Patient Journey: COVID-19
Asymptomatic Testing for Public Health Surveillance
(In areas of elevated community transmission, as per COVID-19 Testing Strategy)

August 21, 2020 (previous version June 23, 2020

Updates
- Title: 'Screening' changed to 'Public Health Surveillance'.
- Removed branching for those with positive tests who do not develop symptoms. A footnote was added instead (see #2).
- Added reminder to fill out Form 1620 for medical isolation.
- Added consultation with LPH and NHQ for broader testing and medical isolation recommendations once a positive is identified.

COVID-19 Testing of an Asymptomatic Inmate for Public Health Surveillance

No medical isolation required while waiting for test results, new entry in InfoPoint COVID-19 Linelist

COVID-19 Positive Test

Immediately begin medical isolation[1]

In addition to general medical isolation protocol:
- Twice daily medical isolation wellness assessments (documented in OHIS-EMR measurements) and treatment as required.
- Begin contact tracing.
- Notify local public health of positive test result.
- Consult with local public health and NHQ for broader testing and medical isolation recommendations for the range/institution.

No symptoms develop

Continue medical isolation for 14 days, discontinue on day 15[2]

Symptoms develop

Follow *Patient Journey for Symptomatic Inmates and Close Contacts*

COVID-19 Negative Test

No medical isolation required

1. For all medical isolation:
   - Update medical isolation flag in OMS
   - Daily medical isolation wellness assessments documented in OHIS-EMR measurements
   - Inmates to clean/disinfect all things they touch when outside cell (phone, tables, etc.), wash hands prior to leaving cell and upon returning, wear mask when out of cell, maintain 2m distance from others when out of cell
   - Where possible, in a separate physical area or designated medical isolation cell
   - Update InfoPoint Linelist as necessary (for example, addition of new symptoms or date of recovery)
   - Staff to follow PPE Guidance
   - Complete Form 1520 (Medical Isolation Form)
1. If the institutional clinician (physician or nurse practitioner) suspects a false positive, they may decide to contact the lab to re-assess test results. If the lab also suspects a potential false positive, the institutional clinician will collaborate with local public health to determine if a re-test is necessary. The patient should be treated as positive while investigating.

Notes
Staff should engage with inmates to explain the rationale for medical isolation and provide information about the associated protocols. Inmates should be educated on the importance of other infection prevention and control measures, such as hand hygiene and maintaining a distance of 2m from others. If concerns arise about inmates following any of the recommended measures noted in this algorithm, institutional management should discuss to determine appropriate response.

Practice Reminder

Symptomatic Patients who Test Negative for COVID-19: Considerations for Medical Isolation

Within CSC, the threshold for testing symptomatic individuals is low, given the expanded list of symptoms for COVID-19, which includes many atypical symptoms.

In the case of **symptomatic inmates who test negative for COVID-19**, institutional physicians and/or nurse practitioners may use **clinical judgement** to make recommendations about medical isolation to the Institutional Head.

The following considerations – related to COVID-19 risk and ethical decision-making – should guide recommendations for medical isolation in the context of symptomatic COVID-19 negative patients.

Considerations

- The patient's clinical presentation and medical history;
- The outbreak status of the institution;
- The rate of transmission in the local community where the CSC institution is geographically situated;
- The type of institution (e.g. intake sites may have a higher risk of introduction from the local community);
- The ethical principles of pandemic response – particularly as they relate to medical isolation and patient restrictions, for instance:
    - *Proportionality*: Restrictions placed upon patients should be proportional to the level of risk.
    - *Non-maleficence*: Decisions should minimize the harm to patients and staff members wherever possible, which requires consideration for the benefits and burdens to patients, the inmate population the isolated patient would be returning to, and staff members.

Institutional physicians and/or nurse practitioners may wish to consult with a colleague (e.g. the regional physician lead or another institutional physician with experience in infectious disease outbreaks and/or COVID-19) when recommending a plan for medical isolation for symptomatic patients who test negative for COVID-19.

Courses of Action

Taking into account clinical judgment and the considerations detailed above, the following courses of action serve as examples of how a negative symptomatic case (and their close contacts) might be managed related to medical isolation.

- **Continue medical isolation**: continue to medically isolate the patient, until one of the following is achieved (whichever is earliest):
    - A minimum of 10 days have passed, with 48 hours symptom free; or
    - The patient receives a second negative test (tested at 4-5 days after the first test), with 24 hours symptom free, at which time medical isolation can be discontinued.

- **Implement modified routine[1]:** release the patient from medical isolation, but continue to modify routine for them and their cohort to the range and/or house, until one of the following is achieved (whichever is earliest):
  - A minimum of 14 days have passed, which accounts for a full incubation period for the symptomatic index patient's cohort; or
  - The index patient receives a second negative test (tested at 4-5 days after the first test), with 24 hours symptom free, at which time modified routine for the index patient and their cohort can be lifted.

If the index of suspicion for COVID-19 is low, discontinuing medical isolation on the basis of a single negative test may be appropriate, but rationale must be well documented in the OHIS-EMR.

Note: Once a symptomatic inmate receives a negative test result, the rest of the range/house and any identified close contacts remain on modified routine until the index case is medically cleared by the institutional clinician (physician or nurse practitioner).

Documentation
The rationale behind any deviation from the COVID-19 algorithms/patient journeys regarding medical isolation **must be thoroughly documented in the OHIS-EMR** by the institutional clinician (physician or nurse practitioner). This documentation should include all considerations that were taken into account, such as:

- The patient's clinical presentation and medical history;
  - Provide details about whether the patient was assessed in-person by the institutional physician or nurse practitioner and the result of that assessment
  - If the patient was not assessed in-person by the institutional physician or nurse practitioner, provide rationale
- The outbreak status of the institution;
- The rate of transmission in the local community where the CSC institution is geographically situated;
- The type of institution (e.g. intake sites may have a higher risk of introduction from the local community); and
- Consultation with colleagues (if applicable).

[1] Modified routine refers to modifying the movement of the patient and/or their cohort to the range- or unit-level. While typically implemented for 14 days to account for a full incubation period of the COVID-19 virus, the institutional physician/nurse practitioner can make a recommendation to discontinue modified routine prior to this, based on clinical judgement.

COVID-19 Contact Tracing

April 17, 2020

COVID-19 is a highly transmittable virus. There is now evidence that asymptomatic transmission is possible and likely occurring, therefore CSC has adopted a comprehensive approach to preventing the spread of this disease.

What is contact tracing?

Contact tracing is a strategy for breaking transmission chains and controlling the spread of disease.

It involves:

- Identifying infected persons
- Taking steps to prevent an infected person from further spreading infection
- Identifying those with whom the infected person may have been in close contact with while infectious

As part of the process, you may receive a phone call from a member of CSC's contact tracing team.

You may be asked questions about the nature and length of interactions with employees/contractors/inmates who have developed symptoms.

If you develop symptoms or are diagnosed with COVID-19, contact your manager immediately.

If you have any questions or concerns, please contact your manager.

If you require support in these unprecedented times, you are encouraged to reach out to an EAP referral agent. Lists of agents are available on the hub (EAP Referral Agents and Regional Contacts page) or by contacting EAP-CISM/PAE-GSIC.GEN@CSC-SCC.GC.CA. You may also contact the Employee Assistance Services at 1-800-268-7708. It is available 24/7.

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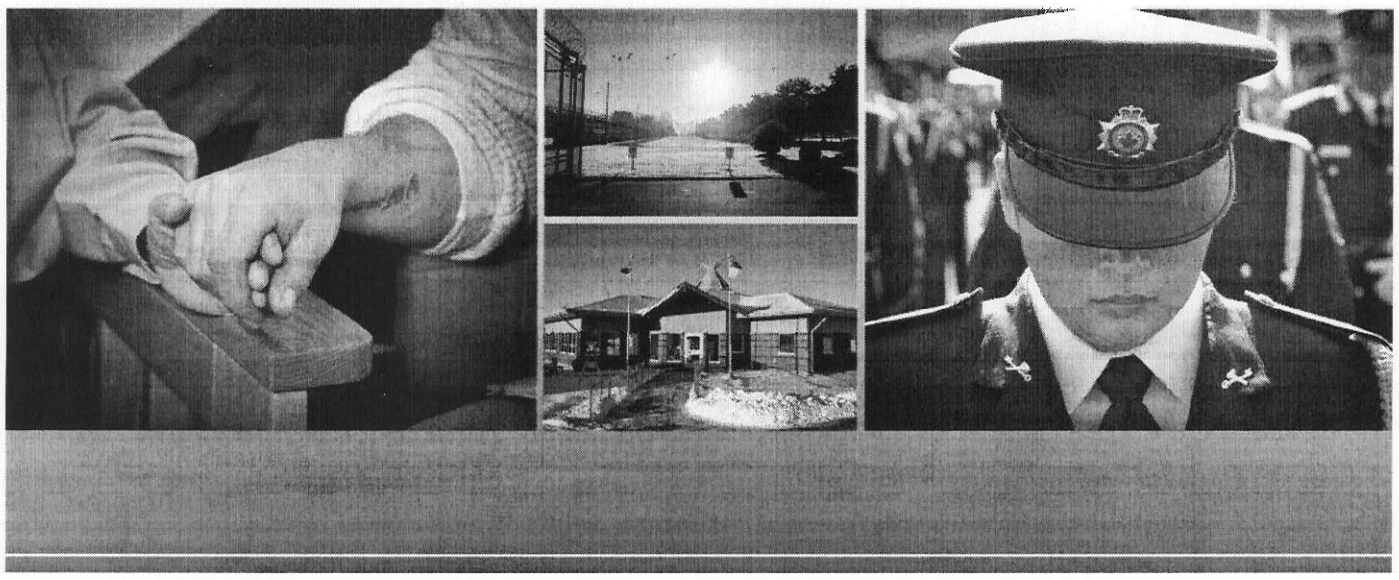

COVID-19 Contact Tracing Guideline

MAY 28, 2020

COVID-19 CONTACT TRACING GUIDELINE

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COVID-19 CONTACT TRACING GUIDELINE

Background

Contact tracing is a strategy for breaking transmission chains and controlling the spread of disease, in this instance COVID-19. It involves identifying infected persons, taking steps to prevent an infected person from further spreading infection, identifying those with whom the infected person may have been in close contact with while infectious, and locating and testing close contacts.

In the CSC context, contact tracing is being initiated with the goal of reducing the spread of COVID-19 within institutions and amongst inmates and staff. When new cases or symptomatic individuals are identified amongst staff, contact tracing teams will be personally calling institutional staff members that have been identified as having worked on the effected units, ranges, or houses. The purpose of these calls is to determine if institutional staff have come into close contact (see definition of close contact in Appendix A) with the case(s)/symptomatic individual(s) in the following timeframes:

- 48 hours prior to symptom onset
- Anytime after onset of symptoms

If determined a close contact in either of the above timeframes, the goal is to gather information about the nature of the contacts with the case(s)/symptomatic individual(s) to determine if further safety measures are required to protect other staff and inmates (ex. staying home from work to self-isolate).

Note: this contact tracing team only seeks to gather information about the nature and extent of contact, and does not seek to notify staff of the need to self-isolate or wear personal protective equipment (PPE). The Warden at the affected institution will determine further action regarding which staff are required to self-isolate (stay home) and will reach out to these staff members accordingly.

Procedures

The following outline the procedures for contact tracing:

When new cases or symptomatic individuals are identified amongst staff, the Warden and Chief of Health Services will determine potential staff contacts and create a list to send to the Regional Manager of Public Health (RMPH). The RMPH will notify the appropriate contact tracing lead and will attach the list in the form of an Excel spreadsheet that will include the following information:

- The names of the case(s) or symptomatic individual(s) in either the staff populations
- List of staff who may be contacts of the case(s) or symptomatic individual(s) to call
    - This will include their first and last names, contact information, job title, and date of last shift, and date of next shift
- A column should be present for 'notes' or 'comments' where you can document any additional, relevant data from your call with the staff member
    - If this column is not present, please add an additional column for this purpose

Contact tracing lead will create a new InfoPoint entry for each case/symptomatic individual

1. Create a new case or symptomatic entry for the provided individual(s) in the InfoPoint.

2. Generate a new CSC Case Number for the case or symptomatic individual using the following instruction:

   The Institutions Name plus 3 digits, for example:

   1. Mission001 (for the first case)
   2. Joyceville002 (for the second case)
   3. OttawaParole001 (for the first case)
   4. GrandValley003 (for the third case)

3. Complete the entry to the best of your knowledge using the information provided by the RMPH (date of symptom onset, test results, etc.)

4. Click save.

Member of the Contact Tracing Team: Calling Staff who are Potential Contacts

5. Open the provided excel document and begin the call.

6. Introduce yourself by name and as a member of the CSC contact tracing team for COVID-19.
   - Ex. "My name is _____ and I am a member of the contact tracing team for CSC."

7. Explain the reason for the call.
   - Contact tracing is part of COVID management: when an individual is identified as a "case" (symptomatic or confirmed COVID positive), we perform a thorough contact tracing exercise to identify close contacts of the cases so we can take the necessary measures to prevent further spread of infection
   - Contact tracing is a very important measure for your safety and for the safety of your work colleagues as it can help reduce the spread of COVID-19
   - Emphasize that any decisions about who stays home will come from the staff's supervisor/manager

8. Ask if you can go through questions about different types of contact they may have had with the case(s) or symptomatic individual(s).

9. If the person agrees, provide them with the name of the case(s)/symptomatic individual(s) and ask if they have had any contact with that person in the past 14 days. If yes, specify the type of contact (some examples include spending time in the same room, having a face-to-face conversation, sharing a couch, or sharing an object with the case(s) or symptomatic individual(s))
   - If more than one individual has been identified as a case or symptomatic individual at the institution, ensure you go through <u>each</u> person when considering recent contacts

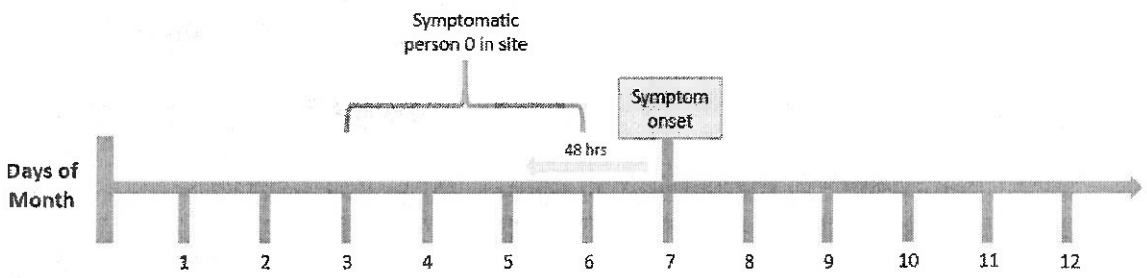
- Document each case or symptomatic individual that the staff member has come in contact with (the linking of cases is important information for contact tracing)
- Document any relevant data in the 'notes' or 'comments' column

a. If there has been no contact with **any** case/symptomatic individual, the staff member would be deemed a **casual contact** and would not require further interviewing (designate individual as a 'casual contact' on the provided excel spreadsheet);

b. If yes to **any** case/symptomatic individual, continue with more specific questions below.

10. Using the date of symptom onset for the index case, determine if the interaction occurred within the following timeframes:
    - 48 hours prior to symptom onset
    - Anytime after onset of symptoms
        - Ex. If contact occurred when the individual was symptomatic but had not yet initiated proper physical distancing protocol due to testing delay

The figure below illustrates the contact tracing timeline for a symptomatic staff member:



11. Determine the nature of the interaction for each case or symptomatic individual identified above using the following suggested questions, using your judgement and knowledge of the individuals role to individualize the questions as necessary (ie. the questions asked of a parole officer may be different than the questions asked of a teacher):
    - Have you recently spent a prolonged period of time within 2 meters of the case?
    - Have you eaten lunch in the lunchroom with the case?
    - Have you carpooled to work with the case?
    - Have you shared equipment (such as computers, keys, etc.) with the case?
    - Have you recently been a part of a training session with the case?
    - Have you had any face-to-face conversations with the case?

a. If no, they would be deemed a **casual contact** and do not require further interviewing. Designate individual as a 'casual contact' on the provided excel spreadsheet.

b. If yes, they may be a **close contact** - continue with contact tracing below.

