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	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
		COVID-19 illness, requiring increased monitoring and support (e.g. oxygen therapy, IV fluids, etc.). • Establish the role of the regional hospitals for patients returning from outside hospitalization following a COVID-19 admission and develop a plan. • Plans should include considerations for triaging patients for admission to the regional hospital (and transferring patients to outside hospital, as clinically appropriate), recognizing the regional hospital's limited capacity should an increased need develop in response to COVID-19.	COVID-19 illness, requiring increased monitoring and support (e.g. oxygen therapy, IV fluids, etc.). • Establish the role of the regional hospitals for patients returning from outside hospitalization following a COVID-19 admission and develop a plan. • Plans should include considerations for triaging patients for admission to the regional hospital (and transferring patients to outside hospital, as clinically appropriate), recognizing the regional hospital's limited capacity should an increased need develop in response to COVID-19.	with moderate COVID-19 illness, requiring increased monitoring and support (e.g. oxygen therapy, IV fluids, etc.). • Implement the established plan regarding the return of patients to CSC from outside hospitalization following a COVID-19 admission.	requiring increased monitoring and support (e.g. oxygen therapy, IV fluids, etc.). • Implement the established plan regarding the return of patients to CSC from outside hospitalization following a COVID-19 admission.

Community Health Services

	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
Individual Mental Health Treatment	☐ Routine individual mental health therapy.	☐ Modified individual mental health therapy ☐ Follow measures outlined in the direction provided to community corrections when meeting in-person with offenders to maintain	☐ Modified individual mental health therapy ☐ Follow measures outlined in the direction provided to community corrections when meeting in-person with offenders to maintain	☐ Modified individual mental health therapy ☐ Triage services based on mental health needs and maintain the following services as able, using	☐ Modified individual mental health therapy ☐ Triage services based on mental health needs and maintain the following services as able, using teleservices as appropriate and available:

	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
		physical distancing (2 meters) and use active screening health questions. ☐ Follow measures for the use of vehicles, as per parole office/community corrections. ☐ Complete day-to-day tasks via telework, as appropriate and respecting privacy of health information. ☐ Continue to consult and collaborate with health services staff, case management and community service providers, as required. ☐ As appropriate and required, clients are encouraged to access provincial/territorial community health services for additional support, in cases of emergency and afterhours.	physical distancing (2 meters) and use active screening health questions. ☐ Suspend in-home visits. ☐ Follow measures for the use of vehicles, as per parole office/community corrections. ☐ Complete day-to-day tasks via telework, as appropriate and respecting privacy of health information. ☐ Continue to consult and collaborate with health services staff, case management and community service providers, as required. ☐ As appropriate and required, clients are encouraged to access provincial/territorial community health services for additional support, in cases of emergency and afterhours.	teleservices as appropriate and available: • Triage new referrals • Review caseloads to prioritize service delivery based on offender need and available resources, with an effort to provide services in response to high priority mental health needs; • Psychiatric clinics; • Respond to offenders at risk for suicide and/or self injury according to relevant professional standards; • Provide services to offenders with PBC conditions to prevent breaches in conditions and those with higher risk of reoffending; and • Continue assessing specific circumstances on a case-by-case basis, including by telephone if possible ☐ Follow measures outlined in the direction provided to community corrections when meeting in-person with offenders to maintain physical distancing (2 meters) and use active screening health questions.	• Triage new referrals • Review caseloads to prioritize service delivery based on offender need and available resources, with an effort to provide services in response to high priority mental health needs; • Psychiatric clinics; • Respond to offenders at risk for suicide and/or self injury according to relevant professional standards; • Provide services to offenders with PBC conditions to prevent breaches in conditions and those with higher risk of reoffending; and • Continue assessing specific circumstances on a case-by-case basis, including by telephone if possible ☐ Follow measures outlined in the direction provided to community corrections when meeting in-person with offenders to maintain physical distancing (2 meters) and use active screening health questions. ☐ Suspend in-home visits. ☐ Follow measures for the use of vehicles, as per parole office/community corrections.

	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
				☐ Suspend in-home visits. ☐ Follow measures for the use of vehicles, as per parole office/community corrections. ☐ Complete day-to-day tasks via telework, as appropriate and respecting privacy of health information. ☐ Continue to consult and collaborate with health services staff, case management and community service providers, as required. As appropriate and required, clients are encouraged to access provincial/territorial community health services for additional support, in cases of emergency and afterhours ☐ As appropriate and required, clients are encouraged to access provincial/territorial community health services for additional support, in cases of emergency and afterhours	☐ Complete day-to-day tasks via telework, as appropriate and respecting privacy of health information. ☐ Continue to consult and collaborate with health services staff, case management and community service providers, as required. As appropriate and required, clients are encouraged to access provincial/territorial community health services for additional support, in cases of emergency and afterhours ☐ As appropriate and required, clients are encouraged to access provincial/territorial community health services for additional support, in cases of emergency and afterhours.
Group Mental Health Treatment	☐ Routine group mental health therapy.	☐ Modified group mental health therapy ☐ Follow measures outlined in the direction provided to community corrections when	☐ Suspend group mental health therapy ☐ Identify any individuals who require supplemental one-on-one follow up in the absence	☐ Suspend group mental health therapy until the outbreak is over ☐ Identify any individuals who require supplemental one-on-	☐ Suspend group mental health therapy until the outbreak is over ☐ Identify any individuals who require supplemental one-on-

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	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
		meeting in-person with offenders to maintain physical distancing (2 meters) and use active screening health questions. ☐ As appropriate and required, clients are encouraged to access provincial/territorial community health services for additional support, in cases of emergency and afterhours.	of group mental health therapy. ☐ Prioritize high risk or vulnerable patients for follow up care at the usual or greater frequency. ☐ As appropriate and required, clients are encouraged to access provincial/territorial community health services for additional support, in cases of emergency and afterhours.	one follow up in the absence of group mental health therapy. ☐ Prioritize high risk or vulnerable patients for follow up care at the usual or greater frequency. ☐ As appropriate and required, clients are encouraged to access provincial/territorial community health services for additional support, in cases of emergency and afterhours.	one follow up in the absence of group mental health therapy. ☐ Prioritize high risk or vulnerable patients for follow up care at the usual or greater frequency. ☐ As appropriate and required, clients are encouraged to access provincial/territorial community health services for additional support, in cases of emergency and afterhours.

Assessments

	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
Intake - New Warrants of Committal or Returns to Federal Custody	☐ Routine intake procedures.	☐ Modified intake procedures ☐ Patients are pre-screened for COVID-19 in provincial jail. ☐ Patients are screened by Operations and by Health (using COVID-19 Screening Form for use by Healthcare, which includes temperature screening) at reception centre or intake unit. ☐ Patients are placed in medical isolation for 14 days. Daily medical isolation wellness assessments are completed by a healthcare professional and documented in the EMR.	☐ Modified intake procedures ☐ Patients are pre-screened for COVID-19 in provincial jail. ☐ Patients are screened by Operations and by Health (using COVID-19 Screening Form for use by Healthcare, which includes temperature screening) at reception centre or intake unit. ☐ Patients are placed in medical isolation for 14 days. Daily medical isolation wellness assessments are completed by a healthcare professional and documented in the EMR.	☐ Modified intake procedures ☐ Patients are pre-screened for COVID-19 in provincial jail. ☐ Patients are screened by Operations and by Health (using COVID-19 Screening Form for use by Healthcare, which includes temperature screening) at reception centre or intake unit. ☐ Patients are placed in medical isolation for 14 days Daily medical isolation wellness assessments are completed by a healthcare professional and documented in the EMR.	☐ Modified intake procedures ☐ Patients are pre-screened for COVID-19 in provincial jail. ☐ Patients are screened by Operations and by Health (using COVID-19 Screening Form for use by Healthcare, which includes temperature screening) at reception centre or intake unit. ☐ Patients are placed in medical isolation for 14 days. Daily medical isolation wellness assessments are completed by a healthcare professional and documented in the EMR.

	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
		☐ Patients are offered a tested for COVID-19 at Day 10-12 of their medical isolation, as per the COVID-19 Testing Strategy. Results should be received before transferring the patient to their parent institution. ☐ Intake assessments, including 1244, should be completed within 24 hours, as per routine procedures. CoMHISS testing and Mental Health Assessments should be completed as per routine procedures.	☐ Patients are offered a test for COVID-19 at Day 10-12 of their medical isolation, as per the COVID-19 Testing Strategy. Results should be received before transferring the patient to their parent institution. ☐ Intake assessments, including 1244, should be completed within 24 hours, as per routine procedures. CoMHISS testing can be delayed if necessary. If testing was not completed, documentation of reasons should be placed in the EMR. Mental Health Assessments should be completed as per routine procedures, prioritizing patients by clinical need as needed.	☐ Patients are offered a test for COVID-19 at Day 10-12 of their medical isolation, as per the COVID-19 Testing Strategy. Results should be received before transferring the patient to their parent institution. NOTE: Avoid transfers to and from outbreak institutions. ☐ Intake assessments, including 1244 should be completed within 24 hours, as per routine procedures. ☐ CoMHISS testing can be delayed if necessary. If testing was not completed, documentation of reasons should be placed in the EMR. ☐ The comprehensive Mental Health Assessment done at intake may be delayed if necessary, but should be prioritized by urgency or clinical need. Rationale for the delay should be documented in the EMR.	☐ Patients are offered a test for COVID-19 at Day 10-12 of their medical isolation, as per the COVID-19 Testing Strategy. Results should be received before transferring the patient to their parent institution. NOTE: Avoid transfers to and from outbreak institutions. ☐ Intake assessments, including 1244, should be completed within 24 hours, as per routine procedures. ☐ CoMHISS testing can be delayed if necessary. If testing was not completed, documentation of reasons should be placed in the EMR. ☐ The comprehensive Mental Health Assessment done at intake may be delayed if necessary, but should be prioritized by urgency or clinical need. Rationale for the delay should be documented in the EMR.
Medical Isolation Wellness Assessments	☐ Discontinue Medical Isolation Wellness Assessments (MIWAs).	☐ Implement MIWAs for any patients on medical isolation ☐ MIWAs occur at the following frequency (at minimum), for the full duration of medical isolation:	☐ Implement MIWAs for any patients on medical isolation, with the following considerations: ☐ MIWAs occur at the following frequency (at minimum), for	☐ Implement MIWAs for any patients on medical isolation, with the following considerations: ☐ MIWAs occur at the following frequency (at minimum), for	☐ Implement MIWAs for any patients on medical isolation, with the following considerations: ☐ MIWAs occur at the following frequency (at minimum), for

