves Medical/Procedural Mask Face Shield (preferred)/Eye Goggles Gown	Gloves N95 Mask Face Shield (preferred)/Eye Goggles Gown	Medical/Procedural Mask

Notes

1. Asymptomatic contacts are treated the same as symptomatic individuals to mitigate the risk of offenders potentially transmitting the virus *before* the onset of symptoms. Data from recent outbreaks also suggests that offenders may not be forthcoming about reporting symptoms; therefore, the use of full PPE is recommended out of an abundance of caution.
2. **New PPE must be donned for each offender in this group** (see below for PPE Reuse in the Zone). Staff/contractors must doff PPE after providing care/performing other tasks within two metres for an offender with symptoms of COVID-19.
3. Face Shields/goggles may be individually issued and reused if the face shield/eye goggles are in good repair and disinfected by the user (see Annex B). They should be replaced or reprocessed between contact with different offenders.
4. Gowns, if cloth, are to be stored and laundered for reuse.
5. Gloves and masks should be safely disposed of after use.

PPE Reuse in this Zone



Change PPE Between Each Offender

In zones dedicated to asymptomatic close contacts of a case, **PPE must be changed after contact with an offender (or their environment) and before initiating contact with a different offender.** This is important in mitigating the spread of COVID-19 between offenders that have COVID-19 (and are presymptomatic) and those who do not.

Before leaving this zone, staff must doff PPE, as well as perform hand hygiene, replace their mask, and replace or repurpose their eye protection (as per Annex B). The goal is to prevent transmission of the virus from contaminated zones to areas of the site that are free from contamination. Donning and doffing should take place in designated areas – these areas should include: a hand washing station equipped with alcohol-based hand rub and/or soap and water; no-touch receptacles for the disposal of gloves and non-reusable face shields and gowns; and no-touch laundry hampers (ideally lined with plastic liners) for reusable gowns. See the section on Donning and Doffing for more information.

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PPE Requirements for Collecting Nasopharyngeal Swabs for COVID-19 Testing

Regulated health professional collecting swab & any staff within 2 metres of offender	Offender*
Gloves Medical/Procedural Mask Face Shield (preferred)/Eye Goggles Gown	Medical/Procedural Mask

*This procedure should be followed regardless of the symptomatic/asymptomatic status of the offender.

Notes

1. The health professional performing the specimen collection, along with any other staff within 2 metres of the procedure, must don PPE prior to entering the room. The test should be performed in a closed room with as few people in the room as possible.
2. The offender should already be wearing a medical/procedural mask at all times while outside of their cell, per universal masking procedures. In preparation for the swab, the offender should be instructed to perform hand hygiene, then lower their mask so that only their nose is exposed, with their mouth and chin remaining covered.
3. Persons performing the specimen collection should stand to the side of the patient, not directly in front of them, and should move away from the patient (to more than 2 metres away) as soon as the procedure is complete.
4. The offender should be instructed to perform hand hygiene and immediately replace the mask to its proper position over the nose, mouth, and chin. If their mask has become contaminated or soiled (e.g. from coughing or sneezing), they should be given a new mask.
5. Following the procedure, face shields/goggles that have been individually issued can be reused if they are in good repair and disinfected by the user (see Annex B)
6. Gowns, if cloth, are to be stored and laundered for reuse.
7. Gloves and masks should be safely disposed of after use.

PPE Requirements for CPR[2]

First Responders	Patient*
Gloves N95 Face Shield (preferred)/Eye Goggles Gown	Medical/Procedural Mask

*Patient refers to any staff, contractor or offender, regardless of symptomatic/asymptomatic status.

Notes

1. All first responders must don PPE prior to initiating CPR.

[2] Please see CSC's COVID-19: Interim Revisions to Cardiopulmonary Resuscitation (CPR) Procedures for the most up to date and additional information.

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2. A medical/procedural mask must also be placed on the patients face to cover their nose, mouth, and chin.
3. Face Shields/goggles may be individually issued and reused if the face shield/eye goggles are in good repair and disinfected by the user (see Annex B).
4. Gowns, if cloth, are to be stored and laundered for reuse.
5. Gloves and masks should be safely disposed of after use.