12. Determine if the interaction(s) discussed above meet the following criteria for a close contact:
    - Approximately 15 minutes face-to-face (<2 meters distance/ 6ft), may be cumulative
    - Closed space with a confirmed case for longer than two hours
    - Any type of physical contact
    - Sharing of items that have not been properly disinfected

Note: If appropriate personal protective equipment was worn for the entire duration of the contact, this is considered a casual contact (see definition of close contacts in Appendix A).

a. If the interaction does not meet the above criteria, they would be deemed a **casual contact** and do not require further interviewing. Designate individual as a 'casual contact' on the provided excel spreadsheet.

b. If the interaction meets the above criteria, this would be deemed a **close contact.** Proceed to step 13.

13. Determine the date of their next scheduled shift to prioritize accordingly if further action is necessary.

Member of the Contact Tracing Team creates a new InfoPoint entry for a contact

14. With the staff member still on the phone, create a new InfoPoint entry for a 'Contact' and continue with the questions in the InfoPoint:
    - To create a contact number, use the original case number of the case/symptomatic individual followed by the initials of the contact. For example: Mission002-XX.
    - If the individual has had close contact with multiple case(s)/symptomatic individual(s), enter multiple contact numbers into the same InfoPoint entry. For example: Mission002-AS, Mission003-AS.

Reminder: Although it is outlined in the InfoPoint, always remember to determine if the close contacts are symptomatic. If they are symptomatic, please verify when symptom onset occurred so that the 48 hour period prior to symptom onset can be calculated for their own contact tracing.

15. Click save.

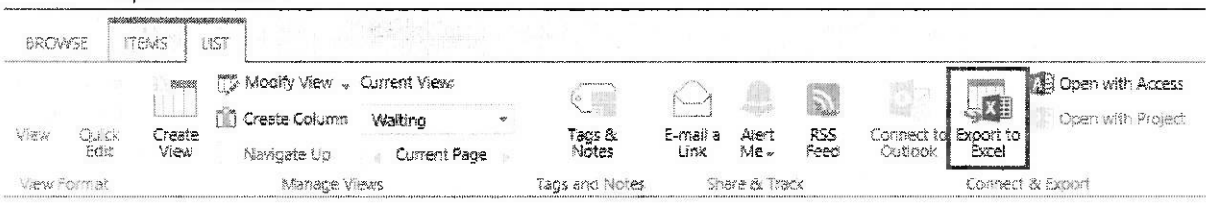
16. Inform the contact that if further action is required, they will receive notification from senior management at their institution with direction. Emphasize the importance of monitoring for symptoms and informing their manager if they develop symptoms.
    - If the staff member asks you whether or not they should be going to work, respond with the following: *I apologize I am unable to provide you with any direction regarding your work schedule or ability to go into the workplace. Please contact your Manager or Supervisor to discuss further.*

17. If you are unable to reach a staff member on your list, leave a message asking for them to call you back and continue to try until you are able to reach them.

Contact Tracing Team Lead (or designated team member) exports InfoPoint data to Excel

Once you have completed entering data for all individuals deemed close contacts in the InfoPoint, designate a member of your contact tracing team to export the data into an Excel spreadsheet using the following steps.

18. In the 'Contact' tab of the InfoPoint, go to the 'List' tab at the top left of the screen and select 'Export to Excel'.



19. A spreadsheet should populate with all data from the InfoPoint. Filter the data by clicking on the dropdown arrow in the 'Institution' column and select the appropriate institution. Then, click on the dropdown arrow in the 'Close contact number' column select only the contacts relevant to your index cases. For example:
    - If the case or symptomatic individual being traced was GrandValley009, select all contacts with the root case number of GrandValley009 prior to their initials (i.e. GrandValley009-AB, GrandValley001-CD, etc.)

20. To facilitate easier interpretation of the data, please create a more concise spreadsheet by deleting all columns except for the following:

Last name / Nom de famille	First name / Prénom	Contact information (cell #, home #, e-mail) / Information du contact étroit (#cellule/# tel/courriel)	Job title / Profession	Date of most recent close contact / Date du dernier contact étroit	Date to self-isolate until (14 days from close contact) / Date de fin de l'auto-isolement (14 jours suite au contact étroit)	Notes

    - In the 'notes' section, provide any other data that will assist senior management in determining if further action (self-isolation) is required.
    - Flag symptomatic staff to senior management for future contact tracing.

21. Once this table is prepared, save with the title 'Contact Tracing' followed by the relevant case number(s) and send to the appropriate senior management (RMPH, Warden, RD, CHS).

22. The contact tracing lead will be responsible to follow up with the institution management (RMPH, Warden, RD, CHS) for the remaining information and enter it into infopoint.:
    - Date of test
    - Result of test
    - Public health return to work date
    - Actual return to work date

Appendix A: Close and Casual Contact Definitions

1) **Close contact of a case:**

   a. An individual who has greater than 15 minutes face-to-face (<2 meters distance) contact with a case/symptomatic individual, in any setting (this may be cumulative, i.e. multiple interactions).
   b. Healthcare workers who have not worn appropriate PPE or had a breach in PPE during the following exposures to the case/symptomatic individual:
      - Health care workers performing assessments, vital signs, etc.
      - Direct contact with the case/symptomatic individual, their body fluids or their laboratory specimen
      - Present in the same room, without appropriate PPE, when an aerosol generating procedure is undertaken on the case/symptomatic individual.
   c. Individuals in the same accommodations as a case/symptomatic individual sharing kitchen, bathroom facilities, living area.
      - Inmates sharing a range, house or cell
   d. Correctional officers who had prolonged close contact for more than 15 minutes (within 2 metres) with a case/symptomatic individual who have not worn appropriate PPE or had a breach in PPE during the following exposures to the case/symptomatic individual while
      - Performing physical searches, pat downs, finger printing, interviewing, home visits, etc.)
      - Direct contact with the case/symptomatic individual, their body fluids
   e. Contacts who have shared a closed space with a case/symptomatic individual for longer than two hours, taking into consideration the size of the room, ventilation and the distance from the case/symptomatic individual.

2) **Casual contact of a case:**

   a. Any individual who has shared a closed space with a case/symptomatic individual for less than two hours.
   b. Healthcare workers, including correctional officers, who have taken recommended infection control precautions, including the use of appropriate PPE, during the following exposures to the case/symptomatic individual:
      - Direct contact with the case/symptomatic individual or their body fluids
      - Present in the same room when an aerosol generating procedure is undertaken on the case/symptomatic individual.
   c. Any individual who has shared a closed space with a case/symptomatic individual for longer than two hours, but taking into consideration the size of the room, ventilation and the distance from the case/symptomatic individual, does not meet the definition of a close contact.

CORONAVIRUS DISEASE (COVID-19)

Manager's Guide COVID-19: Contact Tracing of Symptomatic Employee/Contractor

APRIL 20, 2020

COVID-19 is a highly transmittable virus. There is evidence that asymptomatic transmission is occurring, therefore CSC has adopted a vigorous, adaptive approach to preventing the spread of this disease.

Contact tracing is a strategy for breaking transmission chains and controlling the spread of disease. It involves identifying infected persons, taking steps to prevent an infected person from further spreading infection, identifying those with whom the infected person may have been in close contact with while infectious, and locating and testing close contacts.

In the CSC context, contact tracing is initiated when employees/contractors notify management of either symptoms or diagnosis.

Managers are expected to follow the below steps:

Conversation with employee

You as the manager will:

1. Advise employee/contractor that contact tracing will occur by explaining:
   - All work contacts from the 48hr period prior to symptom onset will be contacted as part of the process for understanding and managing the spread of COVID-19.
2. Instruct employee/contractor to call Public Health (PH) for testing, as required:
   - Where testing is required, employees must inform the provincial public health agency that they are an essential worker for priority testing.
   - If the employee/contractor is denied testing, they should notify their manager.
3. Collaborate with the symptomatic employee/contractor to fill out the information in the spreadsheet provided: Date of symptom onset, types of symptoms, test results, etc.
4. Collaborate with the symptomatic employee/contractor to compile a list of potential work related close contacts (See definition of close contacts in Appendix A), to facilitate the contact tracing process.

5. Advise employee/contractor of return to work policy and formula.
   i. If their local provincial public health agency advises differently, advise them to report the difference in date to contact tracing leads.
   ii. The most stringent of the two policies will be followed.

6. Encourage the employee/contractor to reach out to the Employee Assistance Program for support.
   - The lists of EAP referral agents are available on the EAP Referral Agents and Regional Contacts page of the Hub or by contacting EAP-CISM/PAE-GSIC.GEN@CSC-SCC.GC.CA. You may also contact the Employee Assistance Services at 1-800-268-7708. It is available 24/7.

Working with institutional staff and contact tracing team

You as the manager will:

1. Collaborate with the warden and chief of health services to fill out the spreadsheet provided with a separate list of all employees/contractors who may have been contacts with the symptomatic individual in the 48hrs prior to symptom onset or any time thereafter.
   - For example, those who shared a post or were assigned to the same range/house on the same day.

2. Provide this information to the regional contact tracing lead[1], who will coordinate the contact tracing process to identify close contacts of the symptomatic individual.

Members of the contact tracing team will personally call institutional staff/contractors that have been identified as having worked on the effected units, ranges, or houses. The purpose of these calls is to determine if institutional staff/contractors have come into close contact with the symptomatic individual in the 48 hours prior to symptoms onset or anytime thereafter.

Reporting back to staff

You as the manager will:

1. Provide information about those who have been determined to be close contacts to the appropriate senior managers at the institutional and regional level.

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1 **Regional Contact Tracing Leads**
ATL: Renée Gagnon (506) 851-2360 ONT: Allison Storring (613) 545-8159 QUE: Marie-Helene Dufresne (438) 988-5082 and Simon Bégin (418) 284-5285 PRA: Shannon Harriman-Gerard (306) 220-5142 PAC: Megan Potvin (343) 543-8680 and Gurjit Toor (604) 839-5474

2. Reach out to those close contact employees/contractors to provide instruction on required self-isolation and/or return to work arrangements.

3. Encourage the employee/contractor to reach out to the Employee Assistance Program for support at 1-800-268-7708.

4. Will notify the senior manager of the department of the effected person when advising employees/contractors to stay home from work to medically isolate:
    - IMS (OMS) staff: Simon Bonk
    - HR: Nick Fabiano
    - Tech Services: Ghislain Sauvé
    - Healthcare workers: Chief of Health Services

5. Advise employees to report their date of return to work to the contract tracing leads.

Appendix A

Close Contact Definition

Close contact of a case:

a. An individual who has greater than 15 minutes face-to-face (<2 meters distance) contact with a case/symptomatic individual, in any setting (this may be cumulative, i.e. multiple interactions).
b. Healthcare workers who have not worn appropriate PPE or had a breach in PPE during the following exposures to the symptomatic individual:
    - Health care workers performing assessments, vital signs, etc.;
    - Direct contact with the symptomatic individual, their body fluids or their laboratory specimen;
    - Present in the same room, without appropriate PPE, when an aerosol generating procedure is undertaken on the symptomatic individual.
c. Individuals in the same accommodations sharing kitchen, bathroom facilities, living area
    - Inmates sharing a range, house or cell
d. Correctional officers who had prolonged close contact for more than 15 minutes (within 2 metres) with a symptomatic individual who have not worn appropriate PPE or had a breach in PPE during the following exposures to the symptomatic individual while:
    - Performing physical searches, pat downs, finger printing, interviewing, home visits, etc.;
    - Direct contact with the symptomatic individual, their body fluids

e. Contacts who have shared a closed space with a symptomatic individual for longer than two hours, taking into consideration the size of the room, ventilation and the distance from the case/symptomatic individual.

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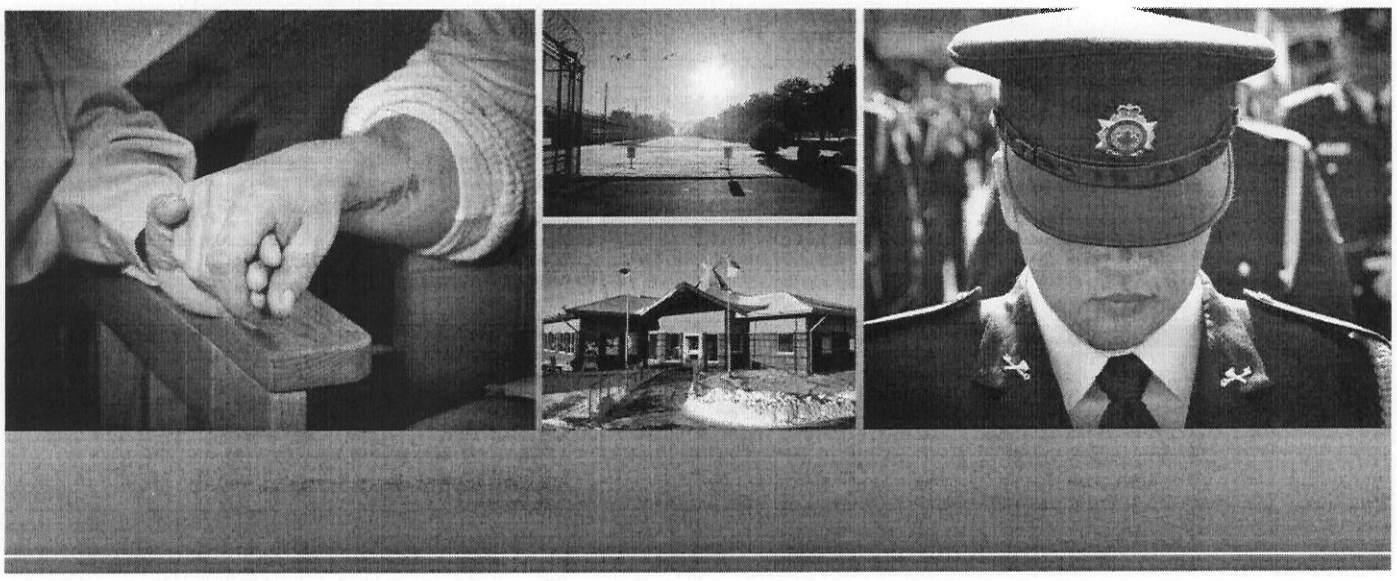


COVID-19: Guidance for Dental Services

JULY 9, 2020

Document History

Revision Date	Document Section	Description of Revisions
July 9, 2020		Document was created.

Introduction

Due to the risks associated with COVID-19, dental workplaces require careful planning and enhanced guidance to support the safe delivery of dental services. Dental workplaces are particularly vulnerable to viral transmission, due to nature of aerosol generating dental procedures, the proximity of the operating field to the upper respiratory tract, and the number of patients seen by a dental contractor in a day. This document provides interim guidance, in the context of the COVID-19 pandemic, for dental contractors in CSC. Dental contractors providing any in-person care amidst the COVID-19 pandemic must also adhere to the direction of provincial public health, and their governing college to promote their safety, as well as the safety of CSC's patients and staff.

This guidance document was developed using the best practice information currently available. It will be updated as new information becomes available.

Infection Prevention and Control

Modifications to dentistry practice in the context of COVID-19 are based on reducing the spread of infection. Infection prevention and control (IPC) practices within CSC are essential to promote the health and wellbeing of patients, employees, and contractors. It is important to note that this document focuses only on IPC measures for COVID-19 in dental settings; for additional information on IPC practices within CSC, please see COVID-19 Infection Prevention and Control Preparedness Guidance and Infection Prevention and Control Guidelines. For further information related to CSC's interim measures related to COVID-19, please see the COVID-19 Resources on the Hub.

Infection Prevention and Control Measures for Dental Procedures (COVID-19)

Practice Requirements

General Infection Prevention and Control Measures

In addition to routine practices (see Infection Prevention and Control Guidelines):

- The dental room must have a closed door because of possible aerosol generating medical procedures (AGMP) such as high speed hand pieces, air water syringes, and ultrasonic instruments.
- The dental room must be decluttered as much as possible (this includes removing any non-dental equipment or supplies stored in the dental room, computers, etc.)
- Ensure the availability of 60-90% alcohol based hand rub (ABHR)[1] or other hand sanitizer approved by Health Canada for COVID-19[2] at entrance and throughout the office.
- A high efficiency particulate air (HEPA) filter should be used if air in the dental room is recycled.
- Only necessary personnel for the dental case must be in the immediate environment.
- Ensure appropriate signage is posted in common areas, including topics such as hand washing, respiratory hygiene, and physical distancing (See CSC Posters and Resources and COVID-19 Wash Your Hands for signage).
- See COVID-19 Infection Prevention and Control Preparedness Guidance for more information on IPC measures for COVID-19.

