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Public Health Agency of Canada | Agence de la santé publique du Canada

Assessment of Infection Prevention and Control Preparedness for COVID-19: Correctional Services Canada Institutions

Centre for Communicable Diseases and Infection Control

Infectious Disease Prevention and Control Branch

Public Health Agency of Canada

Prepared for Correctional Services Canada

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Glossary

ABHS	Alcohol-base hand sanitizer
CSC	Correctional Services Canada
CCDIC	Communicable Disease and Infection Control
COVID-19	Coronavirus disease 2019
EHS	Environmental Health Services
HQ	Headquarters
IPAC Canada	Infection Prevention and Control Canada
IPC	Infection prevention and control
IPC-SAT	Infection prevention and control self-assessment tool
NAC-IPC	National Advisory Committee on Infection Prevention and Control
OHS	Occupational Health and Safety
PHAC	Public Health Agency of Canada
PPE	Personal protective equipment
PSOHP	Public Service Occupational Health Program
SAT	Self-assessment tool

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Introduction

In April 2020, Correctional Services Canada (CSC) contacted the Public Health Agency of Canada (PHAC) as the Government of Canada authority on public health and infection prevention and control (IPC) to seek advice on how to minimize the risk of introducing COVID-19 to institutions. PHAC's Centre for Communicable Diseases and Infection Control (CCDIC), in collaboration with PHAC Regional Operations and Health Canada, conducted a review of CSC's IPC guidance and protocols for COVID-19, developed a training webinar and self-assessment tools and conducted site visits The goal was to assist CSC in the preparation and planning for preventing the introduction of the virus into facilities, early identification of infection, and containment/mitigation strategies for outbreaks. CSC had engaged with local and provincial/territorial public health authorities to ensure that exposed/infected staff and federal inmates receive public health advice that is consistent with the jurisdiction in which they reside.

A number of factors make people living in correctional institutions more susceptible to infections[1]. Infections can be transmitted between inmates, staff and visitors, between institutions through transfers and staff cross-deployment, and to and from the community[2]. Consistent application of prevention measures in correctional settings is an integral part of the public health response to coronavirus disease 2019 (COVID-19) [1,2,3,4,5].

This report provides an overview of the process used for assessment of IPC preparedness for COVID-19 in CSC institutions, key findings and recommendations.

Purpose/Scope

CCDIC develops PHAC IPC guidance for healthcare and advises on IPC issues for healthcare-associated emergency preparedness and response activities. In practice, these activities have included collaboration with other government departments to provide evidence-based recommendations for IPC practice where healthcare services are delivered. The COVID-19 response has created a number of unprecedented opportunities and demands for IPC support in a broader range of settings, including support to CSC for self-assessment of IPC preparedness, detection, and management of potential cases.

It should be acknowledged that there are infection prevention and control challenges associated with the security requirements and physical infrastructure of correctional institutions that are not readily amenable to public health intervention. Issues related to infrastructure or security were therefore considered out of scope for the project. The purpose of this collaboration was to provide IPC, Occupational Health and Safety (OHS) and Environmental Health (EH) expertise to CSC to improve IPC practices. To support the project, PHAC's Centre for Communicable Diseases and Infection Control (CCDIC), in collaboration with PHAC Regional Operations and Health Canada, conducted a review of CSC's IPC guidance and protocols for COVID-19, developed a training webinar and self-assessment tools and conducted site visits.

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CSC is the federal government agency responsible for administering sentences of a term of two years or more, as imposed by the courts. CSC is responsible for managing institutions of various security levels and supervising offenders under conditional release in the community. CSC has approximately 14,000 inmates living in custodial care, and approximately 18,000 staff.

A series of webinars were organized by PHAC which were attended by 257 participants from CSC. A total of 43CSC institutions and one training college located in five administrative regions were visited between April 18 and June 19, 2020 by PHAC staff (53 IPC and EH visits), Health Canada staff (three visits), Fraser Health Authority (seven visits), and external consultant groups (eight visits). Virtual meetings were also provided for some sites in Pacific and Quebec regions. This report provides detailed information on the visits that were completed by PHAC-IPC and EH staff in the Atlantic, Quebec, and Prairie Regions; following the initial visits to the Mission Institution and other priority institutions in the Pacific Region. This report concludes PHAC's assessment process. It is important to note that the CSC Ontario site visits were conducted by an independent consulting group and not governed by PHAC therefore not included in this report.

Since receiving the reports in the spring 2020, CSC has reviewed the input and used the findings as they further develop directives and guidelines in their response to limit the spread of the virus.

Methods

The methodology used includes the review of CSC guidance, site visits, the development of tools and webinars in preparation of the site visits, followed by discussion and a report with recommendations.

As the initial step PHAC reviewed CSC IPC guidelines and provided comments. This was followed by site visits.[i] The goal of the site visits was to observe IPC practices and provide recommendations where needed to prevent, mitigate and/or control the transmission of COVID-19 among staff and inmates. Prior to site visits, in collaboration with HC, CCDIC developed standardized tools to help identify common or significant themes that IPC teams and external consultants could observe during their on-site visits to CSC institutions. The IPC-Self-Assessment Tool (SAT) was provided to CSC institutions in advance to be completed prior to the visit. The tool was based on the Infection Prevention and Control Canada (IPAC-Canada)'s audit tool which is designed to support healthcare settings' evaluation of the implementation of IPC best practices in their establishments. COVID-19 specific content was informed by PHAC guidance [8, 9] applicable to this setting, and a review of local public health protocols and type of signage being used throughout the institutions, i.e., screening at entrance, donning/doffing, etc. The IPC-SAT included some items that are specifically adapted to deal with the current COVID-19 pandemic, while others were applied more broadly to various aspects of IPC best practices. While not exhaustive in scope, nor validated specifically for correctional settings, the IPC-SAT was intended to assist CSC in determining the level of preparedness for COVID-19 including implementation of risk mitigation measures for screening/detection, isolation and management of potential cases.

i The CSC Ontario Region IPC assessments were done by a consulting firm.

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PHAC in collaboration with Health Canada's Public Service Occupational Health Program delivered a series of live, interactive webinars to CSC staff to assist with completing the IPC-SAT. The webinars provided an overview of the impact of COVID-19 on CSC operations in the Pacific Region (specifically related to the outbreak at Mission Institution) and described the goals of the IPC-SAT. Some institutions received a visit from EHS before the IPC team visit (Appendix A).

PHAC Regional Operations mobilized Environmental Health Officers to federal institutions in the Atlantic, Quebec and Pacific Regions. Focus of these visits was on environmental health and safety elements of institutional outbreak prevention and control plans, with an emphasis on environmental cleaning and disinfection practices.

PHAC deployed three teams to conduct the IPC visits in the Atlantic, Quebec, and Prairie regions. CSC Ontario Region contracted an external IPC consulting firm to complete their site assessments and the results were forwarded to CSC Ontario Regional Office and nationally. Each team was composed of a minimum of two staff from CCDIC, at least one of whom had experience in IPC through a combination of formal training, work experience, and professional education/specialization. CSC site visits were organized by CSC Regional Headquarters according to priority; institutions with confirmed outbreaks of COVID-19 were visited first (Appendix A). IPC site visits were semi-structured and included a review of the IPC self-assessment form (IPC-SAT) that was completed in advance, followed by an on-site assessment of COVID-19 specific activities that included signage and availability of personal protective equipment (PPE), donning/doffing stations, placement of suspected and positive COVID-19 inmates, in-facilities outbreak management and operationalization of local public health directives for COVID-19.