PPE Requirements for Transfers to Outside Hospital

If staff are required to escort an inmate to an outside hospital during the COVID-19 pandemic, PPE requirements should take into consideration whether the receiving hospital is actively experiencing a COVID-19 outbreak or not. PPE recommendations are as follows.

Transfer to an outside hospital with no known COVID-19 outbreak

Staff: Transferring an offender who is NOT suspected of COVID-19	Staff: Transferring an offender who is symptomatic or COVID-19 positive	Offender being transferred
Gloves Medical/Procedural Mask This is the minimum standard, however the receiving hospital may request additional PPE. In this instance, hospital guidance should be followed.	Gloves Medical/Procedural Mask Face Shield (preferred)/Eye Goggles Gown (disposable preferred) The receiving hospital may not be able to provide PPE for CSC staff. CSC staff should prepare for this by ensuring they have 3 sets of PPE ready for the transfer: one set for travelling to the hospital, a new set upon arrival to the hospital, and a final set for returning to the institution.	Medical/Procedural Mask

Transfers to an outside hospital with known COVID-19 outbreak

Staff: Transferring an offender regardless of COVID-19 status	Offender being transferred
Gloves Medical/Procedural Mask Face Shield (preferred)/Eye Goggles Gown (disposable preferred) The receiving hospital may not be able to provide PPE for CSC staff. CSC staff should prepare for this by ensuring they have up to 3 sets of PPE ready for the transfer: one set for travelling to the hospital, a new set upon arrival to the hospital, and a final set for returning to the institution.	Medical/Procedural Mask

Note

For all transfers to outside hospital, staff are required to follow hospital instructions regarding the use of PPE, the designated areas for donning and doffing PPE, as well as the appropriate locations for staff to have lunch or breaks. If staff are required to remove their masks for breaks or eating, they should maintain a two metre distance from others and remain in clean/non-contaminated areas, as designated by the hospital.

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PPE Requirements for Warrants of Committal and Returns to Federal Custody

As an interim measure to mitigate the introduction of COVID-19 into CSC institutions, new Warrants of Committal and offenders returning to federal custody must isolate for 14-day upon admission. Upon intake, offenders are expected to be screened by operations and by health services for symptoms of and potential exposures to COVID-19.

Staff/contractors working with asymptomatic offenders that are medically isolating as new admissions to the institution require only routine practices and the universal masking policies, as detailed above (Universal Masking at All Sites and Universal Masking and Eye Protection at Outbreak Sites). Routine practices include, but are not limited to, frequent hand hygiene, physical distancing as much as possible, respiratory hygiene, and appropriate cleaning practices. Offenders may also be offered non-medical masks, as resources allow.

Staff/contractors working with symptomatic offenders require PPE as detailed above (PPE Requirements: Offenders with symptoms of COVID-19).

Considerations for Brief Contacts with Asymptomatic Offenders

The risk of COVID-19 transmission is influenced by the nature and duration of contact with another person. The Public Health Agency of Canada (PHAC) defines prolonged exposure as anything over 15 minutes (which can be a continuous exposure or the cumulative duration of interactions with the same individual). Any interactions under 15 minutes are considered a 'brief' contact. There are several tasks and activities that CSC staff/contractors perform, in contact with offenders, that would be considered brief – some examples include the placement of electronic monitoring devices or cuffing an offender.

Prior to initiating contact within 2 metres of an offender, staff members should do a point of care assessment to determine if the offender is symptomatic before proceeding. If the offender is asymptomatic, both the staff and offender should wear a non-medical mask as a method of source control (i.e. to prevent the spread of their own respiratory droplets to each other or the environment). Staff may also choose to wear gloves when touching the patient, although proper hand hygiene before and after wearing gloves is imperative. Additional PPE is required if the offender is symptomatic, as detailed above (PPE Requirements: Offenders with symptoms of COVID-19).

Donning and Doffing PPE

Proper donning and doffing techniques must be followed at all times. Instructions for donning and doffing are included in Annex D.