	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
		• Symptomatic and COVID-19 confirmed patients: Twice per day • Asymptomatic close contacts and new intakes: Once per day ☐ Completed by a healthcare professional and documented in the EMR.	the full duration of medical isolation: • Symptomatic and COVID-19 confirmed patients: Twice per day • Asymptomatic close contacts and new intakes: Once per day ☐ Completed by a healthcare professional and documented in the EMR.	the full duration of medical isolation: • Symptomatic and COVID-19 confirmed patients: Twice per day • Asymptomatic close contacts and new intakes: Once per day ☐ Completed by a healthcare professional and documented in the EMR.	the full duration of medical isolation: • Symptomatic and COVID-19 confirmed patients: Twice per day • Asymptomatic close contacts and new intakes: Once per day ☐ Completed by a healthcare professional and documented in the EMR.
Wellness Assessment for Patients at High-Risk for Severe COVID-19 Illness	☐ Discontinue wellness assessments for patients at high-risk of severe COVID-19 illness.	☐ Discontinue wellness assessments for patients at high-risk of severe COVID-19 illness. ☐ Institutional health services are expected to maintain and continually update a list of high-risk patients, in preparation for the introduction of COVID-19 into the local community or institution.	☐ Implement wellness assessments for patients at high-risk of severe COVID-19 illness ☐ Assessments should take place, at minimum, three times per week. ☐ Completed by a healthcare professional and documented in the EMR.	☐ Implement wellness assessments for patients at high-risk of severe COVID-19 illness ☐ Assessments should take place, at minimum, three times per week. ☐ Completed by a healthcare professional and documented in the EMR.	☐ Implement wellness assessments for patients at high-risk of severe COVID-19 illness ☐ Assessments should take place, at minimum, three times per week. ☐ Completed by a healthcare professional and documented in the EMR.
SIU Assessments	☐ SIU assessments as per routine procedures.	☐ SIU assessments as per routine procedures. ☐ To facilitate physical distancing when performing the assessment, the clinician should request that the patient stand 2 meters from the door.	☐ SIU assessments as per routine procedures. ☐ To facilitate physical distancing when performing the assessment, the clinician should request that the patient stand 2 meters from the door.	☐ Modified SIU assessments ☐ As much as possible, maintain SIU assessments as per routine procedures. ☐ If unable to maintain regular assessment schedule due to operational limitations, prioritize SIU assessments as follows:	☐ Modified SIU assessments ☐ As much as possible, maintain SIU assessments as per routine procedures. ☐ If unable to maintain regular assessment schedule due to operational limitations, prioritize SIU assessments as follows:

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	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
				• Complete the 24 hour assessment and continue daily assessments • Delay the SIU 14-day assessment if necessary; however, the daily assessment is an opportunity to monitor the patient and if the any mental health deterioration is detected, completed the SIU 14-day assessment immediately. • Delay the SIU 28-day assessment if necessary, but ensure the assessment is completed at some point during the admission. • Document the rationale for any delays in the EMR. ☐ To facilitate physical distancing when performing the assessment, the clinician should request that the patient stand 2 meters from the door.	• Complete the 24 hour assessment and continue daily assessments • Delay the SIU 14-day assessment if necessary; however, the daily assessment is an opportunity to monitor the patient and if the any mental health deterioration is detected, completed the SIU 14-day assessment immediately. • Delay the SIU 28-day assessment if necessary, but ensure the assessment is completed at some point during the admission. • Document the rationale for any delays in the EMR. ☐ To facilitate physical distancing when performing the assessment, the clinician should request that the patient stand 2 meters from the door.
Self-Injury and Suicide Risk Assessments	☐ Routine self-injury and suicide risk assessments.	☐ Routine self-injury and suicide risk assessments, taking into account the risk mitigation and control measures detailed above, under Foundational Measures	☐ Routine self-injury and suicide risk assessments, taking into account the risk mitigation and control measures detailed above, under Foundational Measures	☐ Routine self-injury and suicide risk assessments, taking into account the risk mitigation and control measures detailed above, under Foundational Measures	☐ Routine self-injury and suicide risk assessments, taking into account the risk mitigation and control measures detailed above, under Foundational Measures
Other mental health assessments	☐ Routine mental health assessments.	☐ Routine mental health assessments	☐ Delay mental health assessment if needed	☐ Delay mental health assessment if needed	☐ Delay mental health assessment if needed

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	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
(e.g. intellectual disability, ADHD, comprehensive/ differential diagnosis assessment)		☐ Individual sessions can take place in a room or area that allows for physical distancing. ☐ Cleaning/disinfection required between patients (e.g. chairs, tables). ☐ As appropriate, conduct sessions by telemedicine or virtual service delivery (or use a hybrid approach with virtual and in-person visits).	☐ Prioritize assessments based on urgency and patient need. ☐ Document the rationale for any delays in the EMR. ☐ Individual sessions can take place in a room or area that allows for physical distancing. ☐ Cleaning/disinfection required between patients (e.g. chairs, tables). ☐ As appropriate, conduct sessions by telemedicine or virtual service delivery (or use a hybrid approach with virtual and in-person visits).	☐ Prioritize assessments based on urgency and patient need. ☐ Document the rationale for any delays in the EMR. ☐ Avoid moving patients as much as possible. See patients from outside their room or in a room at the unit/range level or remotely, with safeguards for confidentiality.	☐ Prioritize assessments based on urgency and patient need. ☐ Document the rationale for any delays in the EMR. ☐ Avoid moving patients as much as possible. See patients from outside their room or in a room at the unit/range level or remotely, with safeguards for confidentiality.
Discharge / Release	☐ Routine discharge/release procedures. ☐ Secure outpatient follow-up and medication supply, as necessary	☐ Routine discharge/release procedures ☐ Follow measures as outlined in the document Discharge planning for COVID-19: Health services practice reminder ☐ Offer voluntary COVID-19 testing to all patients prior to release. ☐ Secure outpatient follow-up, as necessary ☐ Ensure access to medication supply, as necessary • NHQ-Pharmacy recommends that prescriptions be provided on release, with the duration of the	☐ Routine discharge/release procedures ☐ Follow measures as outlined in the document Discharge planning for COVID-19: Health services practice reminder ☐ Offer voluntary COVID-19 testing to all patients prior to release. ☐ Secure outpatient follow-up, as necessary ☐ Ensure access to medication supply, as necessary • NHQ-Pharmacy recommends that prescriptions be provided on release, with the duration of the	☐ Routine discharge/release procedures ☐ Follow measures as outlined in the document Discharge planning for COVID-19: Health services practice reminder ☐ Offer voluntary COVID-19 testing to all patients prior to release. ☐ Secure outpatient follow-up, as necessary ☐ Ensure access to medication supply, as necessary • NHQ-Pharmacy recommends that prescriptions be provided on release, with the duration of the	☐ Routine discharge/release procedures ☐ Follow measures as outlined in the document Discharge planning for COVID-19: Health services practice reminder ☐ Offer voluntary COVID-19 testing to all patients prior to release. ☐ Secure outpatient follow-up, as necessary ☐ Ensure access to medication supply, as necessary • NHQ-Pharmacy recommends that prescriptions be provided on release, with the duration of the prescription (e.g. 3-6 months) to be at discretion of physician or

	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
		prescription (e.g. 3-6 months) to be at discretion of physician or nurse practitioner, taking into consideration the current situation regarding challenges in accessing the healthcare system in the community.	prescription (e.g. 3-6 months) to be at discretion of physician or nurse practitioner, taking into consideration the current situation regarding challenges in accessing the healthcare system in the community.	prescription (e.g. 3-6 months) to be at discretion of physician or nurse practitioner, taking into consideration the current situation regarding challenges in accessing the healthcare system in the community.	nurse practitioner, taking into consideration the current situation regarding challenges in accessing the healthcare system in the community.

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Risk Assessments

	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
Psychological Risk Assessments	☐ Routine procedures for psychological risk assessments.	☐ Modified procedures for psychiatric risk assessments ☐ In-person assessments can take place in a room or area that allows for physical distancing. ☐ Cleaning/disinfection required between patients (e.g. chairs, tables).	☐ Modified procedures for psychological risk assessments ☐ In-person assessments can take place in a room or area that allows for physical distancing. ☐ Cleaning/disinfection required between patients (e.g. chairs, tables).	☐ Modified procedures for psychological risk assessments ☐ Avoid moving patients as much as possible. See patients in a room at the unit/range level or remotely, with safeguards for confidentiality. ☐ In-person assessments can take place in a room or area that allows for physical distancing. ☐ Cleaning/disinfection required between patients (e.g. chairs, tables). ☐ Using clinical judgement, psychologists may use videoconference or teleconference technology to conduct assessments, as per Psychological Risk Assessments and COVID-19 Social Distancing Measures, recognizing that there are limitations to virtual assessments. ☐ Considerations for virtual service delivery include the nature of the individual patient's case and circumstances, access to and infrastructure for virtual	☐ Modified procedures for psychological risk assessments ☐ Avoid moving patients as much as possible. See patients in a room at the unit/range level or remotely, with safeguards for confidentiality. ☐ In-person assessments can take place in a room or area that allows for physical distancing. ☐ Cleaning/disinfection required between patients (e.g. chairs, tables). ☐ Using clinical judgement, psychologists may use videoconference or teleconference technology to conduct assessments, as per Psychological Risk Assessments and COVID-19 Social Distancing Measures, recognizing that there are limitations to virtual assessments. ☐ Considerations for virtual service delivery include the nature of the individual patient's case and circumstances, access to and infrastructure for virtual technology at the operational site, the risk of COVID-19 transmission (e.g. is the patient symptomatic), and the current

	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
				technology at the operational site, the risk of COVID-19 transmission (e.g. is the patient symptomatic), and the current level of restrictions in the local community.	level of restrictions in the local community.
Psychiatric Risk Assessment	☐ Routine procedures for psychiatric risk assessments.	☐ Modified procedures for psychiatric risk assessments, with the following considerations: ☐ In-person assessments can take place in a room or area that allows for physical distancing. ☐ Cleaning/disinfection required between patients (e.g. chairs, tables).	☐ Modified procedures for psychiatric risk assessments, with the following considerations: ☐ In-person assessments can take place in a room or area that allows for physical distancing. ☐ Cleaning/disinfection required between patients (e.g. chairs, tables).	☐ Modified procedures for psychiatric risk assessments, with the following considerations: ☐ Avoid moving patients as much as possible. See patients in a room at the unit/range level or remotely, with safeguards for confidentiality. ☐ In-person assessments can take place in a room or area that allows for physical distancing. ☐ Cleaning/disinfection required between patients (e.g. chairs, tables). ☐ Using clinical judgement, psychiatrists may use videoconference or teleconference technology to conduct assessments, as per Psychological Risk Assessments and COVID-19 Social Distancing Measures, recognizing that there are limitations to virtual assessments.	☐ Modified procedures for psychiatric risk assessments, with the following considerations: ☐ Avoid moving patients as much as possible. See patients in a room at the unit/range level or remotely, with safeguards for confidentiality. ☐ In-person assessments can take place in a room or area that allows for physical distancing. ☐ Cleaning/disinfection required between patients (e.g. chairs, tables). ☐ Using clinical judgement, psychiatrists may use videoconference or teleconference technology to conduct assessments, as per Psychological Risk Assessments and COVID-19 Social Distancing Measures, recognizing that there are limitations to virtual assessments. ☐ Considerations for virtual service delivery include, the

	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
				☐ Considerations for virtual service delivery include, the nature of the individual patient's case and circumstances, access to and infrastructure for virtual technology at the operational site, the risk of COVID-19 transmission (e.g. is the patient symptomatic), and the current level of restrictions in the local community.	nature of the individual patient's case and circumstances, access to and infrastructure for virtual technology at the operational site, the risk of COVID-19 transmission (e.g. is the patient symptomatic), and the current level of restrictions in the local community.

