INFECTION PREVENTION AND CONTROL

PROVINCIAL GUIDELINES

Provincial Infection Prevention and Control Guidance for Viral Respiratory Illness in Long-Term Care and Seniors' Assisted Living Settings in British Columbia

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BRITISH COLUMBIA | Ministry of Health

PICNet
PROVINCIAL INFECTION CONTROL NETWORK OF BRITISH COLUMBIA
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Guideline Review

This guidance replaces the *COVID-19 Infection Prevention and Control Guidance for Long-Term Care homes and Seniors' Assisted Living Settings* (August 2022).

Summary of Changes

- Updated to encompass all viral respiratory illnesses (VRIs), including COVID-19, influenza, and Respiratory Syncytial Virus (RSV).
- Added definitions section.
- Added definitions for probable and confirmed VRI cases.
- Updated screening recommendations for health care workers (HCWs), residents, and visitors.
- Updated links to current guidance documents, tools (e.g., signage and posters), and resources.

Acknowledgement
This document was developed by the Provincial Infection Control Network of BC (PICNet) in consultation with the Infection Prevention and Control (IPC)/Workplace Health and Safety (WHS) Provincial COVID-19 Working Group.

Abbreviations

ABHR	Alcohol-Based Hand Rub
AGMP	Aerosol Generating Medical Procedure
AL	Assisted Living
COVID-19	Coronavirus disease, 2019
HCW	Health care worker
IPC	Infection prevention and control
IPCP	Infection prevention and control professional/team
LTC	Long-term care
MHO	Medical Health Officer
PHO	Provincial Health Officer
PICNet	Provincial Infection Control Network of British Columbia
PPE	Personal Protective Equipment
ORA	Organizational risk assessment
SARS-CoV-2	Severe Acute Respiratory Syndrome – Coronavirus-2
VRI	Viral Respiratory Illness
WHS	Workplace Health and Safety/Occupational Health and Safety

Key Terms

Additional precautions: Interventions implemented for certain pathogens or clinical presentations in addition to routine infection prevention and control practices, to reduce the risk of transmission of microorganisms from resident to resident, resident to health care worker (HCW), and HCW to resident.

Aerosol generating medical procedure (AGMP): Medical procedure(s) that can generate a large volume of very small droplets (aerosols) as a result of artificial manipulation of a person's airway.

Airborne precautions: Interventions to reduce the risk of transmission of microorganisms through airborne droplet nuclei (small particle residue of evaporated droplets containing microorganisms that

remain suspended in the air for long periods of time) or dust particles containing the infectious agent. This intervention is one of a number of additional precautions.

Alcohol-based hand rub (ABHR): A liquid, gel, or foam formulation of alcohol (e.g., ethanol, isopropanol) which is used to reduce the number of microorganisms on hands in situations when the hands are not visibly soiled. Optimal strength of alcohol-based hand rubs used in health care settings should be 70% to 90% alcohol.

Cleaning: The physical removal of foreign material, e.g., dust, soil, organic material such as blood, secretions, excretions, or microorganisms, using mechanical and/or chemical means. Cleaning physically removes rather than kills microorganisms.

Cohort: Two or more residents colonized or infected with or exposed to the same organism that are separated physically, in a room or unit, away from other residents. For example, residents with a suspected or confirmed diagnosis, and residents without symptoms suggestive of viral respiratory illness (VRI), can each be a respective resident cohort.

Cohorting HCWs: The practice of assigning specified personnel to only care for residents known to be colonized/infected with or exposed to the same organism. Such individuals would not participate in the care of other residents.

Drug Identification Number (DIN): In Canada, disinfectants are regulated under the Food and Drugs Act and Regulations. Disinfectants must have a drug identification number (DIN) from Health Canada prior to marketing. This ensures that labeling and supportive data have been provided and that it has been established by the Therapeutic Products Directorate (TPD) that the product is effective and safe for its intended use.

Disinfection: The inactivation of disease-producing microorganisms. Disinfection does not destroy bacterial spores. Disinfection usually involves chemicals, heat, or ultraviolet light.

Droplet and contact precautions: Interventions used, in addition to routine practices, to reduce the risk of transmission of microorganisms via respiratory droplets and through direct and indirect contact. Droplet and contact precautions include the use of personal protective equipment (PPE) such as a medical mask, eye protection, gown, and/or exam gloves, whenever an individual is within two metres of the resident. Signage to communicate droplet and contact precaution measures are also used. This set of interventions is one of a number of additional precautions.