Cleaning

- Full cleaning and disinfecting of the dental room before procedures.
- Cleaning and disinfecting in between patients by dental contractor.

[1] **Public Health Agency of Canada (2020).** Infection prevention and control for COVID-19: Interim guidance for long term care homes. Retrieved from: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevent-control-covid-19-long-term-care-homes.html

[2] **Public Health Agency of Canada (2020).** Hard-surface disinfectants and hand sanitizers (COVID-19): List of hand sanitizers authorized by Health Canada. Retrieved from: https://www.canada.ca/en/health-canada/services/drugs-health-products/disinfectants/covid-19/hand-sanitizer.html

- **For AGMP's:** Following the appropriate settle time, dentists must ensure that operatories (including all clinical contact surfaces and equipment) are cleaned and disinfected prior to treating a new patient. This should include all surfaces and floor where droplets could settle.
- **For non-AGMPs:** Clean the operatory room clinical contact and housekeeping surfaces as per normal infection prevention and control (IPAC) protocol

- Full cleaning and disinfecting of the dental room at the end of the day.
- Cleaning and disinfection must be undertaken using appropriate hospital-grade low-level disinfectant that are registered in Canada with a Drug Identification Number (DIN) and labelled as effective for both enveloped and non-enveloped viruses.
- The use of an electrostatic machine is recommended at the beginning and end of the day, as well as after any AGMPs performed on known COVID-19 positive patients, if available at the institution and based on the availability of cleaning staff. Please note that use of an electrostatic machine is in addition to routine cleaning and disinfection, not a replacement.

Personal Protective Equipment (PPE)

The following PPE is required for all dental procedures in CSC: N95 mask (or equivalent KN95 mask approved by Health Canada), face shield, gown, and gloves.

- CSC staff and contract dental providers, must be trained in personal infection prevention and control practices including donning and doffing PPE (COVID-19 Update Personal Protective Equipment).
- Although not all dental procedures are AGMPs, to avoid changing from a procedural medical mask to an N95 mask while attending to the patients, CSC will require that an N95 mask be used for all procedures.
- Staff and contract dental providers must have been fit tested for an N95 mask. If KN95 masks are used, they do not require fit testing. However these masks still require the user to perform a seal check prior to entering the dental room (see COVID-19 Update Personal Protective Equipment for KN95 seal check instructions).
- An N95 mask may be used for the entire duration of the clinic provided it has not been manipulated and is not visibly soiled, damp, damaged or difficult to breathe through.
- A face shield is mandatory and may be used for the duration of the clinic as well, provided it is disinfected between patients and discarded if it is visibly soiled, damaged or difficult to see through (see Reuse Face Shields COVID-19). Regular glasses and loupes can be worn under the face shield in addition, if desired/required.
- Gown and gloves should be changed between each patient, at the appropriate, separated donning and doffing stations.

Please see COVID-19 Update Personal Protective Equipment for PPE guidance that staff and contractors must adhere to while in CSC institutions, which includes universal masking protocols to be followed at all times in between dental procedures.

Security

- The dental room should ideally have a door that allows the correctional officer to have a clear view into the room.
- All persons in the room must wear personal alarms.
- If a correctional officer is waiting outside the dental room, the officer must have the appropriate (PPE) available in case entry to the dental room is required.
- No casual entry into the dental room is permitted during procedures. Place a sign on the door to indicate this (see Appendix A).
- If the correctional officer remains in the room, the officer must wear full PPE including an N95 mask.

Please see the **CSC Dental Relaunch Checklist** (see Appendix B) for a list of considerations when preparing for the relaunch of dental services.

Patient Flow

- Dental contractors should perform a point-of-care risk assessment for all patients prior to commencing the appointment to determine if the patient is experiencing symptoms (see COVID-19 Update Personal Protective Equipment for more information about this assessment) and must brief the patient on the risk of transmission of COVID-19 related to dental aerosols.

- If the patient is experiencing symptoms, the inmate should return to their cell and not enter the dental clinic. The appointment should be rescheduled to a later date (at least 14 days later) if possible. Refer to COVID-19 Algorithm for Symptomatic Inmates.
- If a patient experiencing symptoms requires urgent/emergency dental attention, the dentist may use their clinical judgement to decide whether or not to proceed with the dental procedure.

- Each patient is to have their temperature taken (recorded in OSCAR measurements) prior to commencing the appointment.
  - If the patient's temperature is above 38°C, the patient should not be placed in the dental room, but the dentist should assess if the fever may be related to a dental infection.
  - If there is any indication that the fever may be related to a dental infection or if the patient requires urgent/emergency dental attention for another reason, the dentist may use their clinical judgement to decide whether or not to proceed with the dental procedure.
- All staff, including dental contractors, should be screened by operations for symptoms of COVID-19 upon entering the institution.
- Four handed dentistry (the dentist and the assistant working as a team to provide dental care) should be practiced at all times.
- Prior to leaving the appointment, patients should be instructed to monitor for symptoms and notify Health Services if symptoms develop within the 14 day period after the appointment. Heath Services staff must then follow the COVID-19 Algorithm for Symptomatic Inmates and notify the dental contractors involved in the appointment.

During the Appointment

Have the inmate perform hand hygiene (either with ABHR, another hand sanitizer approved by Health Canada for COVID-19, or soap and water) upon arriving.

Perform hand hygiene and don PPE consisting of gown, N95 mask, face shield, and gloves for all cases by the dental contract staff and security if there is any possible risk of the need for their intervention.

1. Close the door to the procedure room and place a sign on the door that indicates the door should not be opened during the procedure (See Appendix A).
2. Have the patient perform a rinse with a 1% hydrogen peroxide solution for 30 seconds and then repeat for another 30 seconds.
3. High volume suction (HVS) is to be used.
4. Use rubber dam whenever possible.
5. Once the procedure is complete, the inmate should be directed to perform hand hygiene first and then don their mask prior to leaving the room.
6. Change gloves (performing hand hygiene as outlined in COVID-19 Update Personal Protective Equipment).
7. Clean and disinfect operatory using hospital-grade disinfectant while wearing PPE.
8. Doffing of PPE by dental personnel is performed in the designated area and disposed of into the designated no-touch waste receptacle. Follow continuous masking requirements as outlined in the COVID-19 Update Personal Protective Equipment.
9. Ensure the door remains closed post-procedure and is not used for another inmate until settle time is completed.

Settle time

The "settle time" is the amount of time needed for infectious airborne organisms that may be created during an AGMP to settle out of room air or infectious aerosols and land on surfaces. Settle time starts following an AGMP when a pathogen (e.g., COVID-19) has the potential to be aerosolized during the procedure.

If the dental procedure was an AGMP:

- The wait time of either:
  - 15 minutes for AGMPs performed using dental dams for the entire procedure, hydrogen peroxide pre-procedural mouth rinse, proper PPE, and high-volume suction; **OR**
  - 2 hours for AGMPs performed without any one or more of the following: dental dam for the entire procedure, hydrogen peroxide pre-procedural mouth rinse, proper PPE, or high-volume suction (for example, a surgical extraction, where a rubber dam cannot be used),

begins as soon as the room is emptied[3]. The dental room door needs to remain closed for the settle time duration[4] and no other procedures can take place in this time. The time that the door can be opened should be marked clearly on the door (see Appendix C). Once the wait time has expired full cleaning is performed.

If the dental procedure was not an AGMP:

- There is no wait time necessary and routine practices for cleaning/disinfecting the room prior to the next case can proceed according to established practice standard.

Note: If an institution is situated in an area with a low community incidence of COVID-19, a revised approach to reduce the settle time may be considered.

Scheduling

To optimize the number of appointments available in a dental clinic, consider scheduling appointments in such a way that maximizes the number of patients requiring non-AGMPs and minimizes the number of patients requiring AGMPs. This will reduce wait times in between appointments and increase the number of patients seen in a day. For example, consider starting the clinic with non-AGMPs such as dentures, inquiries/checks, triaging, etc. Schedule appointments that will involve the use of high speed hand pieces, air water syringes, ultrasonic instruments, or other AGMPs for the end of the work day, where possible, to better accommodate the settle time.

Consider scheduling patients at a higher risk of severe illness from COVID-19 (older age, those with underlying medical conditions, etc.) at the beginning of the day, first after lunch or on a separate day.

---

[3] **The College of Dental Surgeons of Saskatchewan (2020).** CDSS Alert – COVID-19 Pandemic: IPC Interim Protocol Update. Retrieved from: https://saskdentists.com/images/pdf/temp_files/Alerts__Memos/20200608_CDSS_Alert_Phase_3.pdf

[4] **Centers for Disease Control (2020).** Guidelines for Environmental Infection Control in Health-Care Facilities (2003): Table B.1. Air changes/hour (ACH) and time required for airborne-contaminant removal by efficiency. Available at: https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1

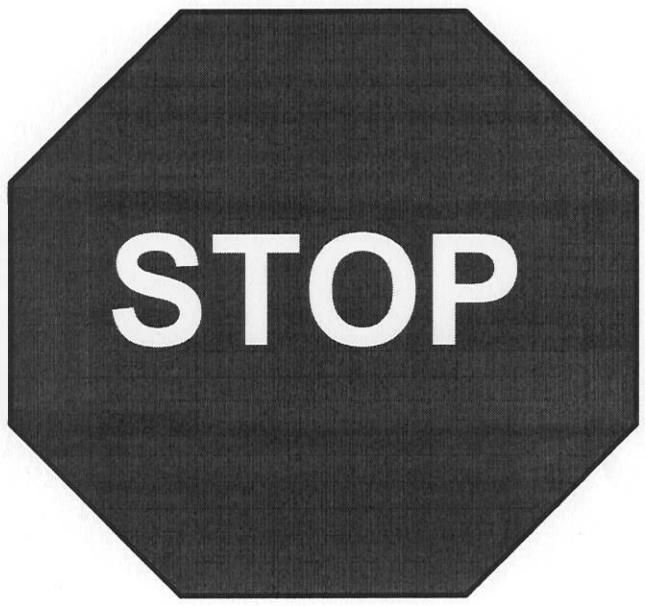
References and Resources

Alberta Dental Association and College (2020). *Expectations and Pathway for Patient Care during the COVID-19 Pandemic. Guidelines for Stage 1: Alberta Relaunch for Dental Practice.* Retrieved from https://www.dentalhealthalberta.ca/wp-content/uploads/2020/05/Expectations-and-Pathway-for-Patient-Care-during-the-COVID-19-Pandemic_5.25.2020.pdf

Public Health Ontario (2020). *COVID-19: Infection Prevention and Control Requirements for Aerosol-Generating Medical Procedures.* Retrieved from https://www.publichealthontario.ca/-/media/documents/ncov/ipac/ipac-aerosol-generating-procedures

Royal College of Dental Surgeons of Ontario (2020). *COVID-19: Managing Infection Risks During In-Person Dental Care.* Retrieved from https://az184419.vo.msecnd.net/rcdso/pdf/standards-of-practice/RCDSO_COVID19_Managing_In_Person_Care.pdf

Appendix A - Door Signage for Dental Procedures



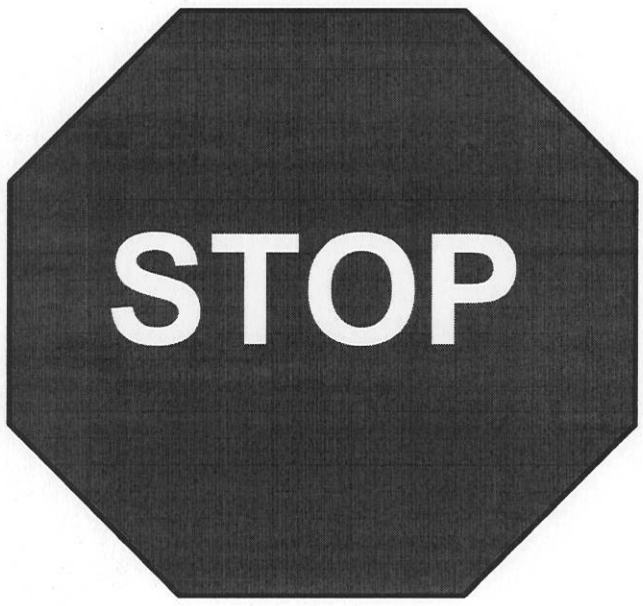
DENTAL PROCEDURE
IN PROGRESS

DO NOT ENTER

Appendix B – CSC Dental Relaunch Checklist

- □ All staff are briefed on new protocols for providing dental services during the COVID-19 pandemic
- □ All staff have been fit tested for an N95 mask
- □ The dental room is free of clutter (meaning it contains only dental equipment/supplies)
- □ All staff understand PPE expectations and have been trained in the donning and doffing of PPE
- □ PPE stations are located just outside dental room (according to COVID-19 Update Personal Protective Equipment guidance)
- □ 60-90% ABHR or other hand sanitizer approved by Health Canada for COVID-19 is available at the entrance and throughout the office
- □ Appropriate signage is visible in common areas (such as hand hygiene, respiratory etiquette, physical distancing, etc.)
- □ A door sign is available to stop any entrance to the dental room while a procedure is underway
- □ Cleaning plan is established to ensure appropriate cleaning and disinfection before patients, between patients, and after patients
- □ Schedule allows for appropriate settle time after appointments that require AGMPs

Appendix C - Door Signage for AGMP Settle Time



AGMP COMPLETED AT:

SETTLE TIME:

SAFE TO ENTER ROOM AT:

Patient Journey: COVID-19
Individuals at High-Risk for Severe Illness from COVID-19

August 21, 2020 (previous version June 23, 2020)

Updates
- For non-outbreak institutions, wellness assessments only required in moderate to high risk levels ('grey' zone to continue to follow care plan)
- Added link to Risk Management Framework in footnotes for more information on risk levels

Individuals at High-Risk for Severe Illness from COVID-19

Identified by Health Services based on underlying conditions

Asymptomatic

Non-Outbreak Institution

Risk Level: Low/Moderate (Grey)[1]

Continue to monitor as per care plan

Risk Level: Moderate to High (Yellow, Orange, or Red)[1]

3 wellness assessments per week

Wellness Assessment for Individuals at High-Risk for Severe Illness from COVID-19[2]

- **No symptoms reported** → Continue with 3 wellness assessments per week
  - *Wellness Assessment for Individuals at High-Risk for Severe Illness from COVID-19[2]*
- **Symptoms reported** → *New entry in InfoPoint COVID-19 Linelist* → Follow *Patient Journey for Symptomatic Inmates and Close Contacts*

Outbreak Institution

Daily wellness assessments

Wellness Assessment for Individuals at High-Risk for Severe Illness from COVID-19[2]

- **No symptoms reported** → Continue with daily wellness assessments
  - *Wellness Assessment for Individuals at High-Risk for Severe Illness from COVID-19[2]*
- **Symptoms reported** → Follow *Patient Journey for Symptomatic Inmates and Close Contacts*

Symptomatic

Follow *Patient Journey for Symptomatic Inmates and Close Contacts*

1. As per the **Risk Management Framework**.
2. Upon completion of a wellness assessment for an individual at high-risk for severe illness from COVID-19, the health professional who performed the assessment must initial next to the patient's name on the list provided by NHQ to confirm that the visit took place and mark cases that require further follow-up. Please see **Practice Reminder on Monitoring Individuals at High-Risk for Severe Illness from COVID-19** for more information.

Hospital Discharge Form

Physician Recommendations for Medical Isolation

AFFIX PATIENT IDENTIFIER STICKER HERE

Patient Name: _____

Date of hospitalization: _____ Date of discharge: _____

Current COVID-19 Outbreak at Hospital:	□ Yes □ No
To your knowledge, was the patient exposed to COVID-19 while in the hospital:	□ Yes □ No
COVID-19 test while in hospital: Date of test:_____ □ Negative □ Positive □ Not tested	

Do you recommend medical isolation for this patient upon returning to a federal correctional institution (which is a congregate living environment, similar to a long-term care home)?