A standardized institution report was developed to provide timely reporting back to CSC institutions by each of the IPC teams. The institution report included items of key importance that were noted on the IPC-SAT and observed by the IPC teams during their visit, including strengths, gaps and main recommendations.

Both EH and IPC teams provided a brief verbal report, including items requiring urgent attention, during the site visit. A site visit trip report was completed and sent to the respective CSC Regional Headquarters, in most cases, within 48-72 hours of the site visit.

The information from the IPC-SAT was manually entered into a spreadsheet Microsoft Excel (2010; Microsoft Corporation, Richmond, WA) and analyzed using SAS EG version 7.1 (2016, SAS Institute Inc., Cary, NC). Frequency of reporting by region was calculated for each of the IPC best practice elements, i.e. administrative controls, engineering controls, and surveillance and outbreak management. The site visit observations were summarized by region by each of the responsible IPC teams and a qualitative analysis was done to identify the main recommendations for each region and overall. It was noted during the PHAC-IPC visits, that the information provided on some of the completed IPC-SAT was incorrect; however the forms were not corrected prior to data entry. This may compromise some of the results. In addition, a crosswalk analysis was performed to assess similar and disparate recommendations between PHAC-CCDIC, the Ontario consulting group, and Fraser Health Authority.

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Results/ Key Findings

Forty-three CSC institutions, and one training college, located in five CSC regions, were visited between April 30 and June 12, 2020. PHAC-EH visits were completed in some institutions prior to the IPC visit. EH visits focused on risk assessments and those aspects of the SAT pertaining to environmental cleaning (practices and products) and occupational health/hygiene, to complement IPC expertise provided by the PHAC-IPC led teams.

Three visits in the Quebec region were completed prior to the development of the IPC-SAT and the webinars. In total, 26 institutions completed the IPC-SAT before the IPC visit and several completed them afterward[ii] (Appendix A). The main areas for improvement that were identified from the 26 IPC-SATs were:

1) The need for basic IPC training to be provided to all persons affiliated with the institution (staff, inmates, volunteers, and visitors), such as proper hand hygiene, donning and doffing, and routine practices and additional precautions;
2) Ensuring compliance with recommended measures such as physical distancing and the use of non-medical masks for the duration of staff shifts, in accordance with local public health directives;
3) Improved environmental cleaning of high-touch and low-touch surfaces. It is recommended that CSC Regional Offices consider using commercial cleaning specialists who specialize in biohazard remediation when an outbreak of COVID-19 is declared in one of their institutions;
4) Better integration with local public health authorities to improve access to IPC and OHS resources (surge capacity and outbreak management); and,
5) Re-evaluating immunization policies for vaccine preventable diseases including influenza, pertussis and staff immunization records.

CSC region-specific results are presented in Appendix B.

CSC regional offices were aware of and responsive to the threat of COVID-19, implementing a wide range of administrative controls and IPC measures that were manifest (at least in part) in the majority of correctional institutions prior to the IPC visit. As an example, the IPC team observed that the CSC institutions that were visited in the Quebec Region in late May and June, 2020, had implemented the EH and IPC recommendations that had been provided to the institutions visited in April and early May,2020.

Common observations noted by the PHAC teams during their visits to the CSC institutions in all regions include:

- The proactive implementation of hand sanitization stations by CSC in response to COVID-19 may have helped minimize the risk of transmission; however, efficacy may have been limited in some instances, by poor placement (i.e., one station for multiple zones), lack of maintenance (i.e., stations empty or non-functional), or poor compliance by both staff and inmates.

ii CSC Pacific Region IPC visits were conducted in response to outbreak management before the IPC-SAT was developed. Institutions completed the IPC-SAT after the visits.

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- While most institutions implemented updated protocols on the environmental cleaning of high-touch, low-touch, and communal surfaces, mandatory training on proper disinfection techniques was not universal (i.e., at times excluded inmate cleaners), occasionally excluded specific areas (i.e., inmate cells, communal showers), and often did not offer guidance on the disinfection of uniforms or personal effects.
- Although CSC institutions appeared to have adequate access to PPE, including masks, gloves, gowns, face shields, and N95 respirators, improvements could be made to inventory management (e.g., ensuring that appropriately sized PPE are available), the universal distribution of PPE (e.g., the provision of PPE to all individuals affiliated with an institution, notably inmates and inmate cleaners), universal mandatory training (e.g., proper donning and doffing technique) and general compliance (e.g., policies to promote the comprehensive use of masks and procedures to document non-compliance or breaches in PPE, particularly among the inmate population).
- The need to designate adequate space so that PPE can be donned and doffed in separate areas and establish a one-way flow from the donning area to the inmate area to the doffing area to prevent cross-contamination.

CSC region-specific gaps and recommendations are highlighted in Appendix C. A comparison of the recommendations provided by this report and the Ontario and Fraser Health Authorities reports (previously submitted to CSC Headquarters) is provided in Appendix D. The Venn diagram and summary table reveals a number of consistent findings and considerations for IPC components across regions and reports. Common findings across all three reports focused on IPC knowledge and resources; outbreak management; and environmental cleaning and equipment. The crosswalk analysis further highlighted that education and training were consistent IPC considerations for PHAC and Ontario Consultants; hand hygiene were consistent considerations for PHAC and Fraser Health Authority; and access to healthcare facilities for Fraser Health Authority and Ontario Consultants. Fraser Health Authority highlighted the consideration of cohorting and placement. PHAC more commonly highlighted considerations related to donning and doffing, signage and movement and screening.

Discussion/Recommendations

This summary report captures a number of common findings and themes that are linked to the overall objectives identified by CSC. Recommendations are based on information collected through the review of policies and procedures, analysis of self-assessment tools, on-site observations, debriefs with CSC and PHAC teams, and ongoing communication and support provided to CSC. These visits took place at a time when a number of public health measures had been put in place by CSC to decrease the risk of introduction and transmission of COVID-19 within and between facilities (i.e. restricted movement, screening, physical distancing and masking, cohorting of inmates/guards, changes to visitor access and programs).

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What was notable from the first visit to the last was evidence of responsiveness and progression, supported by an organizational culture that is familiar with audits, structures such as Standard Operating Procedures, and an action-oriented approach to addressing problems. It was clear that communication took place between institutions and CSC regional offices about OHS, EH and IPC findings, sharing experiences with PHAC prior to visits. This contributed to timely implementation of recommended measures from one site to another.

The continuum of experiences across institutions ranged from no experience with COVID-19 cases, experience with symptomatic individuals and detection of a small number of positive cases, to larger scale outbreak management. The size, complexity, age and program delivery of institutions also varied. Despite these variable scenarios, common themes were noted which resulted in the development of recommendations for consideration by CSC.

CSC Corporate Headquarters (HQ)

Addressing COVID-19 issues within CSC presents an opportunity for capacity building of internal expertise at HQ and/or regional offices to strengthen internal IPC resources. Establishing IPC capacity within the organization, consistent with other healthcare and dentistry capacities will allow CSC to rapidly address any emerging communicable diseases among staff and inmates including those with complex needs, co-morbidities and underlying health issues.

For COVID-19 emergency planning and response, in addition to the review of protocols and operational plans, activities such as table-top exercises simulated management of mock COVID-19 cases is important to identify details that may be unrecognized until exposed during the simulation. Establishing a community of practice network across institutions is encouraged to share the innovative practises developed by an institution to solve a specific problem that can be operationalized across multiple institutions.