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INFRASTRUCTURE AND MAINTENANCE

Facilities and Maintenance

This framework is for:

- Maintenance activities carried out by CSC staff; Public Services and Procurement Canada and contractors; CORCAN construction services, offenders and contractors;
- IM/IT maintenance activities using CSC staff, Shared Services Canada and contractors; and
- Electronic Security System maintenance using contractors.

NOTE: Essential maintenance is defined as maintenance tasks, mandated preventative maintenance and inspections that are critical to the well-being, health, safety and security of staff and offenders.

	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
Maintenance	☐ Routine procedures for facilities maintenance. ☐ Contractors/ staff to comply with standing orders.	☐ Inmates may work with facilities maintenance staff, when required, provided they follow all IPC measures. ☐ Vehicles, equipment, and tools are assigned to a single individual, or, to the minimum number of staff needed for safe use. ☐ Organize maintenance tasks with adequate spacing between each task to maintain appropriate physical distancing.	☐ Where possible, implement a two-team roster for maintenance staff. Two rosters with limited or no overlap between the staff groups, to reduce the transmission risk between groups. Where trades staff numbers are limited, this may not be possible and they may be required to work at more than one operational site. ☐ Supervisors are to closely track facilities maintenance staff who work at multiple operational sites to isolate them from others as much as possible. ☐ Contractors are permitted to perform only emergency/essential maintenance.	☐ Where possible, implement a two-team roster approach, where possible. ☐ Staff working in the infected area, should only work in the infected area. ☐ Contractors are permitted to perform only emergency/essential maintenance. ☐ In the event of an emergency, local discussions will occur to consider if inmates may complete snow removal/maintenance. ☐ All items to be repaired or maintained that are accessible to staff or inmates, (i.e. sink, toilet, lighting, etc.) must be cleaned/disinfected prior to maintenance/repairs are undertaken.	☐ Only essential facilities maintenance will be performed. ☐ Limited facilities maintenance staff at institution, emergency calls only. ☐ Staff who have worked in the outbreak institution will only be permitted to work at a different work institution following a 14-day waiting period or after negative test result. ☐ In the event of an emergency, local discussions will occur to consider if inmates may complete snow removal/maintenance.

	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
			☐ Local contractors may perform maintenance tasks where there is no close contact with inmates and limited contact with staff.	☐ Vehicles and equipment to be cleaned before and after use. ☐ Where possible, institutional staff and offenders are to vacate work area during maintenance activities, unless impossible for operational reasons (e.g. controls posts, etc.)	

Construction

This framework is for:

- Construction projects using Public Services and Procurement Canada and contractors; CORCAN construction services, offenders and contractors;
- IM/IT projects using Shared Services Canada and contractors; and
- Electronic Security System projects using contractors.

NOTE: Essential construction project is defined as construction activities that are critical to the well-being, health, safety and security of staff and offenders.

	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
Construction – new projects decision framework	☐ New projects initiated or continuation of projects determined in accordance with the approved decision framework (Annex B)	☐ New projects initiated or continuation of projects determined in accordance with the approved decision framework (Annex B)	☐ New projects initiated or continuation of projects determined in accordance with the approved decision framework (Annex B)	☐ New projects initiated or continuation of projects in non-COVID zones determined in accordance with the approved decision framework (Annex B)	☐ No projects started at a site where there is an outbreak.
Construction projects **Note**: Major construction projects are required to follow all applicable measures from the Canadian	☐ Routine procedures for construction projects. ☐ Contractors/ staff to comply with standing orders.	☐ Vehicles, equipment, and tools are assigned to a single individual, or, to the minimum number of staff needed for safe use. ☐ Organize construction tasks with adequate spacing	☐ Ongoing projects may continue if contractors have limited to no close contact with inmates and staff. ☐ If there is any contact, Public Health will be consulted prior to continuation.	☐ All ongoing construction projects to be suspended for a minimum of 5 days to assess situation. ☐ An assessment will occur to determine if projects may continue in areas outside of a	☐ All construction projects to suspend activities for a minimum of 14 days.

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	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
Construction Association - COVID-19 – Standardized Protocols for All Canadian Construction Sites, 26 May 2020.		between each task to prevent crowding. ☐ Use of personal protective equipment when physical distancing may not be possible.		COVID zone of a site. Public Health will be consulted. ☐ If workers are on site at the time an outbreak occurs, they will be referred to local public health authorities for assessment for testing.	
CORCAN Construction	☐ As per normal routine	☐ Offenders may work with CORCAN staff, when required, provided they follow all IPC measures.	☐ Offenders will not work with CORCAN staff	☐ Offenders will not work with CORCAN staff	☐ Offenders will not work with CORCAN staff

WORKFORCE AND ADMINISTRATION

Training (CLDCs and Training sites)

	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
Training Planning	☐ All National Training Standard training courses will be delivered ☐ Correctional Learning and Development Centres (CLDCs), Training Sites and National Training Academies, will resume all operations.	☐ The Learning and Development (L&D) Branch will closely monitor and ensure that Infection Control training is offered to targeted employees. ☐ Priority participants will be identified and targeted for NTS training (e.g., greatest time since last requalification, returning to work after a prolonged absence (2 years and more), those with challenges in the last requalification) ☐ The minimum number of Trainers required to safely	☐ All in person training will cease, except critical training authorized by local, regional and national public health authorities deemed safe to continue. This may include outdoor training and possibly CTP if participants remain on the academy grounds. ☐ NTS qualification periods will be reviewed and extended based on risk.	☐ All in person training will cease, until deemed safe by public health authorities. ☐ Learning Centre operations suspended ☐ NTS qualification periods will be reviewed and extended based on risk.	☐ All in person training will cease.

	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
		complete training will be assigned			
Training Space		☐ Maximum class size will depend on space available and 2-meter physical distance between participants. ☐ L&D staff who are able to complete work tasks remotely are supported and encouraged to do so			
Pre-training		☐ All training spaces will be decluttered as per the *COVID-19: Cleaning and disinfection Guidance* and *COVID-19: Institutional Cleaning and step-by-step Guide* documents. ☐ Movement within training areas will be minimized where possible. ☐ Excess furniture in seating areas removed to allow for physical distancing at all times. ☐ Foot traffic will be controlled to provide for 2-meter distance, this includes one way traffic at entrances and exits, where feasible. ☐ All doors and hallways are clearly marked to identify one-way traffic and 2 meter			

	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
		physical distancing at all times. ☐ Re-usable participant printed materials will be quarantined for a period of 3 days before re-use.			
Training Delivery		☐ Participants are assigned seating and/or training space ☐ Training equipment will be assigned to participants, i.e. pens, handcuffs, and cleaned /sanitized before and after use ☐ Non-medical masks or two layer face coverings (e.g. buffs) will be worn indoors at all times. ☐ When training occurs outdoors, non-medical masks will be worn when 2-meter physical distance cannot be respected. ☐ If group work is required, participants will remain in the same cohort for the duration of training.	☐ Employees will be encouraged to complete required online training.	☐ Employees will be encouraged to complete required online training.	☐ Employees will be encouraged to complete required online training.

National Training Academy

	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
Training Planning	☐ Correctional Training Program (CTP) will resume as	☐ The National Training Academy (NTA) will offer	☐ Academy may be temporarily closed	☐ If recruit is symptomatic, they will be isolated and local	☐ Temporary closure of the Academy

	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
	per approved and revised calendar.	training to no more than three CTPs at one time. ☐ Decentralized training in regional administrative sites may be considered.	☐ Recruits may be isolated until an assessment can be completed with local public health authorities, which will inform CSC's decision to return recruits home or keep isolated pending resumption of training. ☐ Firearms training may continue if all training occurs outdoors ☐ Stages 1 and 2 online training may continue.	public health will be contacted for next steps. ☐ If recruit, trainer or other person at the academy is symptomatic, there may be a temporary closure of the Academy ☐ Stages 1 and 2 online training may continue. ☐ Recruits will be isolated until an assessment can be completed with local public health authorities, which will inform CSC's decision to return recruits home or keep isolated pending resumption of training.	☐ Stages 1 and 2 online training may continue. ☐ Recruits will be isolated until an assessment can be completed with local public health authorities, which will inform CSC's decision to return recruits home or keep isolated pending resumption of training.
Training Space	☐ Class of 32 recruits per CTP. ☐ 20 employees or more depending on number of CTPs being delivered. ☐ Participants will sit 4 per table in the classroom	☐ Class size reduced to a maximum of 16 per CTP or as per space limitations that support physical distancing of 2 meters. ☐ Number of employees is kept to a minimum. ☐ Staff who are able to complete work tasks remotely are supported and encouraged to do so. ☐ Only authorized CSC employees and contractors permitted at the NTA		☐ Staff and managers will work remotely while training is suspended ☐ NTA employees may be reassigned to support operational sites.	☐ Staff and managers will work remotely while training is suspended ☐ NTA employees may be reassigned to support operational sites.
Prior to attending the NTA		☐ Recruits will be required to attest to completing the isolation period using the			

	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
		self-screening and isolation form received with their invitation to participate in CTP. ☐ Recruits will be encouraged to travel directly to the NTA, when possible and to minimize non-essential stops ☐ Transport Canada's COVID-19 Information for Travelers will be shared with recruits.			
Pre-training		☐ Excess furniture in seating areas removed to allow for physical distancing at all times. ☐ Foot traffic will be controlled to provide for 2 meter distance at all times, this includes the use of one way traffic at entrances and exits. ☐ All doors and hallways are clearly marked to identify one way traffic and maximum spacing for physical distancing at all times.			
Daily Operations		☐ Trainers will be required to complete and sign a health related measures checklist before each training day. ☐ All staff and recruits will be required to wear a non-medical mask at all times while indoors.			

	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 and Recruits are required to take their temperature each morning before attending training. When temperature is 38°C or higher, recruits will communicate with the designated NTA manager. ☐ Staff and Recruits will complete active screening at the NTA entrance. ☐ Non-touch temperature readings will be taken for all who enter the NTA. Individuals who register a temperature of 38°C or higher will be required to sit at the entrance for fifteen minutes to allow their temperature to normalize. The NTA Manager will be contacted. When fifteen minutes have passed, a second temperature reading will be taken. If the second reading yields a result of 38°C or above, they will not enter the NTA. ☐ Staff will return home immediately, contacting local public health authorities to seek testing for COVID-19. ☐ Recruits who register a temperature of 38°C or higher or who are			

	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
		experiencing COVID like symptoms will be required to isolate in designated area, at Harmony Calderwood house. ☐ Recruits will eat, train and practice with a designated training partner to support any required contact tracing. ☐ Staff and Recruits will be required to wash or sanitize their hands when they arrive at the NTA and at regular intervals throughout the day and before and after touching training equipment, e.g. manipulation of equipment. ☐ Movement within training areas will be minimized as much as possible. ☐ Living accommodations and washroom facilities will be designated to ensure maximum spacing and limited number of people in each space ☐ Non-medical masks will be worn indoor at all times throughout the NTA by all contractors, staff and recruits. ☐ Staff not required to interact with recruits will avoid unnecessary interaction. ☐ Training occurring outdoors may be flexible on non-			

	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
		medical mask wearing, depending on the ability to maintain 2 meter physical distance and other relevant factors. ☐ Recruits will have assigned seating and/or training spaces at all times. ☐ Classrooms designed to have 4 per table will be limited to 2 per table to allow for 2 meter physical distancing. ☐ Training equipment will be assigned to participants and cleaned /sanitized before after use including: e.g. inert OC canisters, handcuffs and other restraint equipment, flashlights, shields, holsters, magazines, magazine pouches, fire arms, fire safety equipment			
Food Services	☐ Food services and meal times will return to pre pandemic routine. Self-Serve food items and condiments will be available.	☐ Food services have been adjusted to allow for maximum spacing. ☐ Only two recruits per dining table at a time. ☐ Only one CTP will eat in the dining hall at one time. ☐ Food will be served to recruits directly by service provider at their table or recruit will take pre packaged food before going to their table.			