Staff/contractors will receive instruction on how to don and doff PPE when wearing it for the first time. Institutional Heads will establish a process to track and regularly monitor PPE training, the issuing of masks and eye protection, as well as the proper use of PPE (including appropriate donning, doffing, and wearing of mask and eye protection), in collaboration with Health Services.

When donning and doffing PPE prior to providing care/performing other tasks with close contacts, symptomatic, or COVID-19 positive offenders, all staff/contractors are required to have an observer (buddy) who will observe and provide verbal correction if the PPE is not being donned or doffed properly.

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Institutional Heads, will establish a location close to the point of care for staff/contractors to doff PPE after providing care/performing other tasks with symptomatic offenders or offenders with a positive COVID-19 diagnosis. The area where PPE is donned should be separated from the area where it is removed and discarded. These areas should be clearly marked.

PPE must be properly disposed of to prevent the spread of infection. Point of care and doffing areas should be equipped with the following to allow for the proper disposal of contaminated PPE:

- Alcohol-based hand rub and/or designated hand washing sinks with soap and paper towels;
- An adequate number of no-touch waste receptacles for gloves, masks, non-reusable eye protection, non-reusable gowns, and paper towels;
- An adequate number of no-touch laundry hampers (with plastic liners) for reusable gowns;
- Accel wipes or Ultra Swipes cleaning products (or an alternate approved product) for the reprocessing of eye protection, if reusable (see Annex B).

Note on N95 and KN95 Respirators

If an N95 mask is warranted, as per the guidance issued above, it is important to ensure the mask is the correct size (as per the user's mask fit test) and sealed properly around the nose and mouth. Users should perform seal checks, prior to entering the room or area where airborne precautions are required, as per their training.

If KN95 masks are used, they do not require the same fit testing as N95 masks. However, these masks still require the user to perform a seal check prior to entering the room or area where airborne precautions are required. See Annex E for instructions on how to don and seal check KN95 masks.

Summary of PPE Requirements

A summary of the PPE requirements is available in Annex F: PPE At-a-Glance.

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Annex A

Ethical Considerations for PPE Use During a Pandemic

- **Individual liberty**: Respect for an individual's autonomy may need to be restricted in order to protect the public from serious harm.
- **Proportionality**: Any restrictions to individual liberties that are taken to protect the public from serious harm should be least restrictive and not bring about greater harm.
- **Reciprocity**: This principle requires that society and organizations support those who face a disproportionate burden in protecting the public good and take steps to minimize that burden to the degree possible.
- **Equity**: This principle, like all principles, considers the needs of staff, contractors, volunteers and offenders. Decision makers need to preserve as much equity as possible to protect the safety and health of all groups.
- **Trust**: Decision-makers are often forced during pandemics to implement various control measures. Ensuring that PPE decisions are grounded in evidence, ethical principles, are transparent and include stakeholder input, to the greatest extent possible, will help engender trust.
- **Solidarity:** Pandemics highlight the interdependence within an organization, between organizations and between jurisdictions. There is a common purpose in promoting equitable care, including in PPE utilization, to ensure the greatest public health benefit both within an organization and across all jurisdictions.
- **Stewardship:** All decisions regarding resource allocation aim to provide the best possible outcomes for all individuals. Decision-makers should look to maximize the benefits when allocating resource and aim for good and equitable outcomes. The intent is to maximize good outcomes and minimize burdens in an equitable manner.

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Annex B

Implementing extended use of eye protection.

Extended use of eye protection is the practice of wearing the same eye protection for repeated close contact encounters with several different patients. Extended use of eye protection can be applied to disposable and reusable devices.

- Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through or when you are removing it and planning to store it for later use.
    - If a disposable face shield is reprocessed, it should be dedicated to one employee/contractor and reprocessed whenever it is visibly soiled or removed (e.g., when leaving the isolation area) prior to putting it back on. See protocol for removing and reprocessing eye protection below.
- Eye protection should be discarded if damaged (e.g., if face shield can no longer fasten securely to the provider, if visibility is obscured and reprocessing does not restore visibility).
- Staff/contractors should make efforts to not to touch their eye protection. If they touch or adjust their eye protection they must immediately perform hand hygiene.