It is recommended that CSC develop a formalized, corporate IPC component as part of their operational strategy moving forward. Expertise to inform the development of the IPC strategy should include IPC professionals, OHS consultants and environmental health officers. To achieve these goals, IPC expertise should be drawn from the private sector or developed by CSC internally. While COVID-19 has brought IPC in correctional institutions to the fore, the issues of communicable diseases in congregant settings will continue into the future. Models exist within CSC healthcare services that are accredited in order to deliver services. It is recommended that accreditation of institutional IPC standards and organizational practices should become part of CSC business moving forward.

Regions

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CSC regional offices recognized and were responsive to the threat of COVID-19 outbreaks, implementing a range of administrative controls and regional IPC practices that were applied by the majority of correctional institutions.

PHAC recommends that CSC draw on a formalized, corporate IPC structure to establish regional IPC teams to: (1) develop a standardized mandatory training regimen for all persons affiliated with CSC institutions, including the use of PPE, hand hygiene protocols, and proper disinfecting technique; (2) enact a comprehensive IPC protocol appropriate for each individual institution; and (3) conduct regular comprehensive IPC audits to improve compliance over time; and develop a community of practice to take best practices from institutions and incorporate these practices regionally and/or nationally.

Institution

Improvements to IPC best practices at the institutional level were identified by PHAC staff through institution-specific self-assessment questionnaires and in-person observations, including administrative controls, engineering controls, and techniques to improve overall compliance.

While the information gathered from on-site visit reports is insufficient to adequately capture the full scope of institution-specific IPC requirements, information presented here may be used by CSC to identify specific areas where improvements to IPC policies and procedures can be implemented.

Institutions were willing to deploy IPC strategies that were recommended by headquarters. In situations where a specific strategy had yet to be developed by headquarters, these institutions demonstrated leadership in designing and rapidly implementing solutions that could be used as models for other facilities. These innovations can be shared within a community of practice.

Once an employee leaves the CSC workplace, they resume membership in the community and are subject to public health guidance and orders in the community in which they reside. Typically, the number of employees working in an institution exceeded the number of inmates in the correctional facility. The risk that COVID-19 will be introduced to the institution by an employee, visitor, contractor, etc. who becomes infected in the community is significant and speaks to the importance of everyone engaging and practicing personal public health prevention measures in all aspects of their lives – these actions are critical to preventing the introduction of communicable diseases, such as COVID-19, into institutions. Thus partnership with the community, health centres and local/regional public health resources is critical to preventing and managing COVID-19 outbreaks within facilities.

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Conclusion

Correctional and detention facilities can prevent introduction of SARS-CoV-2 and reduce transmission by reinforcing a number of occupational health, environmental health and IPC measures, with particular attention to IPC practices among inmates, staff, and visitors[2]. Because many individuals infected with SARS-CoV-2 do not display symptoms, the virus could be present in facilities before infections are identified. Good hygiene practices, vigilant symptom screening, and diligent implementation of personal public health practices on the part of both inmates and CSC staff will be critical to in preventing further transmission.

As CSC moves forward with "shaping the new normal", a risk assessment approach and consistent application of outbreak prevention and control measures, is critical to resumption of programming. Leveraging innovative practices that are developed at the institution level within a community of practice will improve overall infectious disease outbreak response strength. Implementation of a formalized, accredited, corporate infection prevention and control operational strategy will support COVID-19 risk reduction within institutions and serve to mitigate the risk of all communicable disease transmission among inmates into the future.

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Appendix A- Summary of CSC Site Visits by Region

Region/ Institution	Date of IPC-SAT*	IPC visit	EHS^ OHS^^ visit	# of inmates	# COVID-19 (+) inmates at time of visit
ATLANTIC REGION					
Springhill Institution	May 20, 2020	May 27, 2020	^May 27, 2020	413	0
Atlantic Institution	May 21, 2020	June 1, 2020	^May 8, 2020	183	0
Dorchester Medium	May 21, 2020	May 28, 2020	^May 5, 2020	377	0
Dorchester Minimum	May 21, 2020	May 28, 2020	^May 5, 2020	173	0
Nova Institution for Women	May 20, 2020	May 26, 2020	^May 7, 2020	79	0
Shepody Healing Center	May 22, 2020	May 29,2020	^May 5, 2020	32	0
QUEBEC REGION					
Cowansville Institution	May 19, 2020	May 20,2020	^May 8, 2020	390	0
Centre Regional de Reception	May 29, 2020	June 6, 2020	^May 7, 2020	239	1
Archambault Medium	June 9, 2020	May 11, 2020	^May 6, 2020	280	2
Archambault Minimum	June 9, 2020	May 11, 2020	^May 6, 2020	120	0
Donnacona Institution	June 11, 2020	May 21, 2020	^May 4, 2020	280	0
Federal Training Centre (site 600)	June 10, 2020	May 6, 2020	^April 30, 2020	173	0
Federal Training Centre (site 6099) †			^April 30, 2020	330	0
Joliette Institution for Women†	May 11, 2020	May 4, 2020	^April 27, 2020	55	8
La Macaza Institution	May 21, 2020	May 25, 2020	^May 6, 2020	240	0
Training College (CAPC)	May 28, 2020	May 28, 2020	N/A	14	2

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Drummondville Institution	June 9, 2020	June 6, 2020	^May 4, 2020	258	3
Port-Cartier Institution‡	June 5, 2020	June 19, 2020	^April 29, 2020	183	0
PRAIRIE REGION					
Stony Mountain Institution (min)	May 27, 2020	June 3, 2020	N/A	192	0
Stony Mountain Institution (med max)			N/A	595	0
Willow Cree Healing Lodge	May 21, 2020	May 28, 2020	N/A	58	0
Bowden Institution	May 19, 2020	May 21, 2020	N/A	692	0
Drumheller Institution	May 19, 2020	May 22,2020	N/A	656	0
Edmonton Institution for Men	May 20, 2020	May 20, 2020	N/A	276	0
Edmonton Institution for Women	May 20, 2020	May 20, 2020	N/A	165	0
Grierson Institution	May 20, 2020	May 22, 2020	N/A	7	0
Grand Cache Institution	May 23, 2020	May 23, 2020	N/A	268	0
Okimaw Ohci Healing Lodge	May 25, 2020	May 30, 2020	N/A	38	0
Saskatchewan Penitentiary	May 25, 2020	May 28, 2020	N/A	756	0
Regional Psychiatric Centre	May 20, 2020	May 29, 2020	N/A	155	0
Pê Sâkâstêw Centre	May 21, 2020	May 22, 2020	N/A	45	0
ONTARIO REGION					
Bath Institution	May 25, 2020	May 27, 2020	N/A	530	0
(includes Regional Treatment Center)	May 25, 2020	May 27, 2020	N/A	530	0
Beaver Creek Institution	N/C	N/C	N/A		
Collins Bay Institution	June 4, 2020	May 25, 2020	N/A	689	0