	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
Self-Defence/Arrest and Control		☐ Gym floor mats will be cleaned hydra-statically between each group of recruits. ☐ Trainers will wear non-medical masks and adhere to strict hand hygiene at all times. If a trainer is required to physically assist a recruit, they will wash or sanitize their hands immediately. ☐ Each pair of recruits will be designated a space in the gym and on the mats, clearly visibly marked and measured, to ensure 2 meter distance during physical skills training. ☐ All recruits will wear issued CSC uniform and a non-medical masks or two layer face coverings. (e.g. buffs). ☐ Staff and recruits are required to use a handcuff/ restraint cleaning station to clean restraints before and after use on an individual. ☐ Recruits will wash or sanitize their hands prior to switching roles. ☐ Recruits who have been the recipient of pressure points practice will wash their face prior to switching roles. (i.e.: nasal nerve peel, trachea			

	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
		depression, neck nerve series) ☐ Strike bags will be disinfected between exercises.			
Scenario Training		☐ All participants and trainers will wear a non-medical masks or two layer face coverings. (e.g. buffs) at all times. ☐ All Equipment, and areas will be cleaned and sanitized before and after each scenario (e.g. radios, restraints, door handles, table tops) ☐ Any inmate scenarios or role playing will not include any spitting, or screaming at another person. ☐ When required, approved gloves will be worn by and immediately disposed of, and hand hygiene will take place immediately and prior to and after any person requiring to have contact with another person during these sessions ☐ Trainers will ensure that scenarios are facilitated in a manner that each participant only has physical contact with their training partner.			

	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
Chemical and other inflammatory agents	☐ OC exposure will recommence as per regular implementation procedures as part of the Chemical Agent training				

Firearms Training

	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
Training Planning		☐ Priority participants identified and targeted based on certain considerations.	☐ Training assessed for feasibility of resumption and transition to online learning for theory portions.	☐ Correctional Staff Training Officers (CX-03s) may be asked to support Operations.	
Pre-training	☐ Participants advised to stay home when sick ☐ Hand hygiene posters in training areas and washrooms.	☐ Learning and Development Directors will ensure that all training areas (including firing ranges) have a supply of masks, eye protection (ballistic glasses), disposable gloves, disinfectant spray (or wipes) and hand towels. ☐ Training will be scheduled to adhere to physical distancing requirements. ☐ Participants will receive a self-screening form with their invitation to training. The form will indicate that they are <u>not to report</u> to training if they are experiencing any COVID-19 symptoms, have had close			

	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
		contact with a confirmed or probable COVID-19 case, or if they have travelled outside of Canada in the past fourteen days. They will be instructed to contact their manager, as well as the Correctional Learning and Development Centre manager, if they do not attend training. ☐ Removal of any unnecessary tools/equipment in training areas to simplify the cleaning process. ☐ Classrooms will be configured accordingly to ensure 2 meters distance between participants. ☐ Signs in classrooms will indicate the direction of traffic in common areas and hallways. ☐ Strict cleaning protocols will be in place and executed at least once daily in all areas of training locations. ☐ Strict cleaning protocols will be in place for weapons and gear used during training; all safety equipment will be cleaned and sanitized before and after use.			

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	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
Training Delivery	☐ Regular training delivery progressively resumed ☐ Regular class sizes and two Trainers (minimum).	☐ Participants and trainers will wear mask at all time in the classroom. ☐ Personal safety equipment related to firearms will be made available as required. The participant or trainer, will keep the safety equipment for the duration of training. ☐ Participants / trainers will be designated required tools such as pens, markers and note pads so as to limit cross contamination. ☐ Participants will be given an assigned seat in training rooms and must use same seat/workstation for duration of training. ☐ At the range (Range/ outside), mask will be worn when physical distancing cannot be respected. ☐ Upon arrival, everyone will conduct self-screening upon entrance and each and every time they leave their training room. ☐ Physical distancing 2 meters enforced during in-class portions and movement throughout the training space;			

	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
		☐ Procedures will be in place and (communicated to participants and trainers) on use of common areas such as classrooms, stairwells, elevators and washrooms (to be informed by Infrastructure and maintenance WG).			
Training Space		☐ Training room size will determine participant numbers - ensuring physical distancing of 2 meters.			
Firing Ranges		☐ Only outdoor firing ranges will be used; if no running water is available, sufficient hand sanitizer must be made available. ☐ If transportation is required to get to firing range, a CSC vehicle will be used. Cleaning vehicle protocols must be followed before and after use. ☐ Seating in the vehicle will be arranged to ensure maximum personal space to adhere to physical distancing. Face masks will be worn by all during transportation. ☐ Participants will be placed at every second lane when			

	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
		training at firing range; maintain physical distances of 2 meters will be respected as much as possible. ☐ Regular firing range protective gear will be designated to each participant and disinfected before and after use to avoid cross contamination. ☐ Hand washing/disinfecting must be done before and after any transfer of equipment. ☐ Masks and latex gloves must be worn by whomever is loading firearms, ammunition and magazines into cases for transportation. ☐ Masks and latex gloves must be worn during set up/take down of firing range as well as cleaning up rounds.			

Workforce

	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	☐ Gymnasium open – single cohort, ensuring	☐ Gymnasium closed	☐ Gymnasium closed

		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.	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		

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ANNEX A - Definitions

Administrative site refers to administrative buildings, including NHQ, RHS, Correctional Learning and Development Centres, Training Academies

Operational Site: refers to congregate living environments, inclusive of institutions, healing lodges and Community Correctional Centres**.** An operational site may refer to a single institution or a single unit within a clustered or multi-level institution, where units within a clustered institution may have completely separate buildings and staff, with little or no crossover. **Note:** For clustered and/or multi-level institutions, NHQ-HS, in collaboration with regional and institutional heads, will look at the nature of the COVID-19 cases and the infrastructure of the institution, to determine on a case-by case basis the risk category for each area of the institution. This will be done in consideration of the ethical principles guiding CSC's pandemic response, including proportionality between offender restrictions and the identified level of risk.

Site: when not identified is an administrative or operational site, includes both.

Cohort

- 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**.**
- **Health Operations use of Cohort:** In the context **of cohort,** the term 'individuals' refers to offenders; staff cohorts are described in terms of rostering or as 'staff cohorts'. **Note:** Suggestions for when to adjust staff rosters and/or the cohorting of staff groups are part of ongoing discussions with CSC's labour partners and subject to change

Community: A 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.

Considerations for Special Populations

There are a number of populations in CSC that have unique health and social needs and require additional considerations with respect to COVID-19 risk mitigation and access to health services, including:

- Individuals with underlying medical conditions, particularly if poorly controlled
- Individuals over the age of 65
- Indigenous peoples
- Individuals affected by problematic substance use
- Individuals with medium or high mental health needs (including those at risk of suicide or self-harm), as per the Integrated Mental Health Guidelines
- Racialized individuals who are historically underserved by healthcare organizations broadly and often face stigma and discrimination

For individuals with complex or unique health and wellness needs, **integrated care plans** are developed and are subject to review and evaluation on an ongoing basis.

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ANNEX B - Construction Project Decision Framework

Project Level of risk (of contact)

LOW - Outside the fence, no contact with staff or inmates
LOW-MODERATE - Outside the fence, limited contact with staff and no contact with inmates
MODERATE - Inside the perimeter / outside of buildings, limited contact with staff and inmates
MODERATE-HIGH - Inside the perimeter and inside a building, constant contact with staff, no contact with inmates
HIGH - Inside the perimeter and inside the building, constant contact with staff and inmates

Project –Level of Risk (of Contact)					
High				*	*
Moderate - High					*
Moderate					
Low - Moderate					
Low					
	Low	Low - Moderate	Moderate	Moderate - High	High

COVID-19 Transmission Risk (as per CSC National RMF)

* Requires individual project submission explaining detailed mitigation plan

Decision Approval Level

Risk	Regional projects	National projects
	ADCIS	ACCS
	ADCIS	ACCS
	RDC	SDC
	RDC	SDC
	Commissioner	Commissioner

CORRECTIONAL SERVICE CANADA | **SERVICE CORRECTIONNEL** CANADA

CHANGING LIVES. PROTECTING CANADIANS. | TRANSFORMONS DES VIES. PROTÉGEONS LES CANADIENS.

SHAPING THE NEW NORMAL

June 30, 2020
Version 2

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Version Control

Version	Date	Comments/Changes
1	2020-06-23	Initial Integrated Risk Management Framework (IRMF) and Mitigation Strategies
2	2020-06-30	Updated IRMF, includes: • Clean up of format issues; • Clarifications of what is required when the National Risk Management Protocol is met; • Small meal preparation amendment in low-moderate risk; • Additions of: o CBRFs and section 81 facilities - weekend passes and travel permits; o Institutional Employment Program and Vocational Certification; o Security Intelligence Officers; o Mail o Access to institutions by inmate lawyers; Independent Chair Persons, Citizens Advisory Committee members, and staff from other Government Departments. o Inmate Personal Visitors;

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

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

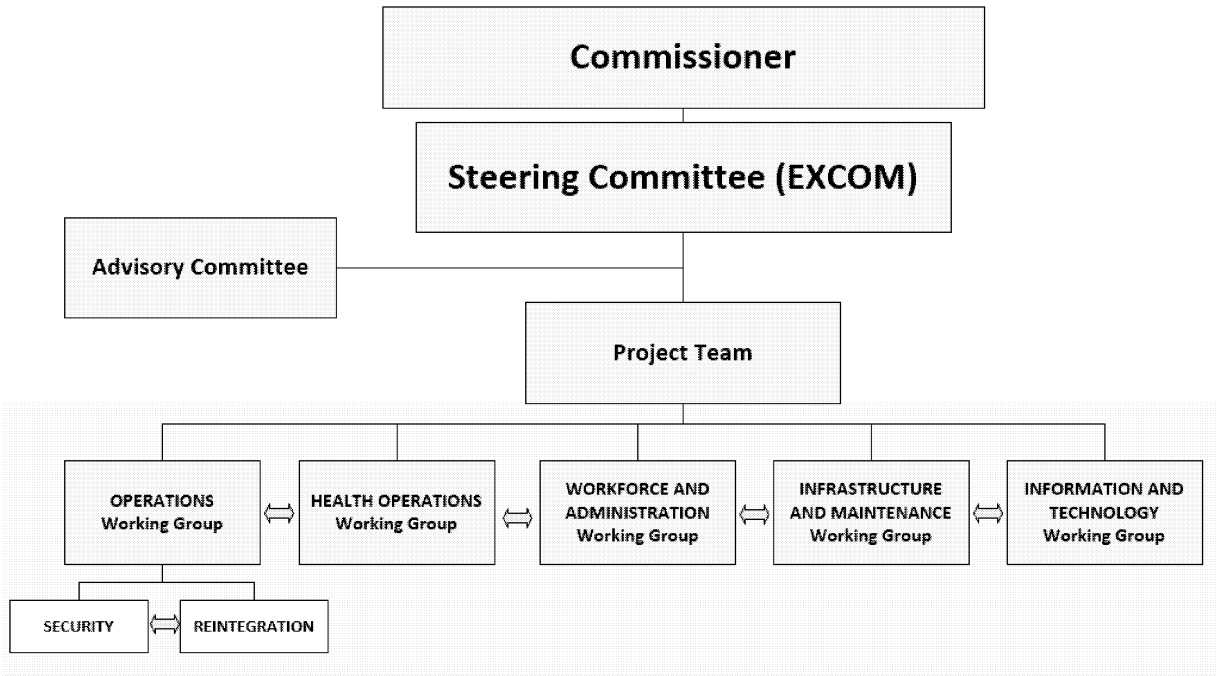
a. Operations – Security and Reintegration
b. Health Operations
c. Workforce and Administration
d. Infrastructure and Maintenance
e. Information & Technology

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.