□ No

□ Yes, I recommend the patient be medically isolated for ___ days, until _____ (YYYY/MM/DD)

Rationale for recommendation regarding medical isolation requirement:

_____

_____

Full Name of Discharging Physician (please print): _____

Physician Signature: _____ Date: _____

(Form version 2020-08-26)

Infection Prevention and Control Sub Assessment: Front Entrance

Institution: _____

Date Completed: _____

Reviewer Name, Title: _____

Reviewer Contact Information: _____

☐ **Institution self-assessment** ☐ **External audit**

Instructions:
This sub-assessment should be conducted in accordance with the Infection Prevention and Control Evaluation Guidelines. Each component (*i.e.*, screening, mask-wearing, and hand hygiene) should be assessed for one hour during peak-entry time into the facility. Depending on the amount of front-entrance traffic and/or the capacity to oversee each component (e.g., hand hygiene stations not co-located with front entrance), this assessment can be spread over multiple days.

1. HAND HYGIENE		
Indicator	**STAFF**	**NON-STAFF**
1.1 Total number of individuals that passed through the front entrance.		
1.2 Number of individuals that performed hand hygiene upon entry.		
1.3 Number of individuals that used proper hand hygiene technique. Refer to the Infection Prevention and Control Guidelines.		

Infection Prevention and Control Sub Assessment: Front Entrance

2. MASK-WEARING		
Indicator	**STAFF**	**NON-STAFF**
2.1 Total number of individuals that passed through the front entrance.		
2.2 Number individuals wearing masks upon entering the institution.		
2.3 Number of individuals using proper mask wearing technique. Refer to the Guidance on the Use of Non-Medical Masks and Personal Protective Equipment.		

Infection Prevention and Control Sub Assessment: Front Entrance

3. SCREENING		
Indicator	**STAFF**	**NON-STAFF**
3.1 Total number of individuals that passed through the front entrance.		
3.2 Number of individuals that passed through the front entrance and were screened for all screening questions in accordance with applicable CSC screening policy documents including: • CSC's COVID-19 Screening Questions • CSC's COVID-19 Screening Form for Use by Operations • CSC's COVID-19 Screening Form for Use by Health Care		
3.3 Number of individuals that had their temperature taken upon entering the institution.		

Infection Prevention and Control Sub Assessment: Mask-Wearing

Institution: _____

Location in institution: _____

Date Completed: _____

Reviewer Name, Title: _____

Reviewer Contact Information: _____

☐ **Institution self-assessment** ☐ **External audit**

Instructions:
This sub-assessment should be conducted in accordance with the Infection Prevention and Control Evaluation Guidelines. In total, five locations should be evaluated in the institution – a separate form should be used for each location. Each location should be evaluated for approximately 45 minutes during peak traffic times. The front entrance should not be a location.

MASK-WEARING		
INDICATOR	**STAFF**	**INMATES**
Q1. Total number of individuals observed.	Total: _____	Total: _____
Q2. Number individuals wearing masks.	Total: _____	Total: _____
Q3. Number of individuals using proper mask wearing technique. Refer to the Guidance on the Use of Non-Medical Masks and Personal Protective Equipment.	Total: _____	Total: _____

Patient Journey: COVID-19

New Warrants of Committal and Returns to Federal Custody

August 21, 2020 (previous version June 23, 2020)

1. All medical isolation to include:

- Inmates to wear mask and maintain distance of 2 metres from others when out of cell
- Inmates to clean/disinfect all things they touch when outside cell (phone, showers, tables, etc.)
- Inmates to wash hands prior to leaving cell and upon returning
- Where possible, in a separate physical area or designated medical isolation cell
- Daily medical isolation wellness assessments documented in OHIS-EMR measurements
- Staff to follow PPE Guidance
- Update medical isolation flag in OMS
- Update InfoPoint Linelist as necessary (for example, addition of new symptoms or date of recovery)
- Complete Form 1620 (Medical Isolation Form)

Updates

- Added branching for asymptomatic positives to indicate that while in medical isolation, symptoms may develop (refers to the symptomatic algorithm)
- Added those who are symptomatic and do not consent to be tested to follow the same guidance as those who are positive
- Operations screening now documented by logbook for those who answer 'no' to all questions, the form is only used if inmate answers 'yes' to any screening question

Intake/Return to Federal Custody

Immediately begin medical isolation[1]

Operations Screening

Ask all screening questions. Document using a logbook for those who answer 'No' to all questions, and the Screening Form for use by Operations only for those who answer 'Yes' to any question.

Health Services Screening

COVID-19 Screening Form For Use By Healthcare

'Yes' to any question

New entry in InfoPoint COVID-19 Linelist, begin contact tracing

Test Immediately

Add swab date, results, and result date in InfoPoint COVID-19 Linelist

COVID-19 Positive Test OR Consent to Test Not Provided

In addition to general medical isolation protocol:
- **Twice** daily medical isolation wellness assessments (documented in OHIS-EMR measurements) and treatment as required
- Discontinue medical isolation when medically cleared, no earlier than 10 days after onset of symptoms with at least 2 days symptom free.
- Notify local public health of positive test result

COVID-19 Negative Test

In addition to general medical isolation protocol:
- **Twice** daily medical isolation wellness assessments (documented in OHIS-EMR measurements) and treatment as required
- Discontinue medical isolation when medically cleared, no earlier than 10 days after onset of symptoms with at least 2 days symptom free and at least 14 days from the date of intake.

'No' to all questions

Offer test at day 10

Consent to Test Not Provided

- No symptoms develop → Continue medical isolation for 14 days, discontinue on day 15
- Symptoms develop → *New entry in InfoPoint COVID-19 Linelist* → Follow *Patient Journey for Symptomatic Inmates and Close Contacts*

Consent to Test Provided

New entry in InfoPoint COVID-19 Linelist and add swab date, results, and result date

COVID-19 Positive Test

In addition to general medical isolation protocol:
- **Twice** daily medical isolation wellness assessments (documented in OHIS-EMR measurements) and treatment as required
- Begin contact tracing
- Notify local public health of positive test result

- No symptoms develop → Continue medical isolation for 14 days, discontinue on day 15
- Symptoms develop → Follow *Patient Journey for Symptomatic Inmates and Close Contacts*

COVID-19 Negative Test

- No symptoms develop → Continue medical isolation for 14 days, discontinue on day 15
- Symptoms develop → Follow *Patient Journey for Symptomatic Inmates and Close Contacts*

Notes

Staff should engage with inmates to explain the rationale for medical isolation and provide information about the associated protocols. Inmates should be educated on the importance of other infection prevention and control measures, such as hand hygiene, wearing a mask, and maintaining a distance of 2m from others. If concerns arise about inmates following any of the recommended measures noted in this algorithm, institutional management should discuss to determine appropriate response.

Patient Journey: COVID-19
Interregional and Intraregional Transfers
June 23, 2020

Inmate Arriving from Interregional and Intraregional Transfer

Transferring from an Outbreak Institution

- Avoid transfers
- If a transfer is absolutely necessary and unavoidable, treat the offender as potentially exposed to the virus:
  - Full droplet/contact PPE required for staff participating in the transfer
  - Medically isolate for 14 days on arrival to the receiving site
  - Land transfers are preferred, avoid air transfers

Transferring from an Institution in an Area with Elevated Community Transmission[1]

- Avoid transfers as much as possible
- If transfer is necessary and unavoidable, out of an abundance of caution, treat the offender as potentially exposed to the virus:
  - Full droplet/contact PPE required for staff participating in the transfer
  - Medically isolate for 14 days on arrival to the receiving site
  - Land and air transfers are both permissible

Transferring from a Non-Outbreak Institution OR an Institution that is not in an Area of Elevated Community Transmission[1]

- No need to medically isolate at receiving site
- Routine precautions for staff participating in the transfer (e.g. non-medical mask, hand hygiene)
- Some provinces have mandated 14-day medical isolation for those travelling from out of province. Review provincial guidance before receiving an inmate from out of province, and medically isolate as necessary.
  - Please see Appendix A: Links for Interprovincial Travel Advice by Province

The Chief of Health Services at the sending institution must confirm provincial travel restrictions prior to initiating transfer and must document having done so in the Health Comments portion of the Assessment for decision.

[1] Institutions situated in an area where NHQ-HS, in collaboration with local public health, has identified that there is evidence of uncontained elevated community transmission.
Note: If an institution falls within 2 of the categories listed above (eg. a non-outbreak institution that is situated in an area of elevated community transmission), please follow the more stringent of the two procedures.

Appendix A: Links for Travel Advice by Province

Province	Link
BC	https://www.healthlinkbc.ca/travel-and-covid-19
Alberta	https://www.alberta.ca/covid-19-travel-advice.aspx
Saskatchewan	https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/treatment-procedures-and-guidelines/emerging-public-health-issues/2019-novel-coronavirus/self-isolation
Manitoba	http://www.manitoba.ca/covid19/soe.html
Ontario	https://www.ontario.ca/page/covid-19-stop-spread#section-4
Quebec	https://www.quebec.ca/en/health/health-issues/a-z/2019-coronavirus/instructions-for-travellers-covid19/#c58168
Newfoundland	https://www.gov.nl.ca/covid-19/individuals-and-households/travel-advice-2/
New Brunswick	https://www2.gnb.ca/content/gnb/en/corporate/promo/covid-19/travel.html
Prince Edward Island	https://www.princeedwardisland.ca/en/information/justice-and-public-safety/travel-restrictions-and-screening
Nova Scotia	https://novascotia.ca/coronavirus/
North West Territories	https://www.gov.nt.ca/covid-19/en/services/travel-moving-around
Yukon	https://yukon.ca/en/health-and-wellness/covid-19/information-people-entering-yukon
Nunavut	https://www.gov.nu.ca/health/information/covid-19-novel-coronavirus

CORRECTIONAL SERVICE CANADA

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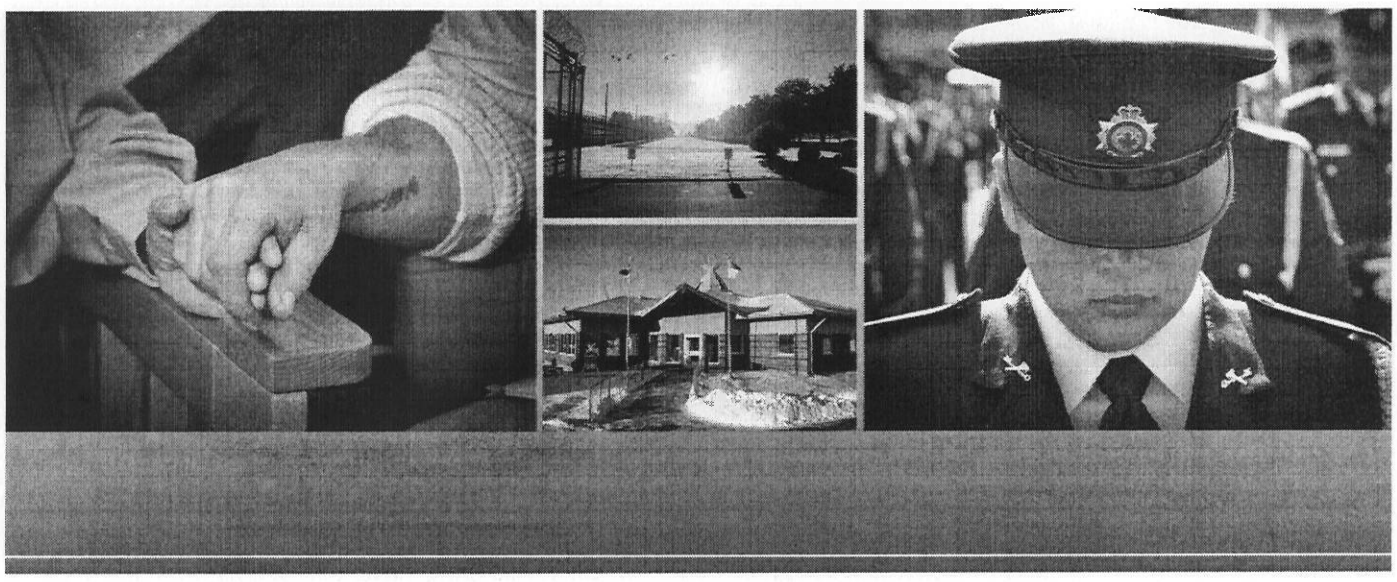

Infection Prevention and Control

Evaluation Guidelines

SEPTEMBER 28, 2020

Correctional Service Canada | Service correctionnel Canada

Canada

00037

Infection Prevention and Control Evaluation Guidelines

Purpose

The purpose of this document is to provide Correctional Service Canada (CSC) Institutions with Infection Prevention and Control (IPC) evaluation guidelines for self-assessments and external audits.

Background

Correctional Service Canada has collaborated with various stakeholders, including the Public Health Agency of Canada (PHAC) and International Federation of the Red Cross, to audit institution IPC practices and measures across the country.

These audits, along with the input and collaboration from CSC and PHAC were used as a framework to create a number of IPC evaluation tools tailored for federal correctional institutions. These IPC tools consist of the:

1. *Infection Prevention and Control Assessment Checklist (Appendix A)*
2. *Infection Prevention and Control Sub-Assessments (Appendix B)*

Correctional Service Canada's IPC evaluation tools are to be used for institution-level self-assessments and external audits in accordance with the instructions that follow. Information from the tools will be used by site, region, and national-level management to identify areas for IPC improvement and to strengthen future IPC measures and practices.

Evaluation Instructions

Self-Assessments

Self-assessments are to be coordinated by the site and will be evaluated using CSC's *IPC Assessment Checklist* and *IPC Sub-Assessments*.

Conducted by:

Self-assessment reviewers will vary based on assessment type:

1. IPC Assessment Checklists are to be conducted **jointly** by:
    - An institutional staff member from Health Services, ideally the Manager of Health Services or equivalent, and
    - An institutional staff member from operations, ideally at the Assistant Warden level or higher.
2. IPC Sub-Assessments are to be conducted by **one** of:
    - An institutional staff member from Health Services, ideally the Manager of Health Services or equivalent, or
    - An institutional staff member from operations, ideally at the Assistant Warden level or higher, or
    - The delegated institutional COVID-19 site manager or equivalent.

Frequency of assessments:

Self-assessment frequency will vary based on assessment type, outbreak risk, and direction from the region:

1. Assessment Type

   - IPC Assessment Checklists should be conducted bi-annually.
   - IPC Sub-Assessments should be conducted quarterly.

2. Outbreak Risk

   In the event of an outbreak, or when an institution has been identified as being at increased risk for an outbreak (*e.g.,* Caution Status for COVID-19), an institution may be directed to conduct their self assessment at the following frequency:

   - IPC Assessment Checklists should be conducted every six weeks.
   - IPC Sub-Assessment should be conducted every two weeks.

External Audits

External audits are to be coordinated by the region, as directed by National Headquarters, and **must** be evaluated using CSC's *IPC Assessment Checklist* and *IPC Sub-Assessments.*

Conducted by:

An accredited third-party IPC auditor.

Frequency of assessments:

At the direction of National Headquarters and/or the region.

Data Entry Instructions

Infection Prevention and Control evaluations (whether from self-assessment or external audit) will be entered into CSC's Public Health InfoPoint system.

1. Upon completion, *IPC Assessment Checklists* will be entered into the IPC Checklist InfoPoint by a designated site-level data entry personnel.

2. Upon completion, *IPC Front Entrance Sub Assessments* will be entered into the IPC Front Entrance InfoPoint by a designated site-level data entry personnel.

3. Upon completion, *IPC Mask Wearing Assessments* will be entered into the IPC Mask Wearing InfoPoint by a designated site-level data entry personnel.

4. Access to these InfoPoints is restricted to National Headquarters, the Regional Manager of Public Health, and designated site-level data entry personnel. Requests to access these InfoPoints can be made through the Regional Managers of Public Health.

5. Every time a new assessment is conducted, a *'New Item'* in the InfoPoint should be created by the designated site-level data entry personnel. **Under no circumstances should an existing self-assessment item be edited.**

6. After clicking on *'New Item'*, the data entry personnel will be prompted to enter the results from the IPC checklist. Once entered, the results can be save.