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Grand Valley Institution for Women	June 9, 2020	June 9, 2020	N/A	174	0
Joyceville Institution	May 21, 2020	May 21, 2020	N/A	781	0
Millhaven Institution (includes Regional Treatment Centre)	May 21, 2020	May 29, 2020	N/A	320	0
Warkworth Institution	May 21, 2020	June 2, 2020	N/A	544	0
PACIFIC REGION					
Fraser Valley Institution for Women	June 10, 2020	April 30, 2020	^April 30, 2020	75	0
Kent Institution	June 12, 2020	May 7, 2020	^May 5, 2020	290	0
Kwikwèxwelhp Healing Village	June 10, 2020	April 30, 2020	^April 30, 2020	29	0
Matsqui Institution	June 10, 2020	April 22, 2020	^^April 22 ,2020	313	1
Mission Institution†	June 11,2020 MIN June 12, 2020 MED	April 18, 2020 April 18, 2020	^^April 19, 2020 ^^April 19, 2020	100 291	0 120
Mountain Institution	June 10, 2020	April 30, 2020	^April 30, 2020	334	1
Pacific Institution	June 11, 2020	April 24, 2020	^May 1, 2020	328	0
William Head Institution	May 27, 2020	May 28, 2020	^^May 28, 2020	139	0

* N/C, not completed and /or submitted to PHAC
† Institution experiencing an outbreak of COVID-19 at the time of the IPC visit
‡Virtual visit (teleconference call), outbreak declared over at the time of the call

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Appendix B- CSC IPC Self-Assessment by Region

The summary represents the aggregate results for self-reported IPC measures undertaken by each CSC institution by region in response to COVID-19.[iii]

Only results of less than 100% are reported. These results do not represent information collected during on-site visits by staff visiting the institutions and are not meant to be interpreted as compliance to any Acts, Regulations and/or directives that govern CSC.

The IPC self-assessment tool (IPC-SAT) was used to identify more general actions undertaken by CSC on best practices recommended for healthcare settings, including acute-care, long-term care, and non-traditional settings (e.g., dental offices, etc.,) but due to time constraints and limited familiarity with correctional facilities it was not specific for correctional settings. Therefore, the information presented should be interpreted with caution. The information may be used to identify areas where improvements to IPC practices can be immediately investigated, or can represent outcome-oriented evidences of IPC action. Only the areas were improvements were self-identified by the institution are listed for each region.

Table 1: The IPC-SAT reported results of less than 100% are highlighted and stratified by CSC region

CSC Region	Reported (%)	IPC Self-Assessment Tool (IPC – SAT)
Section 1: Administrative Control Elements		
Atlantic (6)		*Occupational health and Safety*
	83%	Has requirements for new employees and staff attendance at training and education in IPC (where relevant to position), with documentation of attendance
	83%	Has healthcare worker immunization policies in place for vaccine preventable diseases including influenza, pertussis and staff immunization records
Quebec (9)		*Hand Hygiene*
	89%	Staff receive job-specific training (e.g. HCWs and cleaning staff) and competency validation on hand hygiene at the time of employment and regularly after that
		Triage and screening
	78%	Has policies and procedures in place to screen inmates for signs and symptoms of COVID-19 prior to them entering the infirmary
		Selection and use of Personal Protective Equipment (PPE)
	67%	Institutional staff receive job-specific training and competency validation on proper use of PPE at the time of employment and regularly after that
		Occupational health and Safety
	89%	Staff receive job-specific training (e.g. HCWs and cleaning staff) and competency validation on hand hygiene at the time of employment and regularly after that
	55%	Has requirements for new employees and staff attendance at training and education in IPC (where relevant to position), with documentation of attendance

[iii] Only IPC-SATs completed **before** the IPC site visits are included in this summary

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		Outbreak management
	89%	Cleans and disinfects at least once per day on all low-touch surfaces
		IPC Evaluation or audit
	67%	Has a quality improvement process in place for review of IPC practices
	67%	Has process and tools for IPC assessment/reporting
		Resources
		IPC staff:
	89%	Has access to an occupational health and safety committee and to infection prevention and control staff
	78%	Has adequate surge capacity to respond to disease outbreaks
		Trained Staff:
	78%	Trains all staff and visitors on routine practices and additional precautions, including respiratory etiquette and hand hygiene
Prairies (11)		*Environmental cleaning*
	82%	Has a system for identification and storage of clean and dirty equipment
		Occupational health and Safety
	73%	Staff receive job-specific training (e.g. HCWs and cleaning staff) and competency validation on hand hygiene at the time of employment and regularly after that
	73%	Has requirements for new employees and staff attendance at training and education in IPC (where relevant to position), with documentation of attendance
	55%	Has healthcare worker immunization policies in place for vaccine preventable diseases including influenza, pertussis and staff immunization records
	91%	Has a respiratory program, which includes N-95 fit testing and training on the use of N95 respirators
		Resources
		IPC Staff:
	91%	Has access to an occupational health and safety committee and to infection prevention and control staff
	64%	Has adequate surge capacity to respond to disease outbreaks
		Trained Staff:
	91%	Trains all staff and visitors on routine practices and additional precautions, including respiratory etiquette and hand hygiene
Section 2: Engineering Control Elements		

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Atlantic (6)	50%	Includes the use of barriers such as: Plexiglas, or other physical barriers to separate/direct personnel flow
	67%	Has an airborne infection isolation room(s), with private toilets
Quebec (9)	89%	Has hand hygiene facilities available at entrance/exit to rooms to accommodate putting on/taking off of personal protective equipment (PPE)
	44%	Has an airborne infection isolation room(s), with private toilets
Prairies (11)	91%	Includes the use of barriers such as: Plexiglas, or other physical barriers to separate/direct personnel flow
	73%	Has hand hygiene facilities available at entrance/exit to rooms to accommodate putting on/taking off of personal protective equipment (PPE)
	55%	Has an airborne infection isolation room(s), with private toilets
	91%	Has an adequate number of no-touch waste receptacles for disposal of paper towels, tissues and PPE
Section 3: Specific COVID-19 Recommendations		
Atlantic (6)	50%	Staff and essential visitors and volunteers wear masks for the full duration of the shift/visit and are provided training and education for putting on and removing masks
	0%	All staff are screened upon entry (protocol includes temperature and signs & symptoms of COVID-19)
	83%	Guidance is available for staff regarding handling and cleaning of uniforms and footwear
Quebec (9)	89%	Staff, inmates, essential visitors and volunteers maintain a minimum of 2-meter spatial distancing
	75%	Staff, essential visitors and volunteers are trained on relevant IPC measures such as proper hand hygiene and use of PPE
	78%	All staff are screened upon entry (protocol includes temperature and signs & symptoms of COVID-19)
	89%	*Transportation for inmates with COVID-19 (Contact and Droplet Precautions)* The inmate wears a mask, is instructed to use respiratory hygiene, performs hand hygiene, and is provided with clean clothes, accompanied by a healthcare worker using contact and droplet precautions
Prairies (11)	91%	Staff, inmates, essential visitors and volunteers maintain a minimum of 2-meter spatial distancing
	91%	Staff and essential visitors and volunteers wear masks for the full duration of the shift/visit and are provided training and education for putting on and removing masks

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	91%	Protocols are in place for cleaning/disinfection of personal equipment (e.g. vets, belts, radio, etc.) worn as part of uniforms
	91%	The institution has written procedures for the identification of potentially infectious staff, inmates and any essential visitors
	67%	Guidance is available for staff regarding handling and cleaning of uniforms and footwear
Section 4: Surveillance and outbreak management Elements		
Quebec (9)		*Surveillance in place with:*
	89%	Case definition
	89%	Minimum data elements
		Outbreak management plan in place with:
	89%	When the number of confirmed or suspected COVID-19 cases in the institution is high, consideration should be given to having dedicated teams of staff specific to inmates with suspected or confirmed COVID-19, where feasible
Prairies (11)		*Outbreak management plan in place with:*
	73%	When the number of confirmed or suspected COVID-19 cases in the institution is high, consideration should be given to having dedicated teams of staff specific to inmates with suspected or confirmed COVID-19, where feasible

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Appendix C - Key Findings from PHAC Site Visits by Region

* Outliers were defined as *any institution that differed significantly from the regional findings, i.e. institution with outbreaks, notable variance/ non-compliance in standard procedures, etc.*

This summary of findings does not include the Ontario Region as external consultants conducted the IPC site visits. The Pacific Region is not included as site visits conducted by PHAC occurred before this process was implemented.