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.

NATIONAL RISK MANAGEMENT PROTOCOL TO CHANGE COVID-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.

- If local public health authority identifies that there is evidence of uncontained elevated community transmission, CSC will 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 a signal of increasing risk and a threshold for enhanced vigilance. 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 escalate vigilance and preparedness activities to a higher level of attention and alertness to ensure that all required outbreak prevention measures are 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 the incident threshold has been met (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. The RDC will notify the appropriate Institutional Head/District Director to ensure vigilant infection prevention and 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 required change as per the Risk Management Framework due to the to the COVID-19 transmission risk level. The RDC will inform the site about the change and the need to change mitigation strategies in response to the change in risk.

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.

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.

UNIVERSAL IPC MEASURES	**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**
	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**
UNIVERSAL INFECTION PREVENTION & CONTROL (IPC) MEASURES **General Notes**	☐ Quality improvement spot checks will be conducted by managers, with immediate addressing of any deficiencies	All measures in LOW RISK category continues, unless otherwise indicated ☐ When ACHS signals to the RDC that the protocol threshold has been met, the frequency of quality improvement spot checks conducted by managers will increase, with immediate addressing of any deficiencies	All measures in LOW-MODERATE RISK category (including LOW RISK) continue, unless otherwise indicated	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 activities in the low-moderate or moderate risk may continue at the site	
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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		☐ 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 day 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	☐ 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.		

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	staff/ contractors must follow public health guidance.	and contact manager immediately; ☐ Physical distancing of 2 meters or 6 feet; If necessary, markings will be placed on the floor; ☐ 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	☐ 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 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°C or higher will be required to sit at the entrance for fifteen minutes to allow for their temperature to normalize.	☐ Managers to regularly review procedures and expectations with employees		

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		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 38°C 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			

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		throughout the site, available to both staff and inmates; ☐ 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). ☐ 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	☐ Cleaning/ disinfecting of all tools and equipment (before and after use) is mandatory;			

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	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 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			

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		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, 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.					

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• 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**. ☐ Non-uniformed staff/ contractors who interact with inmates will limit their in person contacts to inmates on their case load ☐ When ACHS signals to the RDC that the protocol threshold has been met; staff rosters and movement may be required to move to a single cohort during this close monitoring phase. In addition staff/contractor movement between security levels will be limited to emergencies only.	☐ 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 ☐ No movement of staff/ contractors between security levels at clustered sites. This includes multilevel institutions where there is a minimum security unit outside the perimeter fence	☐ Limited to no movement in the COVID-19 infected area ☐ All non-critical staff will not be at the site.	☐ Limited to no movement. ☐ All non-critical staff will not be at the site.
Policies	☐ All areas of the work site must be decluttered and surfaces as bare as possible to support required cleaning for ongoing infection prevention and 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;		

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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-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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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	☐ Follow all strategies in low-moderate risk	☐ If possible, RDC will work with provinces to defer or delay new admissions. ☐ Follow all strategies in low-moderate & moderate risk	☐ If possible, RDC will work with provinces to defer or delay new admissions. ☐ Follow all strategies in low-moderate & moderate risk

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		require only routine practices and universal masking.			
Finger printing	☐ Routine per standing order	☐ 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.	☐ Following 14 days of medical isolation where the inmate 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	☐ Fingerprinting is suspended	☐ Fingerprinting is suspended
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					
Security Intelligence Officers	☐ Full complement of Security Intelligence Officers (SIO) on site	☐ Full complement of SIOs on site with appropriate IPC measures	☐ 50% complement of SIOs on site at the same time	☐ 50% complement of SIOs on site at the same time	☐ 50% complement of SIOs on site at the same time
Security Intelligence Officer Administrative Assistants	☐ Full complement of SIO Administrative Assistants on site.	☐ SIO Administrative Assistants on site 50% of the time with appropriate IPC measures.	☐ SIO Administrative Assistants on site 30% of the time with appropriate IPC measures.	☐ SIO assistants to work off site unless presence on site is critical.	☐ SIO assistants to work off site unless presence on site is critical.
Meal service	☐ Normal meal routine	☐ No large group meal service or eating in cafeteria ☐ Food pick up at food services line by double cohort.	☐ No large group meal service or eating in cafeteria ☐ Food pick up at food services line by single cohort.	☐ Meal service at cell level for medically isolated or quarantined inmates.	☐ Meal service at Cell Level ☐ Food trays restricted to inmate's cell / disposable food trays and utensils will be used

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		☐ Inmates return to unit to eat. ☐ Inmates under medical isolation will receive meals at cells. ☐ Small meal preparation – groceries will be picked up by 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.	☐ 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	☐ 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
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 Post Cleaning	☐ Control post cleaning by CSC employees or contractors	☐ Control post cleaning by CSC employees or contractors	☐ Control post cleaning by CSC employees or contractors	☐ Control post cleaning by CSC employees or contractors	☐ Control post 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	☐ Critical industry operations remains open with appropriate IPC measures operated by staff only

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				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.	
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	☐ In outbreak zone, cleaning completed by CSC employees or contractors ☐ 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

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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 ☐ Limited number of offenders for individual work in the hobby rooms at the same time to allow for physical distancing ☐ Increased in-cell activities ☐ Provide materials for in-cell hobby and crafts, as feasible ☐ Provide materials from the Pro-Social Hobbies Module of the SIU Social Program for in-cell activities	☐ 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 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,	☐ For inmates living in units, outside of the outbreak zone, access to computers and legal resources for case preparation will be considered 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. ☐ Returned materials will be quarantined for 72 hours.	☐ Library closed until outbreak is contained

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			renew, or take out books for inmates. ☐ Returned materials will be quarantined for 72 hours		
Leisure and social activities, including ethno cultural services	☐ Regular routine q	☐ 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
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

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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
Visits and Correspondence **Note: 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.					
Mail	☐ Routine per standing order	☐ Mail is placed in quarantine for 72 hours	☐ Mail is placed in quarantine for 72 hours	☐ Mail is placed in quarantine for 72 hours	☐ Mail is placed in quarantine for 72 hours
All visitors	☐ Routine per standing order	☐ All visitors will be actively screened. ☐ Anyone with COVID like symptoms will not be permitted entry. ☐ All visitors will be strongly encouraged to bring their own mask; however, if they arrive without one, CSC will provide them with a mask. Children under the age of two are not required to wear masks. ☐ Non-touch temperature readings will be taken for all who enter a CSC site. See	☐ Suspended or virtual	☐ Suspended or virtual	☐ Suspended or virtual

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		Universal IPC measures for details. ☐ No one other than the Officer or Commissionaire at the front entrance will touch sign in forms or pens. ☐ Hand hygiene – All visitors will wash hands for at least 20 seconds upon entering CSC facility. ☐ No physical contact between visitor(s) and inmate. ☐ Physical distancing of 2 meters must be maintained at all times. ☐ Rooms/locations where visiting will occur will be disinfected before and after each visit, including visitor washrooms, in accordance with national cleaning protocols.			
Lawyers	☐ Routine per standing order	☐ Facsimile (fax) ☐ Regular mail ☐ Telephone ☐ Visits permitted by lawyers from a community where the local public health authority has identified no local community transmission and consistent with interprovincial and	☐ Closed visits in exceptional circumstances ☐ CSC to add lawyer's toll free number to inmate's ITS ☐ CSC to disable three-way call detection for third party service provider numbers provided by lawyer. ☐ Phone contact ☐ Facsimile (fax) ☐ Regular mail	☐ No visits ☐ Remainder of mitigation strategies in moderate risk continue	☐ No visits ☐ Remainder of mitigation strategies in moderate risk continue

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		intraprovincial travel restrictions			
Independent Chair Person	☐ Routine per standing order	☐ As per normal routine with appropriate IPC measures	☐ Suspended, virtual or behind barrier	☐ Suspended or virtual	☐ Suspended or virtual
Staff from other government departments	☐ Routine per standing order	☐ Entry permitted	☐ Essential entry will be considered at the local level as necessary.	☐ No entry (with certain exceptions related to outbreak/public health)	☐ No entry (with certain exceptions related to outbreak/health)
Citizens Advisory Committee members	☐ Routine per standing order	☐ Visits permitted by CAC members who are from a community where the local public health authority has identified no local community transmission and consistent with interprovincial and intraprovincial travel restrictions.	☐ Suspended or virtual	☐ Suspended or virtual	☐ Suspended or virtual
Inmate Personal Visitors	☐ Routine per standing order	☐ Visitor notifies institution a minimum of 48 hours prior to visit. ☐ To support the health and safety of staff and inmates and to support immediate contact tracing if required, V&C capacity will be limited to no more than 20 people, including inmates (excluding officers). This number will be reduced as required, depending on V&C space, to ensure 2 meter distancing is met.	☐ Suspended or virtual	☐ Suspended or virtual	☐ Suspended or virtual

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		☐ V&C Officer will actively screen potential visitors at time of booking visit. ☐ Visits permitted by individuals from a community where the local public health authority has identified no local community transmission and consistent with interprovincial and intraprovincial travel restrictions. ☐ Consideration must be given to the reduced capacity for visits when authorizing individual requests. Normally a visitor would not have more than one visit per week. ☐ No more than three visitors, two of which may be children, at one time. ☐ No physical contact between visitor(s) and inmate. ☐ Inmates and visitors will be 2 meters apart or a physical barrier will be placed between visitor and inmate, such as Plexiglas. ☐ Physical distancing of 2 meters must be maintained between visitor groups.			