Process for cleaning and disinfecting eye protection (reprocessing):

When manufacturer instructions for cleaning and disinfection are unavailable, such as for single use disposable face shields, consider:

1. Perform hand hygiene and don gloves. If the eye protection is visibly soiled, wash first with soap and water and continue with the remaining steps for disinfection.
2. While wearing gloves, carefully wipe the *inside, followed by the outside* of the face shield or goggles using an Accel wipe or Ultra Swipe (or approved alternate product).
3. Carefully wipe the *outside* of the face shield or goggles using an Accel wipe or Ultra Swipe (or approved alternate product).
4. Wipe the outside of face shield or goggles with clean water to remove residue.
5. Fully dry (air dry or use clean absorbent towels).
6. Remove gloves and perform hand hygiene.
7. Store in a designated clean area.

Sources:

BC CDC: http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_EyeFacialProtectionDisinfection.pdf

CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html

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Annex C

Guidance on Extended Use of Masks For Activities Involving Close Proximity to Asymptomatic Individuals

To remove facemask with intent to reuse:

1. Perform hand hygiene ;
2. Remove mask :
   a. Ear-Loop mask style: Remove mask by holding the ear loops.
   b. Tie Back: Remove mask by untying lower ties first. Untie upper ties last ;
3. After removing mask, visually inspect it. If soiled, torn, or saturated the mask should be discarded;
4. If the mask is not visibly soiled, torn or saturated, carefully store the mask in a safe location in a brown paper bag or between two pieces of paper/paper towel with your name on it and marked ‘front’ and ‘back’ on the two sides. Insert your mask so that the front of the mask faces the side of the bag labelled front; and
5. Perform hand hygiene.

To re-apply used mask:

1. Perform hand hygiene ;
2. Minimally handle the mask and re-apply; and
3. Perform hand hygiene.

A single mask can be worn between all activities requiring less than 2 metres of physical distancing so long as all individuals are asymptomatic.

Given the international shortage of medical/procedural masks all staff/contractors should make every effort to maximize the longevity of each mask and prioritize non-medical masks at non-outbreak sites, so that we can collectively preserve supply for higher risk activities.

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Annex D

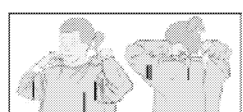
Donning Personal Protective Equipment (PPE)

Preparation

- Ensure that PPE is not damaged and is the right size
- Remove all jewellery and tie back long hair
- **WASH HANDS**

1 Gown

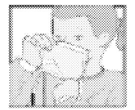
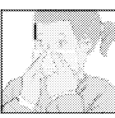
- Put on gown, tie at neck and waist



2 Mask or N95

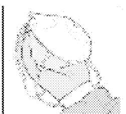
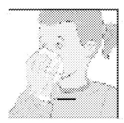
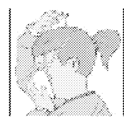
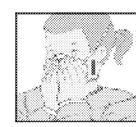
Mask

- Cover nose and mouth with surgical/procedural mask, tie or secure straps around ears
- Shape the mask to your nose

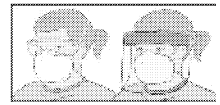
N95

- Hold the N95 in the palm of your hand, with the straps hanging on either side
- Place mask over your chin and then nose
- Secure the upper strap on the top of the head first, then bring the lower strap over the first strap and secure at neck/under hair
- Shape the mask to your nose and check for a good seal with fingers

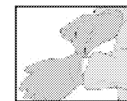
3 Face Shield

- Cover eyes with protective glasses or face shield



4 Gloves

- Insert hands into gloves
- Extend to cover the wrist of the gown



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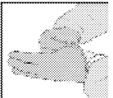
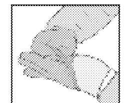
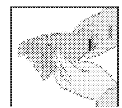
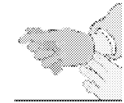
Doffing Personal Protective Equipment (PPE)