CSC Atlantic Region

Findings and Recommendations	
Priorities for action	Entrance: potential for congestion at change of shift for health and operational staff, lack of signage for alcohol based hand rub (ABHR), no clear physical demarcation on flooring to aid in physical distancing, no temperature screening and in some institutions no physical barrier at reception desk (i.e. Plexiglas).
	Many hand washing stations required touching soap dispensers, paper towel dispensers, and waste receptacles, compromising the benefits of good hand hygiene.
	Limited operational surge capacity: either with limited space for isolation or cohorting, or health and operational staff shortages in the event of a large outbreak.
	Unclear distinctions between clean/dirty zones and donning/doffing areas.
	Low inventory of PPE, such as gowns, as well as disinfectant wipes with reduced contact time.
	IPC signage is not always well positioned (i.e. in stairwells) or task based and is often "competing" with other non-COVID signage.
	Most institutions rely on inmate cleaners for enhanced cleaning and disinfection. Procedures need to follow specifications and best practices for environmental health.
	Variable compliance with mask wearing and physical distancing by inmates was observed in a number of facilities (i.e. phones, common areas, yard).
other findings/ recommendations	**Entrance:** ensure that ABRH, with clear signage, is available before and after security clearance and when leaving entrance area, use tape or signage on floor 2 metres apart to promote physical distancing and reduce congestion, consider use of physical barriers (i.e. Plexiglas) as well as mask wearing for sign-in/out procedures. **Lineups and other areas:** Recommend use of 2 metre floor markings in areas where there are inmate lineups (i.e. med line, kitchen and meal lines, and entrance/exit of recreation yards). Appropriate signage for elevator occupancy to avoid crowding and promote physical distancing.
	The number hand washing stations and/or no-touch ABHR dispensers should be increased throughout facilities, particularly when entering and exiting zones and in high-use administrative areas such as meeting rooms. No touch ABHR, soap and paper towel dispensers and waste receptacles are recommended. Consider the of no touch ABHR dispensers in high use areas (i.e. entrance/reception, health services, transition between zones, high use administration areas such as meeting rooms)
	Reconfigure existing donning/doffing space to optimize permanent donning/doffing areas, including clear separation of clean and dirty zones with physical separation and signage for flow/movement of staff, and awareness for when they are entering and exiting clean/dirty zones.

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	Post clear and simple signage for progression of steps for donning/doffing PPE. The use of a buddy system for donning/doffing is recommended, with a trained observer and sign-in/out log sheets with monitoring of PPE breakage/breaches. Doffing area must be clearly visible to buddy/trained observer guiding the doffing process. Potentially contaminated equipment, used PPE, or waste from the dirty zone should never be stored in the clean zone.
	Consider enhanced cleaning of high-touch surfaces based on volume and timing of inmate movements (i.e. before/after recreation time and medication dispensing). Restricted areas (i.e. boardrooms, staff lounge, nursing stations, and control posts) require designated cleaning staff with standard cleaning schedules and log sheets. Additionally, occupants can also clean high touch surfaces before and after use. Showers in COVID isolation units should be cleaned and disinfected after each use. Consider sponge baths for presumptive and confirmed cases to limit movement when showers are not available within the dirty zone.
	Decommission use of water fountains and bookcases. Ensure that recreational items can be designated for individual use or easily disinfected. The use of no touch thermometers is recommended. No outside activities for inmates in isolation units: Presumptive cases should remain in their assigned zone (range or isolated housing unit) Ensure physical distancing in communal/shared staff areas such as boardrooms, nursing stations and control posts.
Outliers*	Facilities had varying quantities of inventory for supplies such as cleaning/disinfecting products and PPE. A regional approach may facilitate procurement and distribution across institutions. At Dorchester Medium, the physical environment and ageing facility complicates engineering controls ○ Layout of isolation range requires further reconfiguration to establish clean and dirty zones, clear donning/doffing areas, and hand hygiene stations. This will be particularly important if the isolation unit is expanded beyond the current designated range to include the 2 other ranges within the same unit (Unit 7). At Springhill, inmate cleaners complete a structured vocational environmental cleaning program with certification. At Dorchester Medium, staffs conduct training and provide supervision of inmate cleaners; 4 inmates had specialized biohazard cleaning designations to assist with environmental cleaning. Dorchester Minimum had identified private family visit units (F-109 and F-95) to accommodate staff donning and doffing as required. Atlantic had identified a large building for temporary staff housing in the event of an institution-wide outbreak.

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CSC Quebec Region

Findings and Recommendations	
Priorities for Action	Screening protocols/procedures incomplete or requiring updating. The questions asked to all individuals entering the institutions required updating and needed to focus on symptoms and temperature check with a no-touch thermometer; where many institutions were omitting this part. Inmates leaving their units for medical issues are required to be screened. In addition, many sites were lacking directional arrows to hand washing sinks after being screened.
	Donning and Doffing stations not necessarily set up properly or efficiently. Posters with steps of donning and doffing were either not present or too small to be able to follow the right steps. The log in/log out and monitoring breach of PPE sheet was not present. Donning and Doffing stations had to be separate from each other and if set up in the same area, must be opposite to each other. In addition, directional arrows were missing on the ground to restrict movement in order to reduce chances of contamination between clean and used PPE.
	Communal equipment and areas were still available in some of the areas of the institutions. Water fountains, book cases, photocopiers were open to the staff to use.
	Cleaning and disinfection procedures need to follow specifications and best practices for environmental health.
Other findings/ recommendations	The emphasis on screening at entry to the institution should be on symptoms. Temperature check (no touch thermometer) is recommended for every individual entering the institution. Furthermore, inmates leaving their unit to for urgent reasons are recommended to be screened.
	Donning and doffing stations should not be side by side. Signs should be bigger and plastered all over the donning and doffing stations. PPE of all sizes should be accessible in the donning station as well as a log in and log out sheet and monitoring PPE breakage. All waste baskets in the doffing station should be a no-touch waste receptacle. Furthermore, staff that are in Zones 2 and 3 are recommended to change their PPE periodically and in particular if there is a breach or gets moist or soiled and inmates (in and out of zones) should be wearing masks when they are with other inmates and staff.
	Common areas such as water fountains and book cases should be closed in order to further reduce the chance of transmission of the virus within the institution if a case were to occur.
Outliers*	IPC and OHS support was provided locally or provincially for most of the institutions; however, there were a couple of institutions that indicated they did not have ready access to this support.