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		☐ Failure to comply will result in termination of visit and a review of visitor privileges. ☐ Visits will be limited to 1.5 hours duration. ☐ As much as possible, doors and windows in V&C to be opened to increase air circulation. ☐ No use of vending machines. ☐ Visitor cannot bring food, beverages, or personal belongings into the institution. Exceptions will be made for accessibility reasons. ☐ All play areas are to be closed and no institutional toys permitted. ☐ No inmate use of washrooms in the visiting area. ☐ Each occupied visitor table will be provided with disinfecting wipes. Visitors are expected to disinfect high touch surfaces in washrooms when required. ☐ Directional signage in V&C areas will regulate traffic flow and inform of physical distancing protocols			

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
Temporary Absences/Work Releases					
Escorted Temporary Absence - Medical	☐ Routine per standing order	☐ When transporting inmate, with COVID-like symptoms: 1. inmate will wear medical/procedural mask 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 – 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	☐ When transporting inmate, with COVID-like symptoms: 1. inmate will wear medical/procedural mask 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 ☐ The receiving hospital may not be able to provide PPE for CSC staff. CSC staff should prepare for this by ensuring they have three sets of PPE ready for the transfer: one set for travelling to the hospital, a new set upon arrival to the hospital, and a	☐ When transporting inmate: 1. inmate will wear medical/ procedural mask 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 ☐ The receiving hospital may not be able to provide PPE for CSC staff. CSC staff should prepare for this by ensuring they have three 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.	☐ When transporting inmate: 1. inmate will wear medical/ procedural mask 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 ☐ The receiving hospital may not be able to provide PPE for CSC staff. CSC staff should prepare for this by ensuring they have three 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.

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
			final set for returning to the institution.		
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

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, Structured Social Programs					
Program Planning	☐ Prioritization of programs (proximity to release or scheduled hearing, Structured Intervention Unit delivery)	☐ Same as Low Risk ☐ Offenders in Structured Intervention Unit could be assigned to participate in a program outside of the unit, per the Threat Risk Assessment (TRA)	☐ Same as Low Risk	☐ Same as Low Risk	☐ Same as Low Risk
Program Delivery		☐ At the first group session, when reviewing rules, review necessity to use PPE (including non-medical masks) 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;	☐ 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 ☐ Offsite 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

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
		☐ 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 **Note**: local discussions will occur between manager and employees who are immunocompromised regarding alternative program delivery as required			
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			

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
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			
Group Size		☐ Limited by size of space – allowing for 3 meters distance between chairs ☐ Maximum 5 participants			
Institutional Employment Program and Vocational Certification					
Program Planning	☐ As per normal routine	☐ Prioritization of participation (other correctional plan activities, proximity to release, interest of offender)	☐ Same as Low-moderate risk		

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		☐ Physical distancing of 2 metres at all times required with exception of specific activities identified in advance of any course that involves a practical portion where safety or task does not allow full 2 metre distancing at all times ☐ For tasks referred to above, these will be clearly outlined with mitigation measure(s) identified and presented for local consultation (union and occupational health and safety representative) and approval as it will be site and course specific. ☐ Specific parameters in above tasks include two types: 1. Where the non-medical mask cannot be worn due to individual having to don another type of shield/mask/helmet (i.e. welding, dust mask. In these cases, at minimum, the individual will ensure no others are within 2-meter distance, wash/sanitize hands, doff the non-medical mask, don the other shield/ mask/helmet, etc. and	☐ No in person group sessions ☐ Individual session delivery, in person or using alternate means including in cell/on unit self-study ☐ Increased homework exercises to facilitate independent learning, as feasible ☐ Session delivery using telephone or video - job search, resume reviews, etc… ☐ Staff work from home unless critical to be onsite ☐ Off site work for tasks, e.g., session prep, post session work, report writing	☐ Following direction health services, some of the measures in moderate risk may be undertaken ☐ Alternative delivery could continue if in compliance with direction from local public health	☐ No in person interventions or individual sessions ☐ No staff on site to deliver group employment coordinator or vocational certification sessions. ☐ Provide materials for in-cell/on unit self-study as feasible

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
		complete activity. Upon completion, inmate will change back to the non-medical mask using doffing/donning procedures 2. Where 2 metre distance can not be maintained due to supervision or safety of task completion, individuals will ensure non-medical mask (or other shield/mask/helmet, etc..) is donned (and subsequently exchanged at end of task) with individuals all being 2 meters apart during this procedure. As much distance as possible will be maintained when completing task and only individuals necessary for safety or procedure of task will be within the 2 meter zone. □ If individuals will need to touch same points (i.e. ladder), they will use gloves (donned and doffed per national procedure) for the task.			
Vocational Certification Program facilitator and Employment Coordinators		□ Vocational facilitator and Employment Coordinator activities combination of on site and off site per institutional routine.			

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
		☐ Off-site work for 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 and movement flow in space where needed ☐ All classroom type spaces to be disinfected between sessions according to national standards ☐ All practical spaces to have tools, equipment and other touch spaces disinfected between sessions according to national standards			

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
		☐ All cleaning will be documented ☐ In locations where staff and inmates share bathrooms, this practice will cease. Separate bathrooms will be identified.			
Group Size		☐ Limited by size of space – allowing for 3 meters distance between chairs or practical practice stations ☐ Maximum five participants for classroom based sessions and maximum eight participants for sessions held in industry type space that is of sufficient size to allow physical distancing requirements identified above.			
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.	☐ 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	☐ Virtual interventions – phone or videoconference	☐ Virtual interventions – phone or videoconference

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
		☐ Individual meetings (with physical distancing) ☐ Virtual interventions – phone or videoconference ☐ All common touch surfaces and tables will be disinfected before and after use.	☐ 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 **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.		

COMMUNITY 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
Community-based Residential Facilities					
Weekend Passes and Travel Permits for Community-based Residential Facilities & Section 81 Facilities The granting of Travel Permits and/or Weekend Passes is to be limited in line with public health guidance and to support infection prevention and control precautions	☐ Return to pre-COVID-19 community access ☐ Offenders are allowed to travel	☐ The Area Director / Parole Officer Supervisor will grant Travel Permits and/or Weekend Passes and will consider the following: • Local / Provincial Public Health guidance • CSC's identification of the risk level for all areas involved in the issuance of the pass • The details each offender's circumstance and request (number of people present, area of residence, type of residence etc.) • Mitigating strategies in place during the travel pass or weekend pass **Note:** Leaving the local community should be exception based, considering public health guidance and risk assessment. ☐ Active screening questionnaire will be completed by the community contact prior to authorizing leave. ☐ Passes will not be approved if the community support is	☐ The granting of Travel Permits and/or Weekend Passes will be as minimal as possible and must be in line with public health guidance and to support infection prevention and control precautions. ☐ Passes may be provided only for essential purposes (e.g., grocery, pharmacy). ☐ All other situations will be dealt with on a case-by-case basis and could be authorized in required circumstances (e.g. employment, fulfilment of legal obligations, intervention activities deemed required), upon approval by District Director or the Area Director. ☐ Active screening questionnaire of offender to be completed before leaving and upon returning to the CBRF/S.81 Facility. ☐ Passes will not be approved if the community support is experiencing COVID-19 like symptoms.	☐ No travel permits and weekend passes will be issued	☐ No travel permits and weekend passes will be issued

COMMUNITY 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
		experiencing COVID-19 like symptoms. ☐ Active screening questionnaire of offender to be completed before leaving and upon returning to the CBRF/S.81 Facility. ☐ Temperature ☐ Offenders will be required to self-monitor for COVID symptoms for the duration of their permit/pass. ☐ Upon returning to the CBRF/S81 Facility, the offender will: • Wash hands immediately upon entering • Change clothing (place in plastic bag until laundry can be done), • Shower • Disinfect items brought into the CCC. **NOTE:** these same steps could be done when arriving to the destination after having left the CBRF/S81 Facility, especially if the weekend pass or travel pass involves travel between risk zones.			

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

CORRECTIONAL SERVICE CANADA

CHANGING LIVES. PROTECTING CANADIANS.

Clinical Management of Patients with COVID-19

GUIDANCE DOCUMENT FOR HEALTHCARE PROFESSIONALS

UPDATED OCTOBER 8, 2020

Created: April 8, 2020

Table of Contents

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 NMAC meeting, June 25, 2020.
October 8, 2020	Integrated relevant guidance from PHAC's Clinical management of patients with COVID-19: Second interim guidance. Updates include: prevalence of common signs, symptoms, and comorbidities; potential complications; reinfection; managing co-infections; and recommendations regarding the use of dexamethasone and Remdesivir.	The document was reviewed and approved by NMAC at the September 24, 2020 meeting. The document was reviewed and approved by HSET at the October 8, 2020 meeting.

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.

According to recent data from the Public Health Agency of Canada, most Canadians with COVID-19 develop only mild or uncomplicated illness (84%), approximately 13% develop severe disease that requires hospitalization and oxygen support and approximately 3% require intensive care unit support. See Canada COVID-19 Daily Epidemiology Report for the most recent figures.

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.

According to a recent epidemiological report by the Public Health Agency of Canada, the median time from symptom onset to hospital admission is 5 days. Among hospitalized patients, the median length of stay is 11 days. See Canada COVID-19 Weekly Epidemiology Report for the most recent figures.

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.

Prevention Strategies/Measures

- **Physical distancing** where possible minimum 6 feet (2 meters) apart.
- **Frequent hand hygiene** with soap and water or 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).
- **Universal Masking,** as per the CSC's COVID-19 update: guidance on the use of non-medical masks and personal protective equipment.

Additional risk mitigation measures are outlined in CSC's Risk Management Framework.

Clinical Presentations / Symptom

Clinical presentation and symptoms of COVID-19 vary in frequency and severity. Symptoms absent at the onset of illness may develop over time with disease progression.

The current estimates of the incubation period range from 1-14 days with median estimates of 5-6 days between infection and the onset of clinical symptoms of the disease. People infected with SARS-CoV-2 may be infectious before symptom onset. The risk of infection from most patients at more than 8 days post symptom onset is likely to be low.

According to PHAC, it has been estimated that up to half of persons infected with COVID-19 will remain pauci-symptomatic (positive case in the presence of very limited symptomatology) or asymptomatic.

Signs and symptoms

Reported frequency of symptoms

More frequent (>50%)	Less frequent (<50%)	Rare (<10%)
• Fever (44-91%) • Cough (57-74%) • Shortness of breath (31–63%) • Fatigue (31–70%) • Loss of appetite (39-84%) • Loss of smell and/or taste (54-88%)	• Sputum production (28–33%) • Muscle aches (11–44%) • Chest pain (16-36%) • Diarrhea (5-24%) • Nausea/vomiting (5-19%) • Headache (6-70%) • Dizziness (9-17%) • Sore throat (11-13%)	• Confusion • Runny nose • Fainting • Skin manifestations

Source: PHAC. (2020-June-18). COVID-19 signs, symptoms and severity of disease: A clinician guide

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.

Disease severity and risk factors for severe disease

Common comorbidities in COVID-19 cases

More frequent (>40%)	Less frequent (10-39%)	Infrequent (<10%)
• Hypertension (17%-82%) • Cardiovascular disease	• Chronic respiratory disease (12%-22%)	• Cancer (2%-7%) • Atrial fibrillation/arrhythmia (3%-6%)

More frequent (>40%)	Less frequent (10-39%)	Infrequent (<10%)
including heart failure (5%-55%) • Diabetes (4%-40%)	• Chronic renal disease (11%-14%) • Obesity (22-29%) • Asthma (11%)	• Endocrine disorders (6%) • Gastrointestinal disease (5%) • Chronic liver disease (2%-3%) • Neurologic diseases, including dementia and stroke (8%-13%)

Source: PHAC. (2020-June-18). COVID-19 signs, symptoms and severity of disease: A clinician guide

Patients on immunosuppressive therapies may not display normal, high spiking fevers, and their white blood cell counts may not be as high. (See COVID-19 Clinical Corner: Treatment Considerations for Specific Patient Populations, Issue 3).