1 Gloves

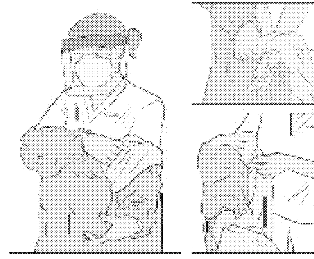
- Grasp the outer surface of palm area of one glove and peel off
- Rumple glove into a ball and hold in the gloved hand
- Slide the bare fingers under the band of the other glove without touching the outside and peel off
- Dispose of the gloves in the appropriate container

Perform hand hygiene

2 Gown

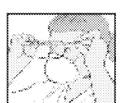
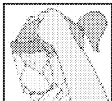
- Unfasten ties without contamination
- Touching only the inside of the gown, pull the gown forward
- With one hand grasp the inside of the opposite sleeve, slide it forward without turning it over to release the hand
- With your free hand, proceed in the same way to remove the other hand
- Turn gown inside out and roll into a bundle
- Dispose of the gown in the appropriate container



Perform hand hygiene

3 Face Shield

- Handle the face shield or protective goggles from the sides or back, avoid touching the front
- Dispose of the face shield or goggles in the appropriate container

Perform hand hygiene

4 Mask or N95

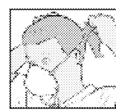
Mask

- Detach the top and bottom ties or remove straps from ears
- Pull mask forward avoiding touching the front
- Dispose of mask in the appropriate container

Perform hand hygiene

N95

- Tilt head slightly forward, pass the lower strap over the head and then the top strap, avoiding touching the filter
- Bring respirator away from face
- Dispose of N95 in the appropriate container



Perform hand hygiene

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Annex E

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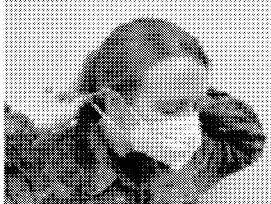
Instructions for masks with ear loops (note, images may differ from actual product):

1. Donning this mask involves proper placement of the straps around the ears. Hold the mask by the ear loops, with nosepiece up. Place a loop around each ear.	
2. These masks are equipped with a nosepiece that is meant to be molded to the user's facial structure. Using your index fingers press gently against the metal strip until it molds to a snug fit. 3. Ensure you adjust the nosepiece. Placing fingers from both hands on top side of nosepiece. Place both thumbs on underneath side of nosepiece and bend slightly at center of nosepiece. 4. Ensure a good fit around your face by pulling the bottom of the mask over your mouth and ensure your chin is inside the mask.	
5. After donning the filtering face piece, perform a face fit check while wearing any accessories (e.g., glasses, goggles, jewelry) that will be worn during use to verify a snug fit around the contour of the mask. • Completely cover the outside of the mask with both hands. Do not push the mask against your face. With your hands in place on the surface of the mask, exhale or breathe out sharply. If you feel air blowing on your face or eyes, the mask needs to be adjusted. To adjust, repeat steps 2 to 5. When mask is a good fit, you will not feel any air blowing on your face or eyes. If you can't get a good fit, try a different model mask.	
6. Remove the mask by carefully drawing both ear loops away from the ears then forward away from the face. The front may be contaminated, so remove slowly and carefully.	
7. **Note, this product is not a NIOSH approved N95 respirator.**	

TEST RESULTS: To expand the availability of N95 masks and respirators during the pandemic, this product has been tested by the Public Health Agency of Canada against GB2626-2006 to determine its acceptability. This standard the NIOSH equivalent that is used outside of North America to approve KN95 masks. This is in accordance with Health Canada policies (https://www.canada.ca/en/health-canada/services/drugs-health-products/medical-devices/masks-respirators-covid19.html#a4). This product was tested at the same flowrate and particle concentration used by NIOSH for N95 filtering facepiece devices and found to have a particle filtration efficiency of greater than 95%.