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CSC Prairie Region

Findings and Recommendations	
Priorities for action	Lack of ABHR at transition points and near high-touch areas.
	Lack of clear plans for implementing donning and doffing zones for PPE in areas where there are cases/PUI/Isolations.
	Most important physical step in prevention of COVID are questions/temperatures/requirement for HH upon entering the facility and there wasn't always screening (some questions forgotten, had to be prompted and in one case it was possible for people to enter without being seen, therefore screened).
	Health care centres did not always have steps in place for separation between HCW and inmate with barriers, e.g., Plexiglas or adequately ensured that inmates are staggered and there is signage/direction etc.
	Lack of hands-on training ensured for all levels (in particular, below manager level) and areas (e.g. HCW, CX, etc.) for PPE and HH, as well as lack of clarity as to who receives the training and lack of documentation of training.
	Needed clear approach to understanding how to house and separate1) asymptomatic inmates under isolation; 2) Persons under investigation; 3) COVID-19 cases.
	Gaps in IPC in management of communal areas, especially issues with communal phones.
	Eating in communal areas or having shared food available at staff meeting points.
	Did not always clearly define the "circle of CSC" meaning that 14d in one facility and clean bill of health and you could go to any facility vs quarantine if coming from remand.
	Not clear when an inmate goes out on hospital visits and what qualifies for re-quarantine – time limit? 4h v O/N.
	Needed to define senior management/health staff to stagger shifts and to dedicated CX and health staff to COVID or PUI wards.
	With only 2 exceptions, the understanding of IPC in general was limited.
	Lack of appropriate IPC procedures for dental procedures conducted within the facility
Other findings/ recommendations	Hire external, professional IPC consultants for audit of facilities and to draft specific IPC guidelines of each of minimum/medium and maximum security facilities.
	Have same consultants educate staff about the concepts of IPC as they apply to CSC for OSH and inmate well-being.
	IPC education for inmates.
	Asking senior CSC management to address the innovative strategies for safe reactivation of programming.
	Reliance on inmate cleaners needs to be re-considered. They need proper training and need to be reliable.
	Clearly articulate the management and be able to delineate the distinct zones for asymptomatic isolation/PUI and COVID cases.

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	Need to perform a dry-run for scenarios for asymptomatic isolation/PUI and COVID cases, as well as transfers into and out of the institution.
	ABHR access through stainless steel locked and timed dispensers an option.
	Use disposable dishes and cutlery.
	Hiring of an environmental services organization to ensure effective cleaning of the facilities.
	Better training for ALL staff on HH and PPE donning and doffing.
	Continue to promote appropriate challenges at the door and adherence to masking.
	Remove communal food and avoid eating in non-designated areas.
	Stagger shift to avoid situation of loss of staff due to self-isolation or cross-transmission of COVID to other parts of the facility.
Outliers*	N/A

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Appendix D – Most Common IPC Considerations across CSC

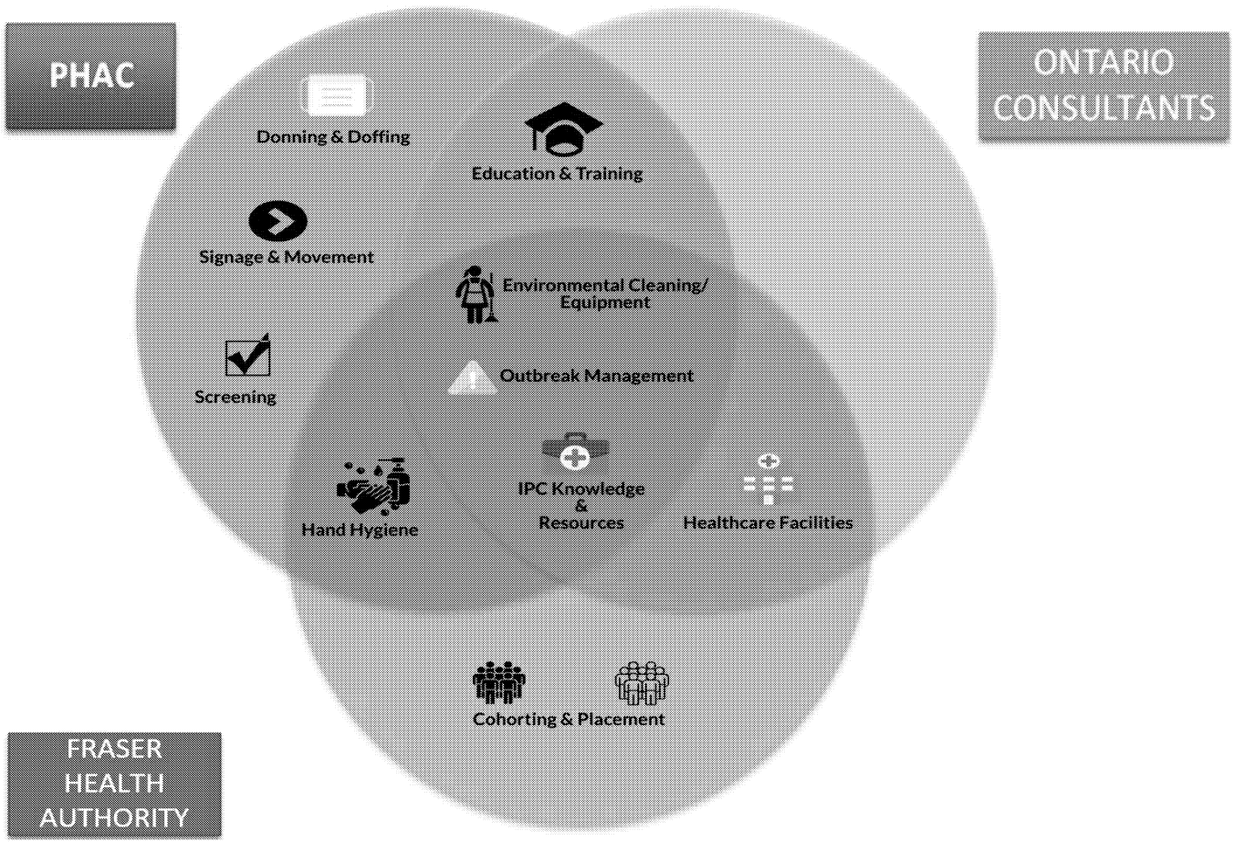

Figure 1: The Venn diagram of the IPC considerations recommended by three different oranizations in the CSC institutions *

Table 2: The IPC considerations that were recommended by the three different organizations in the CSC institutions*

IPC Consideration	Fraser Health Authority [a]	Ontario Consultants	PHAC
Environmental cleaning/equipment[1]	✓	✓	✓
Outbreak management[2]	✓	✓	✓
IPC knowledge and resources[3]	✓	✓	✓
Cohorting and placement[4]	✓		

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Healthcare facilities[5]	✓	✓	
Education and training[6]		✓	✓
Hand hygiene[7]	✓		✓
Donning and doffing[8]			✓
Screening program[9]			✓
Signage and movement[10]			✓

***Legend for Figure 1 and Table 2**

[1] Routine cleaning of the environment, shared inmate and staff equipment and enhanced/more frequent cleaning of high touch surfaces.

[2] Facility has a plan in place to address new suspected/confirmed cases, enhanced cleaning, plans for handling cohorts, communication with local public health, etc.

[3] Staff member on site with knowledge of IPC principles (e.g. IPAC nurse, IPAC physician, IPAC consultant), or access to someone with IPC knowledge off-site

[4] Facility has adequate space and strategy for placement of suspected/confirmed cases and contact into cohorts.

[5] If the institution has a healthcare facility, adequate structural components are in place to prevent transmission (e.g. airborne infection isolation room for AMGPs, Plexiglas dividers between HCWs and inmates, restricted access to the facility, etc.), and if no healthcare facilities are on-site, suspected or confirmed cases are transferred safely to an outside institution, and quarantined on return.

[6] Includes adequate education and training of inmates and staff in IPC principles and interventions (such as respiratory etiquette, physical distancing, hand hygiene, PPE, donning and doffing, etc.)