Complications

In severe cases, COVID-19 can be complicated by respiratory failure, acute respiratory distress syndrome (ARDS), sepsis and septic shock, and multi-system organ failure, including acute kidney injury and cardiac injury.

Patients with COVID-19 may be susceptible to venous thromboembolism (VTE) due to severe infection and inflammation. VTE can present as deep vein thrombosis or pulmonary embolism. Lab abnormalities include elevated D-dimer and fibrinogen levels. A markedly elevated D-dimer is considered a poor prognostic indicator and is associated with increased risk of death from COVID-19. (See COVID-19 Clinical Corner: Considerations for Thrombosis, Issue 5)

Reinfection

There have recently been reported a small number of cases of probable reinfection. The reported case did not show a consistent pattern of presentation. It is known that following infection, the majority of individuals will develop IgM and IgG antibodies within days to weeks of symptom onset. However, the relationship between antibody levels and the level of protection against reinfection, as well as the role of cellular immunity in preventing reinfection (including cross-protective immunity following exposure to common coronaviruses) remains undetermined. Any case of potential reinfection would need specific advice from both an infectious disease physician and the public health physician or the laboratory medicine physician.

For other coronaviruses (e.g. MERS-CoV and SARS-CoV-1), protective antibodies have been reported to decline as early as several months following infection.

Classification of Severity of Disease

There is a spectrum of COVID-19 disease severity, ranging from asymptomatic or mild, to moderate and severe disease. This guidance document mainly addresses the clinical management of mild and moderate illness, as those with severe disease require transfer to outside hospital.

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, dyspnea, nasal congestion, conjunctivitis, loss/alteration of smell and taste, or headache.
- Rarely, may also present with diarrhea, abdominal pain, nausea, and vomiting.
- Many are afebrile or have low-grade fever.
- Older and/or immunosuppressed patients may present with atypical symptoms.
- Symptoms due to physiologic adaptations of pregnancy or adverse pregnancy events, for example, dyspnea, fever, GI symptoms or fatigue, may overlap with COVID-19 symptoms.

Moderate Illness

COVID-19 Treatment Unit/Regional Hospital 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 or suspected respiratory infection plus one of the following:
- Respiratory rate >25 breaths/minute
- SpO_2 ≥ 90% on room air
- Respiratory distress
- Tachycardia

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

- Heart rate >130 bpm
- Signs of dyspnea or increased work of breathing (e.g. grunting, nasal flaring, wheezing)

Investigations of Suspected Cases of COVID-19

Medically isolate the patient and initiate contact and droplet precautions, as per:

- Patient Journey: Symptomatic inmates and close contacts
- COVID-19 update: Guidance on the use of non-medical masks and personal protective equipment
- CSC's Infection Prevention and Control Guidelines

All patients who are clinically suspected of infection with COVID-19 should be tested. Currently, PCR-based molecular testing is predominantly being used in Canada. Since the sensitivity and specificity are linked to the viral load in the specimen, test performance varies during the course of the illness and by specimen type and quality of specimen collection.

Note: False negative test results/interpretations can occur when:

- The patient was not infected at the time of the initial swab, but became infected from a later exposure.
- The patient is infected but is not yet shedding much virus in the upper respiratory tract.
- The patient is shedding the virus but the sample collection was poor.
- Patient's infection is manifesting outside the upper respiratory tract. In symptomatic people with mild infection, the virus is shed just before or soon after symptom onset and in high numbers in the upper respiratory tract, lasting for at least 5-7 days.

Mild Illness

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.

Moderate Illness

These patients would be admitted to the COVID-19 Treatment Unit or a Regional Hospital:

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

• CRP • CK • ALP • AST / ALT • LDH • Cr • eGFR • Lactate • Electrolytes • Glucose	• CBC	• PT • PTT • INR • D-Dimer
Note: Lymphophenia, neutrophilia, elevated serum alanine aminotransferase and aspartate aminotransferase levels, elevated lactate dehydrogenase, high CRP, and high ferritin levels may be associated with greater illness severity. (Source: PHAC's Clinical management of patients with COVID-19: Second interim guidance)		

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

Best Practices for Collection of Nasopharyngeal Specimens

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 (see COVID-19 update: Guidance on the use of non-medical masks and personal protective equipment).

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, nose, and chin) after the procedure is complete. Hand hygiene should be performed by all persons.

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).

Counsel patients with mild COVID-19 about the signs and symptoms of complications that should prompt urgent care (difficulty breathing, pain or pressure in chest, confusion, drowsiness, or weakness). Emphasize importance of immediately reporting these symptoms to health services.

Moderately ill COVID-19 Patient:

These are patients who will be managed in the COVID-19 Treatment Unit or Regional Hospital. 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.

The decision regarding the location of care (i.e. COVID-19 Treatment Unit/Regional Hospital vs. outside hospitalization) should be made on a case-by-case basis and will depend on the clinical presentation, requirement for supportive care, and potential risk factors for severe disease. For patients at high risk for deterioration, admission to hospital should be considered. The median time to acute respiratory distress syndrome (ARDS) ranges from 8 to 12 days.

- 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/about-csc/sectors/health-services/pharmacy/Pages/default.aspx#1
- Immunocompromised Patient, consider:
  - Recommend to consult ID Physician for all immunocompromised patients, for example (e.g., hematological malignancies, transplantation, immunosuppressive agents, etc.)

Note:

- **Dexamethasone:** PHAC received recommendations from the Canadian Clinical Pharmacology Taskforce Group, CPTG, that among hospitalized adult patients who have COVID-19 and require supplemental oxygen or mechanical ventilation, clinicians should strongly consider dexamethasone 6 mg IV daily for 10 days (or until off oxygen or discharge if earlier) or equivalent glucocorticoid dose. This recommendation is categorized under the management of ***critical*** COVID-19 patients (see Appendix D).
- **Remdesivir:** Regarding the use of Remdesivir, the COVID-19 Clinical Pharmacology Task Group, CPTG, provided PHAC a recommendation that its use can be considered either as a therapy or preferably as part of a randomized controlled trial (see Appendix E). Presently, supply and access to Remdesivir may be limited in Canada, likely until the end of 2020. The benefit of Remdesivir on reducing time to recovery in the main clinical trial was highest among hospitalized patients who were not intubated but required supplemental oxygen. Remdesivir is indicated for the treatment of COVID-19 in adults and adolescents (≥12 years with body weight ≥ 40 kg) with pneumonia requiring supplemental oxygen. See Remdesivir product monograph for dosing information.
    - *Note: Remdesivir is administered by IV infusion only, generally in hospital settings. The product monograph recommends clinicians assess kidney and hepatic function at baseline and during treatment.*
- For more information, see:
    - PHAC. (2020). Clinical management of patients with COVID-19: Second interim guidance.
    - Beigel, J. H., Tomashek, K. M., Dodd, L. E., Mehta, A. K., Zingman, B. S., Kalil, A. C., ... & Lopez de Castilla, D. (2020). Remdesivir for the treatment of Covid-19—preliminary report. New England Journal of Medicine.
    - Horby, P., Lim, W. S., Emberson, J. R., Mafham, M., Bell, J. L., Linsell, L., ... & Prudon, B. (2020). Dexamethasone in Hospitalized Patients with Covid-19–Preliminary Report. The New England Journal of Medicine.

Treatment of Co-Infections

The prevalence of acute co-infections or secondary infections coinciding with COVID-19 is not well understood but appears to be low. Overuse of antibiotics should be avoided, and decisions about antibiotic therapy should be made in consultation with an ID physician if possible.

The clinical presentation of COVID-19 is similar to influenza and other respiratory pathogens. During the pandemic, the possibility of COVID-19 should always be considered. Clinical investigation for co-infections, including the potential for influenza, should take into account local epidemiology. When there is ongoing local circulation of influenza, empiric therapy with a neuraminidase inhibitor should be considered for the treatment of influenza viruses in patients with or at risk for severe disease.

For more information, see:

- PHAC. (2020). Treatment of co-infections. Clinical management of patients with COVID-19: Second interim guidance.
- Kondo, Y., Miyazaki, S., Yamashita, R., & Ikeda, T. (2020). Coinfection with SARS-CoV-2 and influenza A virus. BMJ Case Reports CP, 13(7), e236812.

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 F, G & H).

Additional Points for Consideration, Mild & Moderate

- Avoid nebulized medications ;
- Patients requiring CPAP for sleep disordered breathing (SDB) should be managed as per the COVID -19: Interim Revisions to Continuous Positive Airway Pressure (CPAP) Procedures (presently under review);
- Patients with inflammatory conditions on stable doses of NSAIDs could remain on them unless evidence changes[1];
- 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[1];
- 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. Source: The COVID-19 Antimicrobial Management Working Group, Alberta Health Services. Recommendations for Antimicrobial Management of Adult Hospitalized Patients with COVID-19.

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 I and J 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 K – 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 L - 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.

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.

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 proper hand hygiene 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.

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 proper hand hygiene 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 (i.e. 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 F, G, and H)

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

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.</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>

CRB-65

Criteria	Points
Confusion: new onset based on a specific mental test, or disorientation to person, place or time	1
Respiratory rate ≥30 breaths/minute	1
Low Blood pressure: SBP <90mmHg or DBP ≤60mmHg	1
Age ≥ 65 years	1

Score	Risk of Mortality	Suggested Management
0	< 2%	• Outpatient
1-2	~9%	• Consider hospital admission
≥ 3	>19%	• Hospital admission

If a recent urea is available, may use CURB-65 where BUN >7mmol/L = 1 point.

[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:

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Appendix D: COVID-19 CPTG Statement on Dexamethasone

Ad-hoc COVID-19 Clinical Pharmacology Task Group Statement on Dexamethasone

CPTG Meeting Date: June 26, 2020

POLICY QUESTION:

The Public Health Agency of Canada (PHAC) asked the *Ad-hoc* COVID-19 Clinical Pharmacology Task Group (CPTG) for advice on whether known and potential benefits of dexamethasone outweigh known and potential risks in the treatment of hospitalized COVID-19 patients receiving oxygen support.

BACKGROUND:

- As of June 24, 2020, 14 clinical trials were registered worldwide to investigate dexamethasone as a treatment for COVID-19; none of these had treatment sites in Canada [1]. The largest study to date is the UK-based RECOVERY trial, a large randomized controlled trial testing different investigational COVID-19 therapies in hospitalized patients, including low-dose dexamethasone treatment.
- Numerous observational/retrospective studies have reported mixed clinical outcomes associated with corticosteroid treatment of COVID-19 patients. However, this may be due to the stage of disease at time of treatment.
- When given during early stage COVID-19 disease, which is associated with logarithmic replication of SARS-CoV-2, anti-inflammatory properties of corticosteroids may damper the antiviral response. This is supported by evidence of delayed viral clearance when treating SARS-CoV-2 infection [2] as well as SARS-CoV-1 infection [3].
- Corticosteroid administration during later-stage COVID-19 infection, which can be characterized by increased oxygen requirement/ICU admittance, may be beneficial in counteracting the dysregulated immune response associated with COVID-19 induced cytokine storm syndrome/acute respiratory distress syndrome (ARDS). This is supported by observational data that showed lower rates of mortality in COVID-19 patients with ARDS who received methylprednisolone [4].
- Use of corticosteroids in ARDS (all causes) is controversial [5-11].