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Annex F: PPE At-a-Glance

PPE by Zone and/or Offender COVID-19 Status

	Zone and/or Offender COVID-19 Status	PPE Requirements		
		Staff/contractors within 2m of inmate	Staff/contractors within 2m of inmate on CPAP or undergoing dental work	Inmate (when out of cell)
	Offenders Diagnosed with COVID-19 // Zone: COVID-19 Positive	Gloves Medical/Procedural Mask Eye Protection Gown	Gloves N95 Mask Eye Protection Gown	Medical/Procedural Mask
CHANGE PPE BETWEEN OFFENDERS	Offenders with symptoms of COVID-19 // Zone: Symptomatic and/or Awaiting Test Result	Gloves Medical/Procedural Mask Eye Protection Gown	Gloves N95 Mask Eye Protection Gown	Medical/Procedural Mask
CHANGE PPE BETWEEN OFFENDERS	Close contacts of a COVID-19 case // Zone: Close Contacts	Gloves Medical/Procedural Mask Eye Protection Gown	Gloves N95 Mask Eye Protection Gown	Medical/Procedural Mask

PPE for NP Swabs Collection and CPR

Procedure	Staff (Regulated health professional performing swab or First Responder for CPR)	Patient
Collecting Nasopharyngeal Swabs for COVID-19 Testing	Gloves Medical/Procedural Mask Eye Protection Gown	Medical/Procedural Mask
CPR	Gloves N95 Eye Protection Gown	Medical/Procedural Mask

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PPE for Transfer to Outside Hospital

Receiving Hospital's Outbreak Status Offender's	COVID-19 Status	PPE Requirements	
		Staff	Offender
NO KNOWN COVID-19 Outbreak at Receiving Hospital	Transferring an offender who is NOT suspected of COVID-19	Gloves Medical/Procedural Mask *This is the minimum standard, however the receiving hospital may request additional PPE, which should be followed*	Medical/Procedural Mask
	Transferring an offender who is symptomatic or COVID-19 positive	Gloves Medical/Procedural Mask Eye Protection Gown (disposable preferred) *The receiving hospital may not be able to provide PPE for CSC staff. CSC staff should prepare for this by ensuring they have 3 sets of PPE ready for the transfer: one set for travelling to the hospital, a new set upon arrival to the hospital, and a final set for returning to the institution.*	Medical/Procedural Mask
KNOWN COVID-19 Outbreak at Receiving Hospital	Transferring an offender regardless of COVID-19 status	Gloves Medical/Procedural Mask Eye Protection Gown (disposable preferred) *The receiving hospital may not be able to provide PPE for CSC staff. CSC staff should prepare for this by ensuring they have up to 3 sets of PPE ready for the transfer: one set for travelling to the hospital, a new set upon arrival to the hospital, and a final set for returning to the institution.*	Medical/Procedural Mask

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COVID-19: Institutional Cleaning Step-by-Step Guide

July 16, 2020

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Revision History

Version	Date	Approved by
1	July 16, 2020	Steering Committee

Background

COVID-19 is a highly transmittable droplet virus that can spread through person-to-person transmission and contact with contaminated surfaces. Emerging scientific literature also suggests that asymptomatic or pre-symptomatic infections are likely contributing to transmission, particularly in closed environments such as long-term care homes and correctional institutions.

COVID-19 is an enveloped virus. This means it is one of the easiest types of viruses to kill with the appropriate disinfectant when used according to label directions.

Purpose

The intended purpose of this document is to provide staff members, offenders and others involved in institutional cleaning step-by-step procedures based on best practices from public health authorities.

This guide focuses on Correctional Service Canada (CSC) institutions, including Community Correctional Centers (CCC), as a whole and not limited to health care areas.

Environmental Cleaning and Disinfection

Routine cleaning of frequently used surfaces and objects can help to prevent the transmission of COVID-19. Surfaces that are frequently touched are the most likely to be contaminated. Each area has daily duties and weekly duties. Daily duties are the cleaning of high touch areas and weekly duties are low touch areas.

See below for a list of high and low touch surfaces.

High Touch Surfaces Cleaned Twice Daily	**Low Touch Surfaces Cleaned Weekly**
Doorknobs	Floors
Push bars	Walls
Water fountains	Ceilings
Handrails	Window sills
Telephones	Window coverings
Toilet handles	Mirrors

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High Touch Surfaces Cleaned Twice Daily	**Low Touch Surfaces Cleaned Weekly**
Dining tables	Ceiling lights
Light switches	Baseboards
Elevator buttons	
Touch screen surfaces	
Keypads	
IM/IT equipment	
Soap and Hand Sanitizer Dispensers	

Supplies should be provided to inmates to clean and disinfect their cell/room. If the inmate is too sick to clean, a cleaner wearing PPE may perform daily cleaning.