[7] Facility has adequate hand hygiene stations (with either ABHR or soap and water) throughout the facility and hand hygiene is mandatory, reinforced, and performed at appropriate times.

[8] Donning and doffing stations are set up in appropriate locations, fully stocked, adequately spaced apart to prevent cross-contamination and sufficient no-touch waste receptacles in the donning station to dispose of used PPE. In addition, the stations are recommended to include a log in and out sheet and monitors for any possible PPE breaches.

[9] Facility has a stringent screening program for incoming visitors and staff to prevent the introduction of COVID-19 into the facility and it includes temperature check and relevant screening questions for symptoms and risks.

[10] Facility has visible signage in all necessary locations that is easy to read (e.g. PPE donning/doffing, hand hygiene, restriction of visitors, etc.) and has protocols in place for the inmate and staff movement, 2-meter distancing (where feasible) and directional flow.

[a] At the request of the CSC team, education was provided to the Corrections Staff by the Fraser Health Authority IPC team. They focused on basic IPC practices of donning and doffing of personal protective equipment as well as answering a variety of COVID-19 related, and infection control questions.

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Supplementary Information – IPC Self-Assessment tool

Part A (please complete prior to PHAC staff visit)

Institutional Profile Questionnaire	
Name of institution	
City, Province	
Date of self-assessment	
Name(s) and title(s) of institution staff completing the assessment	

		Men's institution			Women's institution		
		Maximum	Medium	Minimum	Maximum	Medium	Minimum
1	Level of security *(select all that apply)*	☐	☐	☐	☐	☐	☐
2	Maximum capacity						
3	Current number of inmates						
4	Maximum number of inmates in the past 30 days						
5	Current number of confirmed Inmate COVID-19 cases						
6	Number of Inmate confirmed cases since the beginning of the crisis						
7	Number of Inmate cases recovered						
8	Number of confirmed COVID-19 employee cases						
9	Number of cases of recovered employees						

10	Number of Registered Nurses		11	Number of Infection Control Professionals	
12	Number of other healthcare workers (support staff)		13	Number of Medical staff	
14	Number of medical beds		15	Number of medical beds in isolation	
16	Does your institution have the ability to cohort inmates with COVID-19?	☐ No → ☐ Yes	16a	Why not? *(skip to question 18)*	

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17	Has your institution been able to cohort all inmates with COVID-19?	☐ No → ☐ Yes ☐ N/A – No cases	17a	Why not?
18	Does your institution have healthcare staff that are designated to care only for cohorted (put together) COVID-19 inmates?	☐ No → ☐ Yes	18a	Why not?

19		How many full boxes of the following PPE does your institution have? Include quantity per box (e.g. 50 pairs of gloves/box)	How many boxes does your institution use per day?
	Medical masks		
	N95 respirators		
	Face shields		
	Disposable gloves (all sizes)		
	Disposable gowns (all sizes)		

Part B - COVID-19 IPC Self-Assessment Tool for CSC (please complete sections 1 through 4 prior to PHAC staff visit)

	Section 1: Administrative Control Elements	Present Yes	Present No	Present N/A	Notes/Comments
Policies and Procedures					
1.	**Respiratory etiquette program**				
a	Our institution has signs posted at entrances with instructions for staff/volunteers/visitors with symptoms of respiratory infection (e.g. covering mouth/nose when coughing or sneezing, using/disposing of tissues, and performing hand hygiene after contact with respiratory secretions)	☐	☐	☐	
b	Inmates receive education on the importance of respiratory etiquette	☐	☐	☐	
2.	**Hand hygiene**				
a	Staff receive job-specific training (e.g. HCWs and cleaning staff) and competency validation on hand hygiene at the time of employment and regularly after that	☐	☐	☐	
3.	**Environmental cleaning* - Our institution:**				
a	Has written environmental cleaning and disinfection policies and procedures for: routine cleaning and disinfection of rooms, cleaning and disinfection of high-touch surfaces in common areas, proper waste disposal, cleaning and disinfection of shared equipment and appropriate handling of linen	☐	☐	☐	
b	Has a process for environmental cleaning staff to document scheduled cleanings	☐	☐	☐	
c	Has supplies for cleaning and disinfection readily available and easily accessible	☐	☐	☐	

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d	Has a system for identification and storage of clean and dirty equipment	☐	☐	☐	
e	Supplies for cleaning and disinfection are readily available, easily accessible and used as prescribed by manufacturer (i.e. cited dilutions and retention time on surfaces)	☐	☐	☐	
	*For COVID-19, refer to Health Canada's list of hard surface disinfectants: https://www.canada.ca/en/health-canada/services/drugs-health-products/disinfectants/covid-19/list.html				
4.	**Triage and screening - Our institution:**				
a	Has policies and procedures in place to screen inmates for signs and symptoms of COVID-19 prior to them entering the infirmary	☐	☐	☐	
b	Has policies and procedures in place to appropriately deal with inmates showing signs and symptoms of COVID-19 (e.g. cohorting (grouping together), isolation)	☐	☐	☐	
5.	**Routine practices and additional precautions**				
a	Our institution has policies and procedures for Routine Practices (RP) and Additional Precautions (AP) that include the use of Personal Protective Equipment (PPE)	☐	☐	☐	

	Section 1: Administrative Control Elements *(continued)*	**Present** Yes	No	N/A	**Notes/Comments**
6.	**Selection and use of Personal Protective Equipment (PPE)**				
a	Institutional staff receive job-specific training and competency validation on proper use of PPE at the time of employment and regularly after that	☐	☐	☐	
7.	**Occupational health and safety - Our institution:**				
a	Staff receive job-specific training (e.g. HCWs and cleaning staff) and competency validation on hand hygiene at the time of employment and regularly after that	☐	☐	☐	
b	Has requirements for new employees and staff attendance at training and education in IPC (where relevant to position), with documentation of attendance	☐	☐	☐	
c	Has an Occupational Health and Safety (OH&S) workplace policy in place with clear roles and responsibilities	☐	☐	☐	
d	Has healthcare worker immunization policies in place for vaccine preventable diseases including influenza, pertussis and staff immunization records	☐	☐	☐	
e	Has a workplace policy that includes a clear expectation that staff do not come in to work when ill	☐	☐	☐	
f	Has a respiratory program, which includes N-95 fit testing and training on the use of N95 respirators	☐	☐	☐	
g	Has a policy and procedure for managing exposures to blood and body fluids that is readily available to staff	☐	☐	☐	
8.	**Outbreak management - Our institution:**				
a	Has a process in place to recognize and respond to disease outbreaks and to address deficiencies as needed	☐	☐	☐	
b	Refers to relevant jurisdictional authority for directives on case reporting and outbreak management	☐	☐	☐	

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c	Has a policy in place to notify the public about unit/institutional closures and/or visitor restrictions	☐	☐	☐	
d	Has a process in place to declare the end of an outbreak	☐	☐	☐	
e	Has attendance management policies to enable Health Care Workers (HCWs) to remain home while ill with an acute respiratory illness that can be spread in the health care setting.	☐	☐	☐	
f	Has an enhanced cleaning schedule in place during outbreaks for dishes and cutlery, kitchen/food preparation and waste management	☐	☐	☐	
g	Has increased the frequency of cleaning high-touch surfaces, high touch surfaces cleaned and disinfected at a minimum of twice daily and when soiled	☐	☐	☐	
h	Cleans and disinfects at least once per day on all low-touch surfaces	☐	☐	☐	
i	Ensures that attention is paid to cleaning and disinfection of any surfaces that may be touched by an infected patient/inmate while out of the room/cell	☐	☐	☐	