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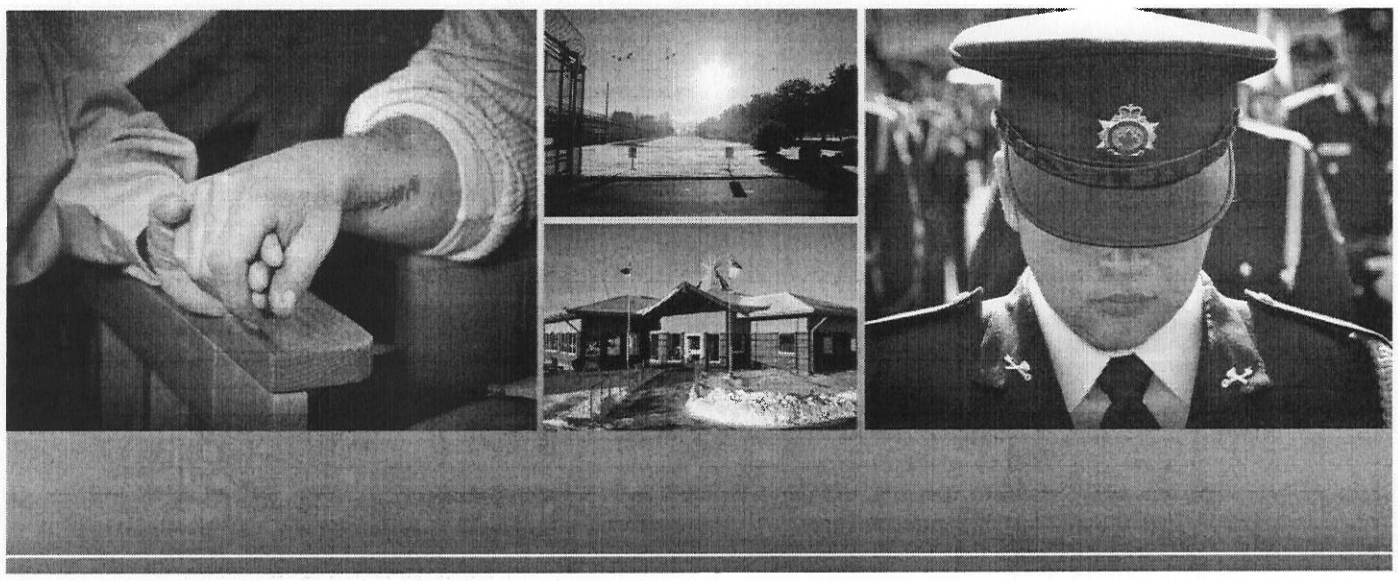

Coronavirus Disease (COVID-19)
Infection Prevention and Control (IPC)
Preparedness Guidance

UPDATED MAY 12, 2020[i]

Table of Contents

This guidance serves as a summary of important preparedness initiatives that need to be in place to facilitate the effective management of COVID-19. This checklist must be considered in the context of other guidance documents and algorithms (links are provided throughout document and in the endnotes). This guideline can be used in conjunction with the Infection Prevention and Control (IPC) Quality Improvement (QI) Preparedness Checklist (under development).

Background

COVID-19 is the infectious disease caused by the most recently discovered coronavirus. This new virus and disease were unknown before the outbreak began in Wuhan, China, in December 2019. COVID-19 has been declared a global pandemic. Those who are infected with COVID-19 may have little to no symptoms. Symptoms[ii], similar to a cold or flu, may take up to 14 days to appear after exposure to COVID-19. Commonly reported symptoms among reported cases include cough, headaches, and weakness[iii]. There is currently no vaccine against or specific treatment for COVID-19. Evidence indicates that the virus can be transmitted to others by someone who is not showing symptoms (asymptomatic/pre-symptomatic). According to the Public Health Agency of Canada[iv] (PHAC, May 12, 2020) at this time, 81% of COVID-19 cases are related to community transmission, while 19% were either exposed while travelling or exposed to a traveler coming to Canada.

Transmission

Current epidemiologic information suggests that human-to-human transmission of COVID-19 can occur when an individual is in close contact[v] with a symptomatic case. In addition, there is now evidence of asymptomatic/pre-symptomatic spread of the virus. Human coronaviruses are most commonly spread from an infected person through: respiratory droplets; close, prolonged personal contact; and touching an infected area, then touching mouth, nose or eyes before washing hands.

Ethical Principles[vi]

The following ethical principles are taken into consideration as CSC reviews and revises its practices:

- **Proportionality:** Decisions to modify services during the pandemic should be proportionate to the real or anticipated limitations in capacity to provide those services. Capacity may refer to staffing, Personal Protective Equipment (PPE), competence in donning and doffing, or system capacity to provide different levels of critical care during surge. Restrictions to services should only be in place for as long as necessary.
- **Non-maleficence:** Decisions should minimize harm to patients wherever possible. This includes consideration for staff safety, which require equipment (PPE) and appropriate training. If certain forms of care cannot be provided, attention must be paid to minimizing pain and suffering.

- **Equity:** Equity requires that all persons in the same categories be treated in the same way unless relevant differences exist, and that special attention is paid to actions that might further disadvantage the already disadvantaged or vulnerable.
- **Transparency:** Decisions to modify services should be clearly communicated in a transparent manner to patients and to the broader community served.
- **Accountability:** Those making decisions must be accountable, and able to provide a clear rationale based on the best available evidence, practices and principles.

Institutions are encouraged to consult with their Workplace Health and Safety Committees on the infection prevention and control measures (e.g. strategically locating hand sanitizer, assessment and modifying routines, strategies for minimizing transmission).

The Infection Prevention and Control Audits that are being conducted across the country are being used to inform the guidance document.

Entering the Institution

Screening[vii]

- National, regional and site-specific communications to staff about staying home if they are sick.
- Bilingual Signage highlighting visitor restrictions and informing staff and contractors, about how to protect themselves (e.g. hand washing, self-monitoring for symptoms, wearing a mask when physical distancing is not possible, etc.). In addition to signage at the front entrance, there must be signage throughout the institution visible to all staff and contractors (e.g. breakroom; boardrooms; offices; hallways; bathrooms; etc.).
- Formal supervised screening and hand hygiene (soap & water or alcohol-based hand sanitizer[viii]), at the front entrance or pre-entry location that ensures required physical distancing is established. This avoids congestion where limited space is available and establishes initial prevention protocols which leaves Entry Security to function safely and unimpeded.
- Staff exhibiting symptoms, regardless of severity, must contact their manager immediately.
- **Formal documented quality improvement spot checks to support adherence to screening and proper hand hygiene technique (i.e. signage is in place, handwashing following proper technique, staff are asked about symptoms).**

Cleaning and Disinfection

- Process for cleaning and disinfecting tools and equipment (i.e. bins) used by staff when being processed at the Principle Entrance/Visitor Security/Duty Office.

- Process for hand sanitization upon entering the institution. All persons entering and exiting the institution must wash their hands with soap and warm water and/or at least at 60% alcohol-based hand rub.
- Process for changing into and out of work clothing. Although there is a low risk of viral transmission on clothing and fabrics, where possible, staff will bring their own work clothing into the institution. It is recommended that staff: 1) change into work clothing once on site; 2) at the end of shift, work clothing will be placed into a plastic bag to take home to launder; and 3) launder used work clothing at home in regular wash hot water cycle and tumble dry. It is recommended that staff use dedicated footwear while at work and that staff shower and wash their hair upon returning home after every shift involving contact with clients or their environment (within 2 meters).
- **Formal documented quality improvement spot checks to support adherence to proper cleaning technique.**

Personal Protective Equipment (PPE)

- Adherence to PPE protocol/ PPE guidance[ix] (e.g. donning of mask).
- A designated location(s) for donning of PPE complete with hand sanitizer, signage, and step -wise donning of PPE to identify a clean versus protected zone can be an effective Infection Prevention Control (IPC) measure. Higher risk PPE donning and doffing locations (medical staff and/or contracted cleaners) must be identified.
- **Formal documented quality improvement spot checks to support adherence to proper technique.**

Warrant of Committal or Return to Federal Custody

- Documented pre-screening by Provincial/Territorial Corrections, including reporting on temperature taken prior to arrival. Pre-screening documentation from the province is scanned and recorded in OMS.
- Immediately screening at intake by operations, using the COVID-19 screening form[x] and additional screening by Health Services as part of the intake process[xi].
- Medical isolation for 14 days in accordance with health services algorithms for intake and symptomatic inmates[xii].
- Inmate education on infection and prevention (cough/sneezing hygiene; handwashing; physical distancing; cleaning living area)[xiii].
- Twice daily wellness checks, documented in the electronic medial record[xiv].
- Non-touch temperature taken 2x daily, if individual consents documented in the electronic medical record.
- PPE and soap and water/at least a 60% alcohol based hand sanitizer strategically located, available and controlled/used as required.

- Practice of physical distancing (>2 m) wherever possible. Develop operational routines that encourage physical distancing and that facilitate the promotion and enforcement of physical distancing among staff and inmates.
- **Documented quality improvement spot checks to support adherence to physical distancing and hand hygiene by staff and inmates**.

Cell/House/Range Assignment and Accommodation and Common Areas

Managing the Institutional Flow to Minimize Contact

- Assessment of how people and items move through the facility and, where possible, grouping activities to achieve optimal movement of staff, inmate and equipment.
- Suspension of group correctional programs, education, and work placements at outbreak sites. Where correctional programs, education and work placements continue, the practice of physical distancing (> 2m) and use of masks is required.
- Modified routines to reduce inmate group size and increase physical distancing.
- In consultation with local public health, arrangements for separating and managing different groups of patients. For example: "asymptomatic negatives;" "recovered and refusals;" "positives" (including asymptomatic positives); "inconclusive tests;" and "symptomatic and pending."
- Practice of physical distancing (>2 m) where ever possible.
- **Strategies for Minimizing Transmission of the Virus Through Physical Distancing**:
  - Establish isolation zones for inmates, where feasible to cohort different groups (symptomatic and COVID positive and asymptomatic contacts). Explore alternatives when zoning is not feasible such as cleaning and setting up unused cells/ranges. Put up posters in each zone to identify what PPE is required in each zone.
  - Modified rostering, in consultation with the union, for Correctional Officers to move more to unit/roster based staffing to reduce possibility of exposure.
  - Changing the post rotations for Correctional Officers to minimize the contact Correctional Officers have with the entire population in line with the requirement for consultation in the global agreement. An example is during the COVID-19 period, a staff member works a limited number of positions and works with a smaller population. This has to occur with CXIs and CXIIs to minimize the contact with groups.
  - Limit cross exposure at shift changeover for correctional officers. This may mean locking up the population at changeover and having Correctional Officers leave the post with only one person remaining to ensure less exposure to the other team of officers coming into work.
  - Limit staff contact, perhaps by having officers enter through the principle entrance, but exit through an alternative exit, if infrastructure allows.

- Adjust Correctional Officer post assignment to ensure officers stay with specific units, so that if there is an outbreak the cross contamination/exposure is limited.

- Appropriate wearing of PPE for staff and inmates (see PPE guidance[ix]).
- PPE and appropriately placed soap and water/at least 60% alcohol hand sanitizer available throughout the institution, prepositioned close to all common use, high touch surfaces.

Food

- Serving arrangements must be consistent with the practice of physical distancing (>2 m), wherever possible.
- In an institution with an outbreak, inmates must be served individualized food trays (if possible individual recyclable paper/cardboard containers) to reduce exposures related to sharing a kitchen. Where possible, individualized food trays are recommended at site without an outbreak, particularly heavily populated institutions.
- Consider transmission potential/prevention where laundry machines are located next to in-use self serve food preparation in a common area.

Laundry

In an outbreak: double bag contaminated laundry (e.g. cloth PPE and patient laundry) and wash at centralized laundry facility, if available. All staff providing direct care to COVID patients who have contact with soiled bedding/linens/laundry must consider additional precautions (e.g. gown and gloves) and practices for handling, including placement in a dedicated soiled linen container.

Ensure there are frequent and enhanced cleaning of the personal (e.g. on unit) laundry machines in between use.

Waste from Cells/Rooms

Process for daily disposal of waste in an outbreak: double bag and dispose of in accordance with municipal guidelines.

Cleaning

Note: Cleaning best practices for Health Centres and Regional Hospitals[xv] are available on the Hub. These practices are expected to be in place at all institutions. In outbreak situations, these practices are to be extended to all institutional areas as appropriate and the following guidance, along with the COVID-19 Cleaning and Disinfecting Guidance and Cleaning and Disinfecting Cells and Public Spaces[xvi] is intended to augment these practices.

Ensure that all cleaning and disinfecting products that are used are on the PHAC approved list[xvii]. Ensure PHAC/HC approved disinfection products, as well as readily available cleaners, are used according to manufactures instruction and contact time.

General Cleaning

- **In an outbreak**, close all impacted areas (i.e. unit and works areas with a suspected or confirmed COVID-19 case) of the institution to enable a deep clean/disinfection.
- Inmate cells in impacted areas must also be thoroughly cleaned and disinfected.
- Review cleaning procedures in detail, in consultation with an IPC expert.
- **Documented quality Improvement spot checks to support adherence to proper cleaning standards.**

Cleaning of Inmate Rooms

- Supplies are provided for inmates to clean and disinfect their room, using approved disinfecting products. Encourage and support inmates to **declutter their living area** to facilitate regular, effective cleaning. This might require storage of cell contents on behalf of inmates.
- **Documented cleaning inspection and education process must be put in place (by the contract cleaner or staff).**

Cleaning of Shared Spaces

- **Declutter:** Removal of all non-essential equipment and materials stored in hallways and common areas.
- Laundry machines/microwave must be cleaned and disinfected before and after use and a schedule for access must be established.
- Showers and sinks must be cleaned and disinfected before and after use, including shower curtains (launder or use disposable shower curtains).
- **Quality improvement spot checks to support adherence to proper cleaning standards and re-education to support effectiveness.**

Cleaning of Shared Equipment

- Telephones must be cleaned and disinfected before and after use, high contact surfaces (light switches; door surfaces), keys, PPAs, pens, electronic scanning/metal detectors. Ensure PHAC/HC approved disinfection products, as well as readily available cleaners, are use according to manufactures instruction and contact time.
- Cleaning transport vehicles (see Memorandum[xviii]).
- **Quality Improvement Spot checks to support adherence to proper cleaning standards and re-education to support effectiveness.**

Cleaning of Health Care Centres (and treatment room outside of HCC)

- **Declutter:** Removal of all non-essential equipment and materials stored in hallways and common areas.
- **Quality improvement spot checks to support adherence to existing Health Care Guidelines.**

Hand Hygiene

- Provide continuous guidance to staff and inmates on hand hygiene and respiratory etiquette.
- Make 60% alcohol based hand sanitizer available for inmates, with appropriate oversight as needed. For example, if unsupervised access is a risk, make it available when staff are present or for certain hours of the day.
- Make 60% alcohol based hand sanitizer available to staff in appropriately situated work areas (e.g. near computers, desks, phones, filing cabinets, control monitoring stations, etc.).

Personal Protective Equipment (PPE)

Health Care providers and staff will use PPE as per the Guidance document[ix].

- Donning and doffing stations are located conveniently, to facilitate desired flow of personnel from clean to protected zones and designed to facilitate the procedural steps required. There must also be strategically located no-touch receptacles for disposal of PPE and monitoring and disposal to prevent overflow. Proper hand hygiene is always part of donning and doffing.
- Donning and doffing is a collegially observed activity (i.e. buddy) and corrected to ensure proper technique (improper donning and particularly doffing can increase the risk of spreading the virus if present).
- Implement education and improvement approach for staff not wearing PPE or not wearing PPE correctly (i.e. it is everyone's responsibility, but a staff as specified at the site must be assigned to monitor, remind, and train staff).
- Process for safe, extended use (re-use) of masks based on available supply is established; planning service delivery to reduce the number of masks used (for example, same mask for cohort groups; see PPE guidance[ix]).
- Posters illustrating donning and doffing are strategically situated as education and reminders.
- Confirm that formal training on donning and doffing has been completed at the site and is available to staff and patients on request. Ensure that staff training is tracked in HRMS.
- Donning and doffing stations are established with clean and protected zones facilitating one-way flow of personnel.

Inmate Communication and Engagement

- Health staff to consult the document on guidance for communication and engagement with patients about COVID-19[xix].
- It is important that inmates understand the rationale for infection prevention and control measures and the benefits to them personally and the institutional community as a whole.
- Provide information on infection prevention and control reasons why the staff are using PPE during higher potential risk activities (e.g., clean- protected person buddy system for medical activities with inmates).
- Explain the requirements for sharing of information with local public health agencies and hospitals, as part of public health safety and infection prevention control within the institutional community.
- Seek inmate suggestions on how best to achieve effective infection prevention and control measures.
- Posters and written information on COVID-19 are provided to inmates and updated as required. Provide communication on inmate television monitors, where feasible.
- Ongoing COVID-19 related meetings with inmate committees and individual inmates.
- Use wellness checks as a means to promote education and answer questions for inmates on medical isolation.