INMATE'S CELL/ROOM CLEANING

Step	**Details**
1	Make sure you have all the cleaning equipment you need such as disposable cloths; paper towels and absorbent materials; waste disposal bags; cleaning agents; appropriate hard-surface disinfectants. Use disinfectant products provided to you by Institutional Services (solution or wipes) to disinfect your cell/room.
2	Wash hands with alcohol-based hand sanitizer or soap and water.
3	Remove all non essential equipment and objects stored in your cell/room to facilitate regular, effective cleaning.
4	Gather your garbage and recycling, place it at the doorway.
5	Dry-dust the desk lamp and television.
6	Gather disposable paper towels. Take 1 towel, wet it with the approved disinfectant. Starting on the left side of the room and working to the right, begin to clean the high-touch surfaces including tables tops, light switches, door handles, drawer knobs, television remote control, etc.
7	New towel – wipe the desk, chair and wardrobe.
8	New towel – wipe the bed rails, headboard and footboard.
9	Using the approved disinfectant – wipe down the soap dispensers, sink, faucet, exterior of toilet bowl including seat – top and bottom. Clean from least-soiled areas (low-touch) to most-soiled (high touch) – from clean to dirty (toilet last).
10	Clean the inside of the toilet bowl with an approved disinfectant and use the toilet brush – wipe down toilet brush container with the disinfectant.
11	Mop your floor using dry dust mops, such as microfiber, to attract and hold debris.
12	Wash hands with alcohol-based hand sanitizer or soap and water after cleaning

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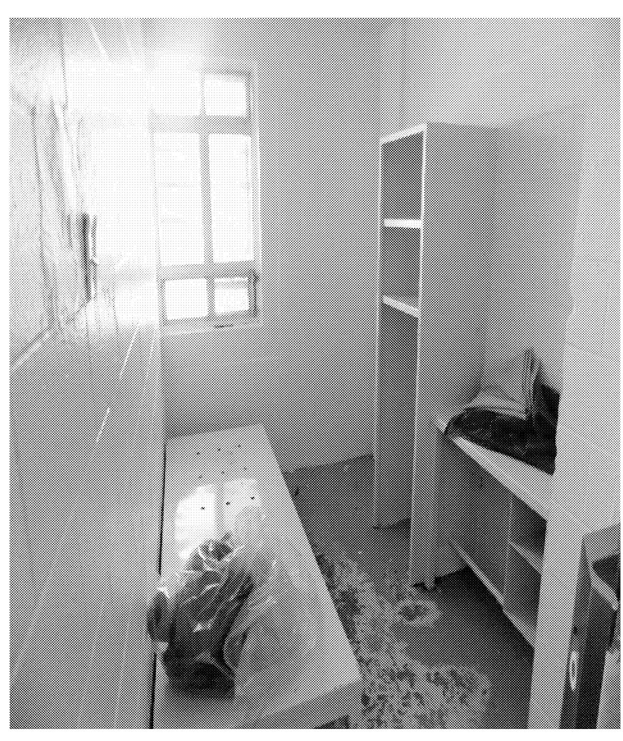