Section 1: Administrative Control Elements *(continued)*		**Present**			**Notes/Comments**
		Yes	No	N/A	
9.	**Accommodation and Signage - Our institution:**				
a	Has protocols in place for determining appropriate placement of inmates based on assessment of infection transmission risk	☐	☐	☐	
b	Has clear protocols for determining inmate placement and room sharing based on assessment of infection transmission risk when single rooms are limited	☐	☐	☐	
c	Separates Inmates with a cough or other symptoms of an acute respiratory infection from non- symptomatic inmates by a minimum distance of 2 metres in common areas and shared inmate rooms	☐	☐	☐	
d	Has clear infection prevention and control signage at key locations as needed (e.g., covering coughs, hand hygiene)	☐	☐	☐	
10.	**IPC Evaluation or audit - Our institution:**				
a	Has a quality improvement process in place for review of IPC practices	☐	☐	☐	
b	Has processes and tools for IPC assessment / reporting	☐	☐	☐	
Resources					
1.	**IPC staff - Our institution:**				
a	Has access to an occupational health and safety committee and to infection prevention and control staff	☐	☐	☐	
b	Has adequate surge capacity to respond to disease outbreaks	☐	☐	☐	
2.	**Trained staff - Our institution:**				
a	Trains all staff and visitors on routine practices and additional precautions, including respiratory etiquette and hand hygiene	☐	☐	☐	

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Section 2: Engineering Control Elements		Present			Notes/Comments
		Yes	No	N/A	
1.	**Our institution:**				
a	Has an established program for maintaining heating, ventilation and air conditioning (HVAC) systems appropriate to the care setting	☐	☐	☐	
b	Includes the use of barriers such as: Plexiglas, or other physical barriers to separate/direct personnel flow	☐	☐	☐	
c	Has hand hygiene facilities available at point-of care (e.g. alcohol-based hand rub, dedicated hand hygiene sink)	☐	☐	☐	
d	Has hand hygiene facilities available at entrance/exit to rooms to accommodate putting on/taking off of personal protective equipment (PPE)	☐	☐	☐	
e.	Has personal protective equipment (PPE) that is readily available and easily accessible in a variety of sizes	☐	☐	☐	
f.	Has an airborne infection isolation room(s), with private toilets	☐	☐	☐	
g.	Has an adequate number of no-touch waste receptacles for disposal of paper towels, tissues and PPE	☐	☐	☐	

Section 3: Specific COVID-19 Recommendations		Present			Notes/Comments
		Yes	No	N/A	
1.	**Our institution ensures that:**				
a	Staff, inmates, essential visitors and volunteers maintain a minimum of 2-meter spatial distancing	☐	☐	☐	
b	Staff, essential visitors and volunteers are trained on relevant IPC measures such as proper hand hygiene and use of PPE	☐	☐	☐	
c	Staff and essential visitors and volunteers wear masks for the full duration of the shift/visit and are provided training and education for putting on and removing masks	☐	☐	☐	
d	Inmates with respiratory symptoms should wear a mask and follow respiratory etiquette	☐	☐	☐	
e	Protocols are in place for cleaning/disinfection of personal equipment (e.g. vets, belts, radio, etc.) worn as part of uniforms	☐	☐	☐	
f	If cohorting (housing people together) is necessary, only patients who are confirmed to have COVID-19 infection are cohorted (put together)	☐	☐	☐	
g	The institution has written procedures for the identification of potentially infectious staff, inmates and any essential visitors	☐	☐	☐	
h	All staff are screened upon entry (protocol includes temperature and signs & symptoms of COVID-19)	☐	☐	☐	

Section 3: Specific COVID-19 Recommendations *(continued)*		Yes	No	N/A	Notes/Comments
1.	**Our institution ensures that *(continued)*:**				
i	Inmates are educated on COVID-19 transmission prevention measures (i.e. hand hygiene) and prompt reporting of signs and symptoms	☐	☐	☐	

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j	Guidance is available for staff regarding handling and cleaning of uniforms and footwear	☐	☐	☐	
k	Movement of staff between COVID-19 positive and negative inmates is minimized as much as possible	☐	☐	☐	
l	Volunteers and visitors are restricted to those deemed essential and in some cases visitors may be prohibited (e.g. during outbreaks)	☐	☐	☐	
m	Have environmental services staff wear the same PPE as other staff when cleaning and disinfecting areas where they will be within 2-metres of inmates, and otherwise according to institution policies and procedures	☐	☐	☐	
n	If an inmate is transferred from an institution with a known outbreak of COVID-19 or is a known contact of a COVID-19 case, contact and droplet precautions must be implemented for 14 days and then reassessed. The inmate should be moved to a single cell. If this is not possible, other IPC measures should be applied (e.g. physical distancing, inmate wearing a mask, etc.)	☐	☐	☐	
o	Prior to working every shift, staff should report to institution management if they have had potential exposure to a case of COVID-19 to determine whether restrictions are necessary (which may depend on local jurisdictional guidance), as well as consulting their own healthcare provider for any needed follow-up	☐	☐	☐	
2.	**Transportation for inmates with COVID-19 (Contact and Droplet Precautions) – our institution ensures that:**				
a	Written intake procedures or protocols are in place to identify inmates with signs and symptoms for COVID-19 at the time of admission or transfer	☐	☐	☐	
b	Transport of patients with confirmed or suspected COVID-19 is restricted to essential diagnostic tests and therapeutic treatments	☐	☐	☐	
c	Contact and droplet precautions are maintained by staff during transport	☐	☐	☐	
d	The inmate wears a mask, is instructed to use respiratory hygiene, performs hand hygiene, and is provided with clean clothes, accompanied by a healthcare worker using contact and droplet precautions	☐	☐	☐	
e	Droplet and contact precautions are communicated to the transferring service and receiving unit ahead of transfer	☐	☐	☐	
f	Enhanced cleaning and disinfection protocols are followed for any surfaces that may be touched by the patient while out of the room and for the transport vehicle	☐	☐	☐	

Section 4: Surveillance and outbreak management Elements		**Present**			**Notes/Comments**
		Yes	No	N/A	
1.	**Our institution has Surveillance in place with:**				
a	Case definition	☐	☐	☐	
b	Screening & Reporting	☐	☐	☐	

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c	Minimum data elements.	☐	☐	☐	
d	Notification and Communication system in place to inform surveillance results to Senior Management.	☐	☐	☐	
2.	**Our institution has an Outbreak management plan in place, which includes:**				
a	Increased frequency of cleaning with a focus on high-touch surfaces	☐	☐	☐	
b	Increased frequency of active screening for COVID-19 symptoms in inmates	☐	☐	☐	
c	Contact tracing of individuals (staff, essential volunteer, visitors, and inmate) with potential exposure to the infected individual (either staff, essential volunteers, visitors or inmate) is conducted by the appropriate group (refer to relevant jurisdictional authority for directives)	☐	☐	☐	
d	Further restriction of movement of inmates within the institution, with discontinuation of all non-essential activities, including communal activities	☐	☐	☐	
e	Non-essential inmate transfers and new inmate admission are restricted in the context of an outbreak of COVID-19	☐	☐	☐	
f	Reviewing and reinforcing visitor restrictions	☐	☐	☐	
g	When the number of confirmed or suspected COVID-19 cases in the institution is high, consideration should be given to having dedicated teams of staff specific to inmates with suspected or confirmed COVID-19, where feasible	☐	☐	☐	

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