Clinical Coverage and Human Resources Organization

Physician

- Where feasible, increase the number of days, in person and remotely accessible (e.g. telehealth), so that a physician is available 7 days per week and maintain availability of on-call (standby) physician coverage after hours.

Health Care Staff

- Where feasible, develop plans to expand availability of non-physician coverage by health care at "COVID unit" (e.g. zone specified for offenders who have tested positive for COVID).
- Ongoing recruitment for health care staff, including specialists in infection prevention and control, to maintain and expand services where required.

Health Care Staff Rosters

- Establish, where possible and in consultation with the union, two staff rosters with limited to no overlap between the staff groups, in order maximize physical distancing and reduce cross contamination. Where two rosters are not possible, the use of zones to limit the potential for cross contamination may also be used.

- Where possible, avoid staff working at more than one site or at additional sites outside of CSC (e.g. hospitals). Recognize that this may not be possible in the context of staff shortages. When working at more than one site is necessary, mitigate: a) by duration of assignment (weeks vs days at the same site); b) use of separate office space (if available) and ensure thorough cleaning before and after usage.
- Integrated provision of care, whereby all health care providers (nurses, psychologists, mental health practitioners, social workers, occupational therapists, etc.) are providing care in their area of expertise (counselling and support; suicide assessment; mental health treatment; inmate communication and engagement; family contact; spiritual care; etc.), as well as supporting general care provision (inmate assessment, wellness checks, etc.).

Clinics and Organization of Health Care Service Delivery

- Consult the document on guidance for communication and engagement with patients about COVID-19[xix].
- Working together, the physician leads (primary care and psychiatry), institutional physicians, nurse practitioner, and Chief Health Services and Chief Mental Health Services, review essential services and determine the most effective, efficient, and safe way of organizing services. For example: review specialty clinics and establish alternative ways of delivering service (for example, OAT administered at the cell … Suboxone with or without post security observation – security decision; exchange of supplies for PNEP at the cell; etc.).
- Each site must establish a list of individuals who are at higher risk for severe illness as defined by the CDC and PHAC[xx].
- Consider the use of telemedicine technology both within the institution (physician/NP/ mental health, etc., in one room and the patient in another area); and externally (consultation, assessment, and treatment via video from the community or regional office or hospital, etc.).
- Dental, optometry, physiotherapy on basis of urgency and in the absence of alternative (rely on primary care physician's judgement. Consider the advice of the respective provincial governing bodies and revise as needed.

Contact Tracing Team Lead[xxi]

- Contact tracing is an important IPC mechanism in managing the spread of the virus to staff/inmate. Through contact tracing, close contacts are identified and decisions are made about whether or not they need to be away from the work site.
- Each Region must have a lead for contact tracing, who is trained in the process and proficient in the use of the designated Infopoint. Understand the protocols for isolation,

return to work, and early return to work (always in consultation with the local public health agency).

Collaboration with Local Public Health Agency

There must be a **verifiable documented process** for the following:

- Contact person(s) for local public health (not just a number to call) for daily reporting to public health (**use of required local public health agency forms**); ongoing verbal discussions with local public health agency.
- Systematic documentation on all information that is shared with local public health agencies.
- Ensure inmates understand CSC's requirement to share certain information, the rationale and benefits to them personally and to the overall institutional community, the external community (public health safety), and hospitals.
- Process for accessing swabs (i.e. if CSC purchased swabs that are not used by the local labs), testing, documenting, etc.
- Work to establish local infection prevention control committee with representation from local public health (grouped according to local public health catchment area. The committee should include senior operations; Elder, etc.).
- National Headquarters, Health Services is informed of sharing of personal health information in order to inform the Office of the Privacy Commissioner

Hospital Contact

There must be a **verifiable documented process** for the following:

- Specific contact with the local hospital (the primary care physician lead should be the main CSC contact).
- Protocol for admission and discharge (inclusive of the threshold of care possible in the institution in combination with CSC's 24/7 continuing/transitional care unit).
- Clinical care guidance outlines the requirements for a continuing/transitional care 24/7 unit (oxygen; IV etc.).
- Protocol for contacting an appropriate individual at a hospital in the event of an inmate escort to determine and confirm hospital policies, practices, controls, and PPE for the inmate and escorting staff.

Sharing of Information

There must be a **verifiable documented process** for sharing information with public health agencies and health authorities.

Daily Reporting

Reporting on the following (as per the CSC COVID-19 Testing).

- Hospitalization
  - CSC hospital or infirmary
  - Outside hospital
- Positive, negative, inconclusive, pending
- Recovery
- Death
- Staff positive cases, work refusals and office closures (monitored by labour relations)

Inmate Release

- See guidance document on inmate releases[xxii].
- Release of inmates to the community must be planned in consultation with local public health and in accordance with legislative requirements.

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[i] Draft - Updated April 30, 2020; Revised May 4 2020, inclusive of feedback from Public Health Agency of Canada. Revised May 10, 2020 based feedback received from Labor Relations/Occupational Health & Safety, Regional Deputy Commissioners and National Health and Safety Policy Committee.

[ii] Signs or symptoms may include:
- Fever (temperature of 37.8°C or greater), OR
- Any new or worsening respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, hoarse voice, sore throat or difficulty swallowing), OR
- Any new onset atypical symptoms including but not limited to chills, muscle aches, diarrhea, malaise, or headache.

[iii] Public Health Agency of Canada (May 12, 2020). https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html

[iv] Public Health Agency of Canada. https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html

[v] See Appendix A Contact Tracing Guidelines for definition of close and casual contact.

[vi] Principles provided by Mike Kekewich and Dr Jacky Parker, Department of Clinical and Organizational Ethics, The Ottawa Hospital.

[vii] COVID-19: Screening Questions

[viii] Alcohol based hand sanitizer must be at least 60% alcohol.

[ix] COVID-19 Update Personal Protective Equipment

[x] Inmates COVID-19 Brief Screening for Use by Operations

[xi] COVID-19 Screening Form for Use by Healthcare

[xii] New Warrants of Committal/Returns to Federal Custody and Symptomatic Inmates Algorithms and Commissioner's Directive 822, *Medical Isolation and Modified Routine for COVID-19*

[xiii] Inmate education on infection and prevention (cough/sneezing hygiene; handwashing; physical distancing; cleaning living area)

[xiv] Tip No.84 New COVID-19 Measurements Documentation

[xv] Cleaning Best Practices for Health Services

[xvi] COVID-19: Cleaning and Disinfecting Guidance and Cleaning and Disinfecting Cells and Public Spaces

[xvii] The Public Health Agency of Canada lists approved hard surface disinfectants for emerging viral pathogens https://www.canada.ca/en/health-canada/services/drugs-health-products/disinfectants/covid-19/list.html

[xviii] Memorandum CSC COVID-19 Preparedness: Cleaning Requirements

[xix] Guidance on Staff Communication and Engagement with Patients about COVID-19

[xx] Based on what we know now, those at high-risk for severe illness from COVID-19 are:
- People 65 years and older

People of all ages with underlying medical conditions, particularly if not well controlled including:

- People with chronic lung disease or moderate to severe asthma
- People who have serious heart conditions
- People who are immunocompromised
    - Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications
- People with severe obesity (body mass index [BMI] of 40 or higher)
- People with diabetes
- People with chronic kidney disease undergoing dialysis
- People with liver disease

https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html

- People with hypertension (https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/diseases-conditions/people-high-risk-for-severe-illness-covid-19/coronavirus-factsheet-people-at-high-risk-en.pdf)
- Monitoring Vulnerable Individuals for COVID-19: Health Services Practice Reminder

[xxi] COVID-19 Contact Tracing Guideline; COVID-19 Contact Tracing Poster, Manager's Guide COVID-19: Contact Tracing of Symptomatic Employee/Contractor, Symptomatic Employee/Contractor Guide - Contact Tracing for COVID-19, Return to Work for Staff/Contractor Algorithm, and Contact Tracing of Symptomatic Employee/Contractor Algorithm

[xxii] Bulletin Case Management: Release/Discharge Planning in Light of COVID-19; Discharge Planning for COVID-19: Health Services Practice Reminder

FILE PATH	FILE NAME	ITEM TYPE	DATA ID	VERSION	STATUS	DETAILS
	asymptomatic-screening-patient-journey.pptx	Document	53450958	1	Succeeded	
	consideration-medical-isolation-hs-practice-reminder.docx	Document	53400963	1	Succeeded	
	contact-tracing-all-staff-guide.docx	Document	53401949	1	Succeeded	
	contact-tracing-guideline-august5.docx	Document	53459149	1	Succeeded	
	contact-tracing-managers-guide.docx	Document	53400069	1	Succeeded	
	covid-dental-guidelines-july9.docx	Document	53457138	1	Succeeded	
	high-risk-individuals-patient-journey.pptx	Document	53457841	1	Succeeded	
	hospital-discharge-form.docx	Document	53401071	1	Succeeded	
	institutional-checklist-ipc-front-entrance-december10.docx	Document	53459355	1	Succeeded	
	institutional-checklist-ipc-mask-wearing.docx	Document	53403817	1	Succeeded	
	intake-algorithm-e.pptx	Document	53400959	1	Succeeded	
	inter-intra-regional-transfers-patient-journey.pptx	Document	53459148	1	Succeeded	
	ipc-evaluation-guidelines.docx	Document	53450962	1	Succeeded	
	ipc-preparedness-checklist.docx	Document	53459154	1	Succeeded	
	return-hospital-patient-journey.pptx	Document	53400279	1	Succeeded	
	return-temporary-absence-patient-journey.pptx	Document	53402828	1	Succeeded	
	return-work-staff-contractors.pptx	Document	53403816	1	Succeeded	
	screening-form-for-healthcare.docx	Document	53401954	1	Succeeded	
	screening-form-for-operations.docx	Document	53457843	1	Succeeded	
	symptomatic-employee-contractor-guide.docx	Document	53399727	1	Succeeded	
	symptomatic-inmates-algorithm.pptx	Document	53400961	1	Succeeded	
	symptomatic-staff-algorithm.pptx	Document	53457136	1	Succeeded	
	testing-strategy-covid19-july8.docx	Document	53456825	1	Succeeded	
	testing-strategy-covid19-november5.docx	Document	53402381	1	Succeeded	

Patient Journey: **COVID-19** Return from Outside Medical Visits

August 21, 2020
(previous version June 23, 2020)

Return from a Hospital Admission

Immediately begin medical isolation[1]

HS to confirm that discharging physician provided recommendations for medical isolation per Hospital Discharge Form: Recommendations for Medical Isolation. It may be necessary for HS to contact the discharging hospital if no recommendation was provided upon discharge.

Operations Screening upon return

Ask all screening questions. Document using a logbook for those who answer 'No' to all questions, and the Screening Form for use by Operations only for those who answer 'Yes' to any question.

Health Services Screening[2]

COVID-19 Screening Form For Use By Healthcare

'No' to all questions AND the institutional clinician (physician or nurse practitioner) recommends that medical isolation is NOT required (taking into account the recommendation from the discharging physician)

Return to range/house

Return from a Day / Ambulatory Visit

Operations Screening upon return

Ask all screening questions. Document using a logbook for those who answer 'No' to all questions, and the Screening Form for use by Operations only for those who answer 'Yes' to any question.

'Yes' to any question

Immediately begin medical isolation[1]

Health Services Screening

COVID-19 Screening Form For Use By Healthcare

'No' to all questions

Return to range/house

'No' to all questions

Return to range/house

'Yes' to any question OR the institutional clinician (physician or nurse practitioner) recommends that medical isolation IS required (taking into account the recommendation from the discharging physician)

New entry in InfoPoint COVID-19 Linelist

Test[3]

Add swab date, results, and result date in InfoPoint COVID-19 Linelist

COVID-19 Positive Test OR No Test/Consent to Test Not Provided

In addition to general medical isolation protocol:
- **Twice** daily medical isolation wellness assessments (documented in OHIS-EMR measurements) and treatment as required.
- Update InfoPoint Linelist as necessary (for example, addition of new symptoms or date of recovery).
- Discontinue medical isolation when medically cleared:
  - If symptomatic: no earlier than 10 days after onset of symptoms with at least 2 days symptom free
  - If asymptomatic: 14 days from the date of the test
  - **OR** 14 days from date of return if no test
- Begin contact tracing.
- Notify local public health of positive test result.

COVID-19 Negative Test

Institutional clinician (physician or nurse practitioner) to use clinical judgment to determine a recommendation for medical isolation.
See Practice Reminder on Considerations for Discontinuing Medical Isolation. Potential courses of action include:
- Continuing medical isolation
- Implementing modified routine[4]
- Considering a second test 4-5 days after the first test

Institutional clinician must document rationale regarding recommendations for medical isolation in OHIS-EMR.

Updates
- Title change: from 'hospitalization' to 'outside medical visits'
- For overnight admissions, institutional clinician to determine medical isolation requirements (considering recommendation of discharging physician)
- Only Operations Screening required upon return from day visit if asymptomatic.
- Adjusted two categories at the top of the map (overnight vs. day visit – not separated by outbreak status)
- Test for symptomatic inmates is at clinician discretion (worked in option for 'no test')
- Operations screening now documented by logbook for those who answer 'no' to all questions, the form is only used if inmate answers 'yes' to any screening question

Notes
Staff should engage with inmates to explain the rationale for medical isolation and provide information about the associated protocols. Inmates should be educated on the importance of other infection prevention and control measures, such as hand hygiene, wearing a mask, and maintaining a distance of 2m from others. If concerns arise about inmates following any of the recommended measures noted in this algorithm, institutional management should discuss to determine appropriate response.

1. All medical isolation to include:
   - Update medical isolation flag in OMS
   - Daily medical isolation wellness assessments documented in OHIS-EMR measurements
   - Inmates to clean/disinfect all things they touch when outside cell (phone, tables, etc.), wash hands prior to leaving cell and upon returning, wear mask when out of cell, maintain 2m distance from others when out of cell
   - Where possible, in a separate physical area or designated medical isolation cell
   - Update InfoPoint Linelist as necessary (for example, addition of new symptoms or date of recovery)
   - Staff to follow PPE Guidance
   - Complete Form 1620 (Medical Isolation Form)

2. If the inmate returns from a hospital admission outside of Health Services business hours, the inmate continues medical isolation until the Health Services Screening can be performed.

3. If hospital admission was related to a COVID-19 diagnosis or if the patient was previously tested while at the hospital, any additional testing is at the discretion of the institutional clinician (physician or nurse practitioner).

4. Modified routine in this instance refers to range level movement within the institution.

Patient Journey: COVID-19
Temporary Absences
August 21, 2020

Non-Medical Overnight Temporary Absences and PFVs

Immediately begin medical isolation[1]

Operations Screening upon return

Ask all screening questions. Document using a logbook for those who answer 'No' to all questions, and the Screening Form for use by Operations only for those who answer 'Yes' to any question.

Health Services Screening

COVID-19 Screening Form For Use By Healthcare

'No' to all questions

No symptoms develop → Continue medical isolation for 14 days, discontinue on day 15

Symptoms develop

New entry in InfoPoint COVID-19 Linelist

→ Refer to *Patient Journey for Symptomatic Inmates and Close Contacts*

'Yes' to any question

New entry in InfoPoint COVID-19 Linelist

→ Refer to *Patient Journey for Symptomatic Inmates and Close Contacts*

Notes

Staff should engage with inmates to explain the rationale for medical isolation and provide information about the associated protocols. Inmates should be educated on the importance of other infection prevention and control measures, such as hand hygiene, wearing a mask, and maintaining a distance of 2m from others. If concerns arise about inmates following any of the recommended measures noted in this algorithm, institutional management should discuss to determine appropriate response.

Non-Medical Temporary Absences and Work Releases (daily returns to the institution)

Operations Screening upon return

Ask all screening questions. Document using a logbook for those who answer 'No' to all questions, and the Screening Form for use by Operations only for those who answer 'Yes' to any question.