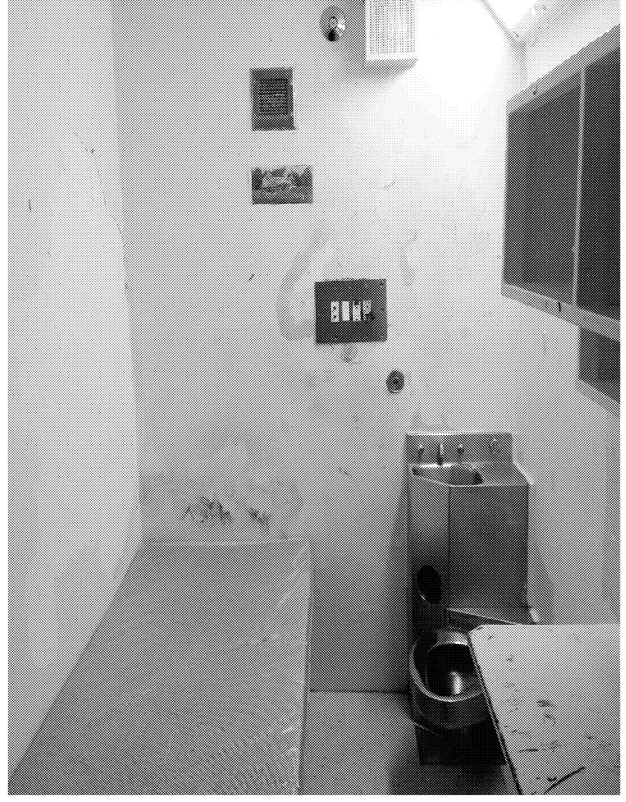

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COMMON AREAS CLEANING
(Living Units, Kitchens, Ranges)

Step	Details
1	Make sure you have all the cleaning equipment you need such as disposable cloths; paper towels and absorbent materials; waste disposal bags; labels and tape; cleaning agents; appropriate hard-surface disinfectants; caution/wet floor sign; personal protective equipment (as per Health and Safety protocol); etc.
2	Perform hand hygiene and put on disposable gloves.
3	Gather the garbage in the unit, place it at the doorway. Gather the recycling, place it at the doorway. Clean inside and outside of waste container.
4	Remove gloves, do hand hygiene, and put on new gloves. **Change gloves during cleaning and disinfection activities if they become heavily soiled or damaged during use** – To change gloves, remove soiled/damaged gloves and place in lined container, wash hands with soap and water, and apply new gloves.
5	Gather disposable paper towels. Take one towel, wet it with an appoved disinfectant. Starting on the left side of the room and working toward the right, clean the following: • Light switches • Door handles/door pulls (exterior and interior) • Door frames (exterior and interior) next to door handles/door pulls • In kitchens, ranges: drawer/cupboard handles, refrigerator door handles, microwave door handles, lever on toaster, handle on kettle and coffee pot. Spot-clean surfaces of appliances as required.
6	Take a new towel – clean the television remote control (if there is a television in the room), spot-clean walls and window on door (exterior and interior).
7	Always starting from the left of the room and working to the right, clean the furniture with a new towel: benches, hard surfaces of chairs and tables. Spot-clean fabric surfaces of chair.
8	Scrub sink with an approved disinfectant and rinse with water; wipe the faucet, taps, soap dispenser and paper towel holder with a new towel using the same approved disinfectant.
9	Take a new towel – Clean the countertop.
10	Place caution / wet floor sign at the entry of the living units, kichens and/or ranges.
11	Dry-mop then wet-mop floor, starting from the left and working to the right.
12	Replace paper towel and soap (if needed).
13	Remove caution / wet floor sign when floor is completely dry.
14	Remove gloves and wash hands with alcohol-based hand sanitizer or soap and water after cleaning.

Notes: Where possible, when cleaning floors it is recommended to use dry dust mops, such as microfiber, to attract and hold debris.

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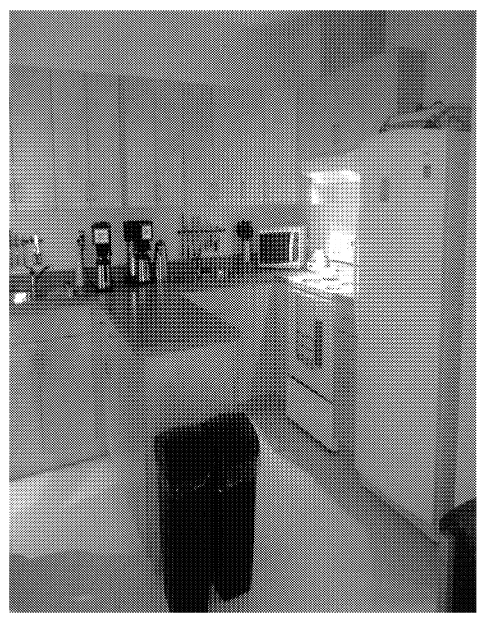

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