Clinical Evidence of Efficacy to Date:

- On June 22, 2020, Horby et al. released a preliminary report of clinical findings from the dexamethasone treatment arm of the RECOVERY trial on a pre-print website without peer review, one arm of many investigational treatment arms from the RECOVERY trial, a large randomized controlled multi-centre trial conducted at 176 NHS hospitals in the UK (n=2,104 randomized to dexamethasone; n=4,321 patients randomized to receive standard of care) [12].
    - Inclusion criteria: Hospitalized patients with confirmed or clinically suspected COVID-19 (no specified disease severity, age, or other demographic/clinical factor; age was restricted to over 18 years of age until May 9, 2020 when a protocol modification removed the restriction). Pregnant and breastfeeding women were eligible.
    - Baseline characteristics: The majority of patients were male (64%); mean age 66.1 years

- Treatment was standard of care plus low-dose dexamethasone (6mg once daily by oral or i.v. administration up to 10 days) or standard of care alone.
- Primary Outcome:
- The authors reported a significant reduction in the primary outcome of 28-day mortality for patients on 6 mg daily treatment of dexamethasone (454/2104 (21.6%) compared to those receiving standard of care alone (1065/4321; 24.5%; RR 0.83 (0.74-0.92); p<0.001) with available data (4.8% of patients had not completed 28 day follow-up).
- Secondary outcomes (not adjusted for multiplicity):
    - Significantly more patients in the dexamethasone group were discharged from hospital by day 28 (1360/2104 (64.6%)) than those treated with standard of care alone (2639/4321 (61.1%); RR 1.11 (1.04-1.19); p=0.002).
    - For those patients not receiving invasive mechanical ventilation at time of randomization, patients randomized to the dexamethasone treatment arm had significantly less risk of requiring invasive mechanical ventilation or death (425/1780; 23.9%) vs. those receiving standard of care alone (939/3638 [25.8%]; RR 0.91 [0.82-1.00]) or invasive mechanical ventilation alone (921/1780 [5.2%] - dexamethasone arm, compared to 258/3638 [7.1%] - standard of care arm; RR 0.76 [0.61-0.96]).
- The following subgroup analyses were reported but were not reported in the trial registry and do not appear to be adjusted for multiple testing (and therefore there is an elevated risk of finding statistical significance when it does not exist):
    - Subgroup Analyses*: Oxygen Requirement.* **The impact of dexamethasone on reducing mortality was greatest for patients receiving invasive mechanical ventilation, where 28-day mortality was reduced by 35%** (29% for those randomized to dexamethasone vs. 40.7% for those receiving standard of care alone, RR 0.65 [95% CI 0.51-0.82]). Twenty-eight-day mortality of patients receiving oxygen without invasive mechanical ventilation was reduced by 20% in response to dexamethasone treatment (21.5% dexamethasone vs. 25% usual care, RR 0.80 [95% CI 0.70-0.92]). There was no reported evidence of clinical benefit, and while not significant, a numerical increase in 28-day mortality rate (17% dexamethasone vs. 13.2% usual care), for patients not receiving respiratory support (rate ratio 1.22 [95% CI 0.93 to 1.61]).
    - Subgroup Analyses: *Age.* **Patients <70 years old had a numerically better clinical response to dexamethasone treatment compared to patients aged 70-80 years or 80 years and above, as observed by reduced incidence of mortality at 28-days.** Of 1142 patients aged <70 years receiving dexamethasone, 124 died by day 28 (10.9%) compared to 413/2506 patients receiving standard of care (16.5%; [RR 0.64; 0.52-0.78]). For patients aged ≥70 <80, mortality rate at day 28 was 146/467 (31.3%) for those randomized to dexamethasone, compared to 262/860 for those receiving standard of care alone (30.5%). For patients aged ≥80, mortality rate at day 28 was 184/495 (37.2%)

for those receiving dexamethasone compared to 390/955 for those receiving standard of care alone (40.8%).

- Subgroup Analyses: Days Since Symptom Onset. Consistent with increased clinical benefit observed for those patients requiring additional oxygen support, dexamethasone treatment had a greater impact at reducing mortality for patients with >7 days since symptom onset at time of trial randomization. Twenty-eight-day mortality for patients with >7 days since symptom onset: 201/1184 (17.0%; dexamethasone) vs. 581/2507 (23.2%; standard of care) (RR 0.68 [0.58-0.80]). Twenty-eight-day mortality for patients with ≤7 days since symptom onset: 252/916 (27.5%; dexamethasone), vs. 478/1801 (26.5%; standard of care) (RR 1.01; 0.87-1.17).
- The study did not perform subgroup analyses on whether the patients received treatment by oral or i.v. administration of dexamethasone. Unlike i.v. administered dexamethasone, oral dexamethasone is only 70-80% bioavailable. It is therefore unknown whether outcomes were affected by differing concentrations of drug according to route of administration.

Clinical Evidence of Safety to Date:

- In the preprint issued by Horby et al., there was no outcome associated with safety reporting [12]. The authors note the full peer-reviewed publication is anticipated shortly, and if any safety signals are reported, they will be reviewed by the CPTG in full.
- Notwithstanding the indication for COVID-19, dexamethasone administration has a well-defined safety profile. Short-term dexamethasone is associated with several adverse effects that critically-ill patients may already be pre-disposed to, including hyperglycemia, psychiatric adverse effects, hypertension, infections, edema, and gastrointestinal bleeding. It is unclear if data on adverse effects were monitored and collected in a systematic manner, as this is not described in the protocol or preprint manuscript.

Authorization/Licensure Status in Canada

- Dexamethasone is currently approved in Canada for multiple indications.

CONSIDERATIONS:

- Dexamethasone has a well-defined safety profile and is an approved drug in Canada for numerous indications.
- Current evidence demonstrates low-dose dexamethasone treatment has a clear benefit for severe hospitalized patients with COVID-19, with the greatest benefit observed for patients that require supplemental oxygen or mechanical ventilation, who are < 70 years old with time from symptom onset > 7 days.
- The benefit-risk profile for dexamethasone for the treatment of elderly (>70y old) COVID-19 patients requiring supplemental oxygen is still unknown, as safety information from the trial has not been published.

- There is growing evidence that COVID-19 may cause ketosis and ultimately trigger diabetes in some patients, however research on this association and molecular mechanism is still ongoing [13-16]. Given glucocorticoid therapy for non-COVID-19 indications has been associated with new-onset hyperglycemia [17], dexamethasone treatment for patients with COVID-19, especially in those with diabetes, may cause glycemic dysregulation.
- There is no current shortage of i.v. formulations of dexamethasone. However, oral formulations of dexamethasone have historically been in and out of short supply in Canada and are currently in Tier 3 shortage at the present time, with an undetermined timeline to return to historical levels. There is concern that injectable formulations will be used to offset the shortage of oral formulations for existing, approved indications. Hospitals have restricted allocations based on historical demand for ordering injectable formulations of dexamethasone to prevent a shortage.
- Well-established steroid equivalents to dexamethasone have defined safety profiles, are approved in Canada for numerous indications, and have historically been used to treat ARDS as well as sepsis from non-COVID-19 causes.

RECOMMENDATIONS:

The Clinical Pharmacology Task Group recommends that among hospitalized patients with COVID-19 who require supplemental oxygen or mechanical ventilation, dexamethasone 6 mg IV for 10 days (or until discharge, if earlier) or equivalent glucocorticoid dose should be strongly considered. This guidance is not meant to replace clinical judgment or specialist consultation.

This guidance will be updated as peer-reviewed evidence emerges, particularly regarding risks and benefits in older age groups, for those with different clinical presentations, and for different demographic subgroups such as sex and age.

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Approved by the Clinical Pharmacology Task Group on July 12, 2020

Appendix E: COVID-19 CPTG Statement on Remdesivir

Ad-hoc COVID-19 Clinical Pharmacology Task Group Statement on Remdesivir

CPTG Meeting Date: June 12, 2020

POLICY QUESTION:

The Public Health Agency of Canada (PHAC) asked the *Ad-hoc* COVID-19 Clinical Pharmacology Task Group (CPTG) for advice on whether known and potential benefits of remdesivir outweigh known and potential risks in the treatment of patients hospitalized with COVID-19.

BACKGROUND:

As of June 17, 2020, 24 clinical trials were registered worldwide to investigate remdesivir as a treatment for COVID-19, with 2 trials in Canada. These include CATCO (Canadian Treatments for COVID-19), the Canadian-led arm of WHO's multinational Solidarity treatment trial (Sunnybrook Research Institute) and a Gilead-led expanded access open-label trial. A series of developments have brought into question the benefit-risk of remdesivir.

Clinical Evidence of Efficacy to Date:

- On April 29, 2020, Wang et al. published clinical findings from a Gilead-led phase 3 randomized controlled trials (RCT), sponsored by the National Key Research and Development of China, testing remdesivir in hospitalized adults with severe COVID-19 (n=237 patients enrolled and randomized; China). The authors reported a numerical reduction in time to clinical improvement (21.0 vs. 23.0 days), median duration of invasive mechanical ventilation (7.0 vs. 15.5 days), and median duration of oxygen support (19.0 vs. 21.0 days), in response to treatment. However, the trial was underpowered to show efficacy due to premature termination from insufficient enrolment and therefore all reported differences are statistically insignificant. The study reported similar rates of the percentage of patients with undetectable viral load at day 28, mortality at day 28, and the median number of days in hospital, for patients treated with remdesivir compared to those treated with placebo. [1].
- On May 22, 2020, Beigel et al. published preliminary results from a National Institute of Allergy and Infectious Diseases (NIAID) -led phase 3 RCT testing remdesivir in hospitalized adults with severe COVID-19 (n=1,063 patients enrolled and randomized; multinational). The authors reported a statistically significant reduction in time to clinical recovery compared to placebo (11 vs. 15 days; $p<0.001$). In addition, the odds of improvement in clinical status at day 15 was statistically higher with remdesivir than with placebo (OR 1.50; $p=0.001$). Patients who underwent randomization during the first 10 days after the onset of symptoms had a lower rate ratio for recovery compared to patients who underwent randomization more than 10 days after symptom onset (1.28 vs. 1.38). The study reports that patients with severe disease had a higher ratio for recovery than patients with mild-to-moderate disease (1.37 vs. 1.09). However, only 11% of patients had mild to moderate disease, therefore this subgroup analysis is not controlled for type I error. At day 14, mortality rates (Kaplan-Meier estimate) were 7.1% in patients who received remdesivir vs. 11.9% in patients receiving placebo (HR=0.70; 95% CI, 0.47 to 1.04). Note: 28% of patients included in the trial had not reached the 28-day follow-up point at time of publication [2].
- On May 27, 2020, Goldman et al. published clinical findings from a Gilead-led randomized, open-label non-controlled phase 3 trial comparing a 5-day vs. a 10-day treatment course of remdesivir in hospitalized patients (≥ 12 years old) with severe COVID-19 not requiring