'Yes' to any question

Immediately begin medical isolation[1]

Health Services Screening

COVID-19 Screening Form For Use By Healthcare

'Yes' to any question

New entry in InfoPoint COVID-19 Linelist

→ Refer to *Patient Journey for Symptomatic Inmates and Close Contacts*

'No' to all questions

→ Return to range/house

Health Services to educate inmate on how to monitor for symptoms for the next 14 days and report any symptom immediately (document interaction in OHIS-EMR)

'No' to all questions

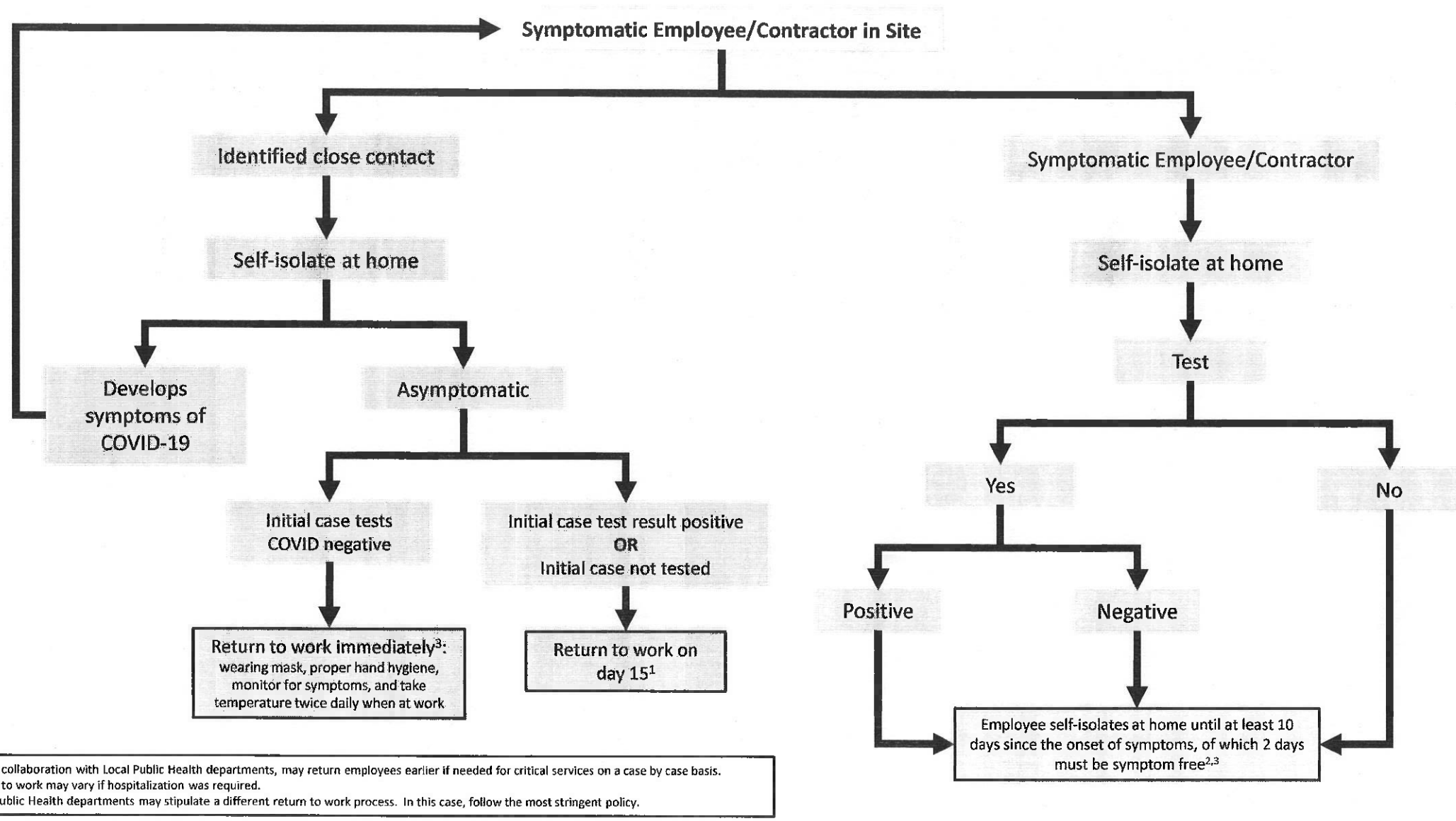
→ Return to range/house

Health Services to educate inmate on how to monitor for symptoms for the next 14 days and report any symptom immediately (document interaction in OHIS-EMR)

1. All medical isolation to include:
   - Update medical isolation flag in OMS
   - Daily medical isolation wellness assessments documented in OHIS-EMR measurements
   - Inmates to clean/disinfect all things they touch when outside cell (phone, tables, etc.), wash hands prior to leaving cell and upon returning, wear mask when out of cell, maintain 2m distance from others when out of cell
   - Where possible, in a separate physical area or designated medical isolation cell
   - Update infoPoint Linelist as necessary (for example, addition of new symptoms or date of recovery)
   - Staff to follow PPE Guidance
   - Complete Form 1620 (Medical Isolation Form)

May 8, 2020

Return to Work for Staff / Contractor



1. CSC, in collaboration with Local Public Health departments, may return employees earlier if needed for critical services on a case by case basis.
2. Return to work may vary if hospitalization was required.
3. Local Public Health departments may stipulate a different return to work process. In this case, follow the most stringent policy.

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PROTECTED **B** ONCE COMPLETED

PERSONAL INFORMATION BANK

COVID-19 SCREENING FORM FOR USE BY HEALTHCARE To be completed: • As part of the intake process with form 1244 • When an asymptomatic inmate develops symptoms • Upon return from an outside hospital • Prior to transfer to another institution • Prior to release to the community		**SEND FORM TO HEALTH CARE** FPS Number (if possible): Family name: Given name(s): Date of birth:
Region:	Institution:	Date Completed:

A. Is the person presenting with:		
□Yes □No	Fever (temperature of 38°C or greater)?	Date of symptom onset (YYYY/MM/DD)
□Yes □No	Any respiratory symptoms (cough, shortness of breath, runny nose or sneezing, nasal congestion, sore throat, difficulty swallowing)? Please specify: _____	Date of symptom onset (YYYY/MM/DD)
□Yes □No	Any atypical symptoms (including but not limited to chills, muscle aches, diarrhea, malaise, headache)? Please specify: _____	Date of symptom onset (YYYY/MM/DD)
B. In the 14 days before onset of illness, has the patient:		
□Yes □No	Had **close** contact with a confirmed case or case under investigation of COVID-19?	Date of contact (YYYY/MM/DD)
□Yes □No	Had **close** contact with a symptomatic individual?	Date of contact (YYYY/MM/DD)

□ Yes to any one of A or B	**□ No to all the above questions**
• Refer to the relevant algorithm • Provide treatment as required	• Refer to the relevant algorithm • Monitor for symptoms

Personal information will be protected under the provision of the *Privacy Act*. The information is stored in the Standard Bank # 060.
Original: Copy Offender Health file

2020-07-09

00060

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PROTECTED **B** ONCE COMPLETED

FOR INMATES

INMATES COVID-19 BRIEF SCREENING for use by Operations To be completed: • For all new WOC and inmates returning to federal custody • For inmates returning from an outside hospital outside of Health Services business hours		**SEND FORM TO HEALTH CARE** FPS Number (if possible): Family name: Given name(s):
Region:	Institution:	Date Completed:

1. In terms of how you are feeling today:	
□ Yes □ No	Do you feel like you have a fever?
□ Yes □ No	Are you experiencing any respiratory symptoms (such as cough, shortness of breath, runny nose, sneezing, nasal congestion, sore throat, difficulty swallowing)?
□ Yes □ No	Are you experiencing any strange symptoms (such as chills, muscle aches, diarrhea, headache, loss of taste or smell)?
2. In the past 14 days:	
□ Yes □ No	Have you had **close** contact* with someone who has been tested for COVID-19?
□ Yes □ No	Have you been in **close** contact* with a symptomatic person?

□ **'Yes' to any of the above:**	□ **'No' to all of the above:**
• Begin medical isolation • Provide mask • Notify Health Services of 'yes' response • Health Services Screening to follow	• Begin medical isolation, unless inmate is returning from outside hospital (refer to *the Patient Journey: Algorithm for return from hospitalization*) • Provide mask • Health Services Screening to follow

***Close contact** is defined as:
- Shared a close, confined space for 2 hours
- Close, face-to-face interaction for 15 minutes within 2m distance (may be cumulative)
- Household contacts (living or sleeping in the same home)

Note: If appropriate PPE was worn the individual is not a close contact

2020-07-08

Symptomatic Employee/Contractor Guide

Contact Tracing for COVID-19

April 17, 2020

COVID-19 is a highly transmittable virus. There is evidence that asymptomatic transmission is occurring, therefore CSC has adopted a vigorous, adaptive approach to preventing the spread of this virus. Contact tracing is a strategy for breaking transmission chains and controlling the spread of virus. It involves identifying infected persons, taking steps to prevent an infected person from further spreading infection, identifying those with whom the infected person may have been in close contact with while infectious, and locating and testing close contacts.

If you develop symptoms or are diagnosed with COVID-19, contact your manager immediately.

You will be provided the following information and instructions:

1. Your manager will discuss with you your symptoms, when they began, and any close contacts you may have (see Appendix A for definition of close contact).

2. With the help of your manager, compile a list of potential work close contacts to facilitate the contact tracing process. See definition of close contacts in box below for further information.
   - For example, those you shared an enclosed space for more than 2 hours or had more than 15 minutes face-to-face conversation within 2m.

3. The contact tracing process will then be initiated, which involves contact tracing teams reaching out all work contacts from the 48hr period prior to symptom onset.
   - This will help contain the spread of COVID-19.
   - Specific symptoms and testing results will not be disclosed in this process. Work contacts will only be notified that you are experiencing symptoms.

4. You will be instructed to call Public Health (PH) for testing
   - It is important that you notify PH that you are an essential worker with priority testing.
   - If you are denied testing, notify management for assistance immediately.

5. Your manager will inform you of your date to return to work.
   - If your local PH advises a different return to work, report to manager and contact tracing lead[1].
   - The most stringent of the two policies will be followed. Report your actual date back to work to contact tracing team leads by email

If you require support in these unprecedented times, you are encouraged to reach out to an EAP referral agent. Lists of agents are available on the hub (EAP Referral Agents and Regional Contacts page) or by contacting EAP-CISM/PAE-GSIC.GEN@CSC-SCC.GC.CA. You may also contact the Employee Assistance Services at 1-800-268-7708. It is available 24/7.

Contact your manager for any further information or assistance.

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1 **Regional Contact Tracing Leads**
ATL: Renée Gagnon (506) 851-236 ONT: Allison Storring (613) 545-8159 QUE: Marie-Helene Dufresne (438) 988-5082 and Simon Bégin (418) 284-5285 PRA: Shannon Harriman-Gerard (306) 220-5142 PAC: Kuljeet Randhawa (604) 851-3224 and Clarence Turgeon (343) 548-9024

Appendix A
Close Contact Definition

Close contact of a case:

a. An individual who has greater than 15 minutes face-to-face (<2 meters distance) contact with a case/symptomatic individual, in any setting (this may be cumulative, ie. multiple interactions).
b. Healthcare workers who have not worn appropriate PPE or had a breach in PPE during the following exposures to the case/symptomatic individual:
    - Health care workers performing assessments, vital signs, etc.
    - Direct contact with the case/symptomatic individual, their body fluids or their laboratory specimen
    - Present in the same room, without appropriate PPE, when an aerosol generating procedure is undertaken on the case/symptomatic individual.
c. Individuals in the same accommodations as a case/symptomatic individual sharing kitchen, bathroom facilities, living area.
    - Inmates sharing a range, house or cell
d. Correctional officers who had prolonged close contact for more than 15 minutes (within 2 metres) with a case/symptomatic individual who have not worn appropriate PPE or had a breach in PPE during the following exposures to the case/symptomatic individual while
    - Performing physical searches, pat downs, finger printing, interviewing, home visits, etc.)
    - Direct contact with the case/symptomatic individual, their body fluids
e. Contacts who have shared a closed space with a case/symptomatic individual for longer than two hours, taking into consideration the size of the room, ventilation and the distance from the case/symptomatic individual.

Patient Journey: COVID-19
Symptomatic Inmates and Close Contacts

August 21, 2020 (previous version June 23, 2020)

Updates
- For symptomatic inmates that test negative, the institutional clinician (physician or NP) can use clinical judgement to determine recommendations for medical isolation and MUST document rationale.
- Clarification of date of discontinuation of medical isolation for range or close contacts
- Added 'where possible' for separate physical area for medical isolation
- If clinician does not clear index case earlier, added that range/close contacts should continue medical isolation for 14 days
- Added reminder to complete Form 1620 for medical isolation
- Added those who do not consent to be tested (both symptomatic inmates and close contacts) to follow the same guidance as those who are positive

Symptomatic Inmate

COVID-19 Screening Form For Use By Healthcare, new entry in InfoPoint COVID-19 Linelist, begin contact tracing

Immediately begin medical isolation

Twice daily medical isolation wellness assessments (documented in OHIS-EMR measurements) and treatment as required

Test

Add swab date, results, and result date in InfoPoint COVID-19 Linelist

COVID-19 Positive Test OR Consent to Test Not Provided

In addition to general medical isolation protocol:
- Discontinue medical isolation when medically cleared, no earlier than 10 days after onset of symptoms with at least 2 days symptom free.
- Notify local public health of positive test result.

COVID-19 Negative Test

Institutional clinician (physician or nurse practitioner) to use clinical judgment to determine a recommendation for medical isolation. See Practice Reminder on Considerations for Discontinuing Medical Isolation.
Potential courses of action include:
- Continuing medical isolation
- Implementing modified routine[2]
- Considering a second test 4-5 days after the first test

Institutional clinician must document rationale regarding recommendations for medical isolation in OHIS-EMR.

Asymptomatic inmate(s) living on same range/house as index case or close contact(s) [1]

Modified routine[2] for cohort (range or house) until index case test results received[3]

Index case test result negative

Cohort continues modified routine[2]:
- Until the index case is medically cleared by institutional clinician OR
- For 14 days from the date of index case symptom onset OR from the date of last exposure[4] (whichever is most recent), discontinue on day 15

Index case test result positive OR index case does not provide consent for test

Immediately begin medical isolation for range/close contacts[5]

Testing of range/close contacts

New entry in InfoPoint COVID-19 Linelist, add swab date, results, and result date in InfoPoint COVID-19 Linelist

COVID-19 Positive Test OR Consent to Test Not Provided

In addition to general medical isolation protocol:
- Twice daily medical isolation wellness assessments (documented in OHIS-EMR measurements).
- Begin contact tracing.
- Notify local public health of positive test result.

No symptoms develop

Continue medical isolation for 14 days from date of test, discontinue on day 15

Symptoms develop

Return to top of patient journey map (for both the symptomatic inmate and their range/close contacts)

COVID-19 Negative Test

No symptoms develop

Continue medical isolation for 14 days from the date of index case symptom onset OR from the date of last exposure[4] (whichever is most recent), discontinue on day 15

Symptoms develop

Return to top of patient journey map (for both the symptomatic inmate and their range/close contacts)

All medical isolation to include:
- Update medical isolation flag in OMS
- Daily medical isolation wellness assessments documented in OHIS-EMR measurements
- Inmates to clean/disinfect all things they touch when outside cell (phone, tables, etc.), wash hands prior to leaving cell and upon returning, wear mask when out of cell, maintain 2m distance from others when out of cell
- Where possible, in a separate physical area or designated medical isolation cell
- Update InfoPoint Linelist as necessary (for example, addition of new symptoms or date of recovery)
- Staff to follow PPE Guidance
- Complete Form 1620 (Medical Isolation Form)

1. CHS in collaboration with site management may identify additional inmates as close contacts of the symptomatic individual (that do not live on the same range/house). These close contacts will also be medically isolated.
2. Modified routine in this instance refers to range level movement within the institution.
3. Identified close contacts from a different range than index case can await index case test results either in medical isolation in own cell, or on modified routine in a cell on index case's range. Inmate should be given the choice between the two options, as long as it is feasible to move close contact to index case range based on operational and security considerations.
4. In most cases, the date of last exposure will be the date the index case was removed from the range/began medical isolation.

Note: Staff should engage with inmates to explain the rationale for medical isolation and provide information about the associated protocols. Inmates should be educated on the importance of other infection prevention and control measures, such as hand hygiene, wearing a mask, and maintaining a distance of 2m from others. If concerns arise about inmates following any of the recommended measures noted in this algorithm, institutional management should discuss to determine appropriate response.

May 8, 2020

Contact Tracing of Symptomatic Employee/Contractor

Symptomatic Employee/Contractor

Contact site Manager

- Manager advises employee/contractor that Contact Tracing will occur and all work contacts from the 48hr period prior to symptom onset will be contacted to contain the spread of COVID-19.
  - if asymptomatic: contact tracing will occur from the day of the test
- Instruct employee/contractor to call Public Health for testing.
- Provide information on date and protocol for return to work.
- Work with employee/contractor to compile list of potential work contacts and send to tracing team.

Staff was in contact with inmates

Contact Health Services

Tracing is completed by Health Services for inmate contacts

Symptomatic staff was on site during the 48 hour period

Site sends contact list to the Tracing Team and tracing is initiated.

Tracing results are sent back to site identifying casual, close and symptomatic individuals

Symptomatic staff was NOT on site during the 48 hour period

Contact tracing is not required

Any symptomatic staff identified during the tracing process will require review and possible initiation of new tracing event

Close contacts of symptomatic staff must self-isolate until test results are received for the index case.

Casual contacts are able to return to work while self monitoring for symptoms

Index case receives a negative result

Close contacts are able to return to work[1] while self monitoring for symptoms.[2]

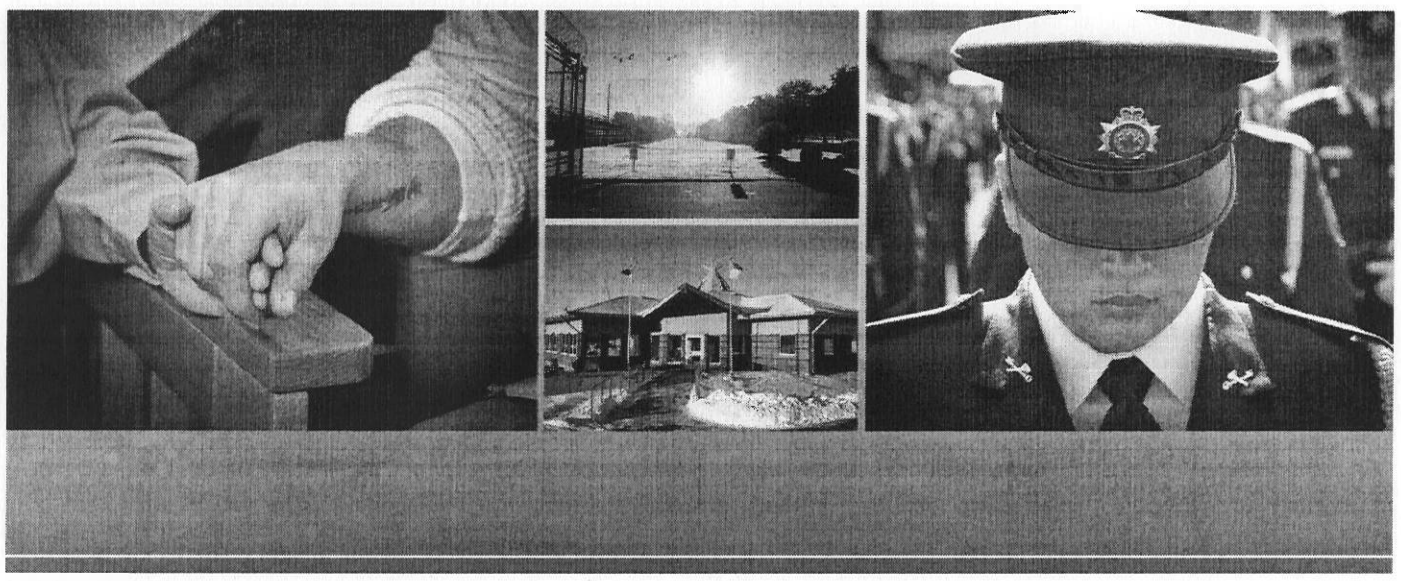
Index case receives a positive result

Close contacts remain at home for 14 days and are advised to follow the direction of Local Public Health.[3]

1. CSC, in collaboration with Local Public Health departments, may return asymptomatic employees earlier if needed for critical services on a case by case basis.
2. Should a close contact develop symptoms, follow this algorithm and the return to work algorithm from the beginning.
3. Local Public Health departments may stipulate a different return to work process. In this case, follow the most stringent direction.

CORRECTIONAL SERVICE CANADA

CHANGING LIVES. PROTECTING CANADIANS.



COVID-19 Testing Strategy

JULY 8, 2020

Document History

Revision Date	Document Section	Description of Revisions
May 13, 2020		Document was created.
May 22, 2020	Updates made throughout the document.	Expanded the introduction to the testing strategy; extended the strategy to include CCCs; new additions were made to the symptomatic testing strategy regarding asymptomatic contacts; added a section regarding testing new Warrants of Committal and returns to federal custody; extended the proportion of staff/contractors eligible for asymptomatic screening in the context of elevated community transmission.
June 18, 2020	Updates made to throughout the document.	Testing strategy now includes intakes and releases, as well as extends asymptomatic screening to all staff/contractors and all offenders at identified at-risk sites. Document reorganized to improve the structure and flow.
July 8, 2020	Added Appendix A.	The consent form for the disclosure of COVID-19 testing information upon release (Appendix A) may be used to obtain voluntary, informed consent from offenders who agree to COVID-19 testing and who agree to have their testing information released to community partners for discharge planning

COVID-19 Testing Strategy

Purpose

CSC's COVID-19 Testing Strategy is intended to support clinical decision-making, with respect to COVID-19 testing, within CSC institutions and Community Correctional Centres (CCCs).

Specific scenarios where testing is universally warranted to contain and prevent the spread of COVID-19 within CSC institutions/CCCs is provided.

In addition to the specific testing scenarios outlined below, physicians and/or nurse practitioners may also order COVID-19 tests, based on their clinical judgement. Like all diagnostic tests, testing for COVID-19 require physician or nurse practitioner authorization and patient consent.

Introduction

In response to the COVID-19 public health risk, CSC has implemented a series of comprehensive measures to prevent and contain the spread of the virus in federal institutions and CCCs. The COVID-19 Testing Strategy is meant to compliment, not replace, these efforts. Testing, even when done on a large scale, does not replace the need for timely contact tracing and diligent implementation of infection prevention and control measures.

This strategy outlines the scenarios within which timely testing can contribute to identifying and/or preventing the introduction of COVID-19 within CSC institutions and CCCs, and facilitating prompt implementation of containment measures. These scenarios include:

- Testing on **intake and release**;
- Early screening of **symptomatic staff/contractors and offenders**, and their contacts (both symptomatic and asymptomatic); and
- **Asymptomatic screening** in the context of elevated community transmission.

COVID-19 Symptoms

COVID-19 can present in many different ways, often with very mild symptoms. Early identification of any symptom and prompt testing is critical. Symptoms may include:

- Fever;
- Any respiratory symptoms (such as dry 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, malaise, loss of taste or smell).

Intake and Release

Testing Guidance

CSC is extending voluntary asymptomatic testing to new Warrants of Committal or returns to federal custody. As an interim measure in response to the COVID-19 pandemic, an offender with a new Warrant of Committal or an offender returning to federal custody is required to medically isolate for 14 days upon arrival to a federal institution. This is to prevent the risk of introducing COVID-19 from the local community into CSC's institutions.

To further strengthen our preventative measures, an offender with a new Warrant of Committal or return

to federal custody will be tested at Day 10 to 12 of medical isolation, to help inform clinical decisions related to COVID-19, prior to the offender being transferred to their parent site.

Offenders are also offered voluntary COVID-19 testing prior to release back into the community. The local public health authority is notified of positive results and a plan for release is jointly developed.

Sharing of Health Information related to COVID-19 Testing upon Release

Community partners (e.g. parole offices, community-based residential facilities/halfway houses, and Chiefs or band councils in Indigenous communities) may request the COVID-19 status of an offender for release planning. The consent form for the disclosure of COVID-19 testing information upon release (Appendix A) may be used to obtain voluntary, informed consent from offenders who agree to COVID-19 testing and who agree to have their testing information released to community partners for discharge planning.

COVID-19 testing is voluntary. If a patient refuses COVID-19 testing upon release, or does not sign the consent form for the disclosure of COVID-19 testing information upon release, the Chief of Health Services may respond to community partners requesting such information (such as parole offices, halfway houses, and chiefs and/or band councils in Indigenous communities) with the following:

- Health Services does not have the authority to share personal health information if the patient has not provided informed consent.
- The offender has not consented to the sharing of information regarding COVID-19 testing.

Symptomatic Staff and Contractors

Testing Guidance

Testing is indicated for the following individuals:

- All symptomatic staff/contractors;
- Any offender or staff/contractor that is defined as a close contact of the symptomatic staff/contractor, as outlined within CSC's COVID-19 Contact Tracing Guidelines. Testing will be offered once the index case is confirmed positive.

Given the closed nature of a correctional institution, consideration may also been given to testing asymptomatic casual contacts who had frequent contact with the symptomatic staff/contractor.

Note that symptomatic staff/contractors and close contacts who are staff/contractors are referred to their local public health authority for testing (as per COVID-19 Contact Tracing Guidelines) and follow-up.

Symptomatic Offenders in Institutions/CCCs

Testing Guidance

Testing is indicated for the following individuals:

- All symptomatic offenders;
- Any offender or staff/contractor that is defined as a close contact, as outlined within CSC's COVID-19 Contact Tracing Guidelines. Testing will be offered once the index case is confirmed positive.

Given the congregate living quarters in CSC institutions, broader testing of asymptomatic offenders is indicated in institutions with a COVID-19 outbreak (where an outbreak is defined as one or more confirmed case(s) of COVID-19). The testing approach for asymptomatic offenders, who were

potentially in contact with the symptomatic individual, depends on the living arrangements.

Therefore, in institutions with **an active COVID-19 outbreak**, testing is also indicated as follows:

- **In house/apartment style accommodations (e.g. minimum security institutions, women's sites, and healing lodges)**: all members of the household are tested, along with any households that have been in contact with the household of the infected offender(s).
    - For example, if the affected household attends the gym, meals, or receives outdoor time with other households, these households should also be tested.
- **In medium or maximum security institutions:** offenders will be tested based on how the offenders were cohorted and/or the level of restrictions that were in place 48 hours before the symptom onset of the first case.
    - For example, if the institution was locked down to range level, 48 hours before the onset of symptoms in the first case, all offenders in the range should be tested; if the institution was locked down to the pavilion level, 48 hours before the first case, testing should be extended to all offenders in the pavilion.

Testing Considerations for Outbreak Sites

In an outbreak institution, CSC's Health Services, in collaboration with local public health and the Public Health Agency of Canada (PHAC), may identify a need for enhanced testing of staff/contractors and offenders, beyond what is described above. This may include offering testing to all offenders and staff at the institution affected by a COVID-19 outbreak, including to those not identified as close contacts. Symptomatic individuals and close contacts should, however, be prioritized for testing.

Asymptomatic Screening

Background

There is emerging evidence of unrecognized asymptomatic and pre-symptomatic transmission of COVID-19. This means that despite active screening for symptoms among all staff entering CSC institutions and the diligent application of infection prevention and control measures, there is a risk that staff, contractors, or offenders arriving from the community may unwittingly introduce COVID-19 into CSC institutions.

COVID-19 transmission will typically start first in the community and then be introduced into a CSC institution, which is a closed setting that could allow for wide spread transmission if cases are not detected quickly. Given the infrastructure of correctional settings, as well as the risk of asymptomatic/pre-symptomatic transmission, the following asymptomatic screening approaches to testing will complement existing measures to prevent and contain outbreaks within these environments.

Purpose

The purpose of asymptomatic screening among staff and offenders is to identify, as early as possible, the presence of COVID-19 within CSC institutions, in order to facilitate the fastest containment possible. This will be achieved through testing asymptomatic staff and offenders with the goal detecting the presence of COVID-19 early, in locations where there is wide spread community transmission, and executing appropriate outbreak control measures in a timely manner.

Asymptomatic screening is warranted in institutions where there is a higher risk of transmission in the local community. Other factors such as offender population size and risk for severe outcomes may also be considered. These factors are monitored regularly by CSC's NHQ-HS; institutions flagged for being at risk may be identified for asymptomatic screening measures.

Principles

The principles of asymptomatic screening among staff and offenders, specifically for the CSC context, are as follows:

- Asymptomatic screening will be conducted at select institutions identified as at risk by CSC's NHQ-HS and in collaboration with regional/site management;
- All staff, contractors, and essential volunteers actively reporting for duty will be offered testing;
- All offenders will be offered testing;
- Participation is voluntary.

Testing Guidance

Parameter	*Testing Guidelines for Screening Staff When Community Transmission is Elevated*
Setting	Institutions identified as at-risk by CSC's NHQ-HS and identified for asymptomatic screening.
Participants	All staff, contractors, and/or volunteers actively reporting for duty in the institution will be offered testing. All offenders will be offered testing.
Recruitment	Staff, contractors, and/or volunteers actively reporting for duty at the identified site will be provided the opportunity to sign up for testing. Offenders will also be provided the opportunity to sign up for testing. Participation is voluntary. If there is a need to limit testing capacity, based on the availability of resources, testing will be allocated based on a first-come-first-serve basis to those who have expressed interest. CSC will strive to test all who express interest.
Test Results	**In the context of asymptomatic screening only, individuals tested are presumed negative until they receive their results.** This is because this form of surveillance is only done where there is currently no evidence of COVID-19 in the institution. This differs from the testing approaches for symptomatic staff/contractors and offenders (and their close contacts) where cases are presumed positive until test results are received. If asymptomatic screening yields **one or more positive** COVID-19 case: • Contact tracing must be initiated as per the COVID-19 Contact Tracing Guideline. • Given the risk of asymptomatic transmission, broader testing may be required. The decision to implement this will be made in consultation with institutional heads, regional HS team, NHQ-HS team, and local and federal public health authorities. If asymptomatic screening yields **no positive** COVID-19 cases: • Testing may be continued at the discretion of the NHQ-HS Team, in consultation with the RDC and Institutional Head if the institution continues to be identified as at risk. In these cases, the number of tests and frequency of re-testing will be determined on a case-by-case basis.
Testing Procedures	**Sample Collection and Laboratory Testing** • Sample collection (via nasopharyngeal swabs) and laboratory testing will be completed in collaboration with local public health authority or private lab as needed.
Reporting	Reporting procedures will be established locally with each local public health authority when asymptomatic screening is warranted.

Testing Cases for Recovery

At this time, CSC does not recommend testing cases for recovery, in accordance with guidance from PHAC.

Staff and contractor cases are deemed 'recovered':

- Based on CSC's Return-to-Work algorithm.

Offender cases are deemed medically recovered in the following circumstances:

- If the offender was symptomatic: 10 days after symptom onset with at least 48 hours symptom free;
- If the offender was asymptomatic: 14 days after test date;
- In the case of immunocompromised offenders: the recovery period may be extended to 21 days after symptom onset in those at high risk of a prolonged transmission period (e.g. offenders who are immunocompromised or taking immune-suppressing medication) or those who have been hospitalized, based on the clinical judgement of the institutional physician. If the offender was hospitalized, this decision should be made taking into account any recommendations from the discharging hospital physician.

Consent for Disclosure of COVID-19 Testing Information upon Release

Privacy: Upon release, community partners may request your COVID-19 status. These partners may include parole offices, community-based residential facilities/halfway houses, and chiefs and/or band councils in Indigenous communities. Community partners may request this information to assist in their planning for your release, as well as to help prevent the spread of COVID-19.

If you consent, your COVID-19 testing information will only be shared if:

- The community partner(s) requesting the information is/are involved in your specific release plans; AND
- The community partner(s) request your COVID-19 testing information.

Upon request, the following information will be disclosed to the relevant community partner(s):

- Date of COVID-19 test(s); and
- COVID-19 test result(s).

Contact information: If you have any questions or concerns, please contact a member of health services staff.

I am satisfied with and understand the information given.

I authorize Correctional Services Canada to share my test results with the following parties involved in my release (select all that apply):

- ☐ Parole office
- ☐ Community-based residential facility or halfway house
- ☐ Chiefs and/or band councils, if release to Indigenous community
- ☐ Other (please specify): _____

Full name (print):	
Signature:	**Date:**

Witness Statement: (Only Health Services staff may be signed witnesses) I observed the person providing consent when they signed the consent form.	
Full name (print):	
Signature:	**Date:**

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