Hand hygiene: A process for the removal of soil and transient microorganisms from the hands. Hand hygiene may be accomplished using soap and running water or the use of alcohol-based hand rubs. Hand washing with soap is required whenever hands are visibly soiled.

Health care worker (HCW): Individuals providing or supporting health care services. This includes, but is not limited to nurses, physicians, nurse practitioners, emergency service providers, pharmacists, dentists, podiatrists, respiratory therapists and other allied health professionals, students, support services (e.g., housekeeping, dietary, maintenance, hairdressers), and volunteers.

Infection prevention and control (IPC): Measures practiced by health care workers and others in health care facilities to decrease transmission and acquisition of infectious agents (e.g., hand hygiene, use of personal protective equipment, and cleaning and disinfection). IPC measures include routine practices and contact, droplet and airborne precautions.

Infection prevention and control professional (IPCP): Trained and knowledgeable individuals and teams who have the primary responsibility for development, implementation, evaluation, and education related to policies, procedures, and practices for the prevention and control of infections in health care settings.

Long-term care (LTC): Long-term care settings provide 24-hour professional supervision and care in a protective, supportive environment for people who have complex care needs and can no longer be cared for in their own homes or in an assisted living residence.

Medical mask: A medical grade face mask that meets ASTM International (or equivalent) performance requirements for bacterial filtration efficiency, particulate filtration efficiency, fluid resistance (synthetic blood), pressure differential, and flame spread. Respirators have differing characteristics from medical masks and are defined below. Medical masks include surgical and procedure masks.

Outbreak: An increase in the occurrence of cases of infection or disease over what is expected in a defined setting or group in a specified time period; synonym of epidemic but used more often when limiting the geographic area.

Organizational risk assessment (ORA): An assessment done by organizations/institutions to identify and evaluate the risk of exposure to infectious agents in the health care environment and to implement appropriate control measures (e.g., communicable disease safety plan) according to the hierarchy of controls to minimize the risks.[1]

Personal protective equipment (PPE): Clothing or equipment worn by individuals for protection against hazards such as chemicals, blood, body fluids, and infectious secretions.

Respirator: PPE that provides respiratory protection for the wearer to reduce the risk of inhaling airborne particles, including infectious agents by forming a tight seal, protecting the mouth and nose, and filtering out air particles. The device is tested and certified in accordance to established standards by the Canadian Standards Association, Health Canada, National Institute for Occupational Health and Safety, or equivalent and approved for use by the health authority or organization. Examples include disposable filtering facepiece respirators such as N95 respirators, elastomeric respirators, and powered air-purifying respirators (PAPRs).

Resident: A person receiving care in a LTC home or in a registered seniors' assisted living residence.

Resident (patient) care area: Any room or area within a LTC and seniors' assisted living facility (including a contracted facility), where residents are actively receiving care. This includes any location where emergency health services are being provided. It does not include locations such as administrative areas or private offices, which are not generally accessed by residents, or areas where care is not being provided, such as foyers, hallways, cafeterias, chapels, and family rooms.

Respiratory droplets: Range of small (aerosols) and large fluid particles that are generated when a person coughs or sneezes or when an AGMP is done.

Routine practices: The practices recommended in Canada to be used with all residents to prevent and control transmission of infectious microorganisms in health care settings. These include point-of-care risk assessment (PCRA), hand hygiene, respiratory hygiene, resident placement and accommodation, use of PPE, aseptic technique, safe linen and waste handling practices, equipment cleaning, and disinfection.[2]

Test-based strategy: The decision to discontinue additional precautions based on having negative test results.

Viral respiratory illness (VRI): Any new-onset of acute infectious respiratory illness suspected or confirmed to be caused by a viral agent (e.g., SARS-CoV-2, influenza, RSV) with either upper- or lower-respiratory tract involvement, presenting with symptoms of a new or worsening cough and often fever. Refer to Section 2 of this document for Probable VRI and Confirmed VRI case definitions.

Workplace health and safety (WHS): Trained individuals responsible for the anticipation, recognition, evaluation, and control of hazards arising in or from the workplace that could impair worker health and well-being. This includes prevention of communicable disease transmission to workers.

1. Introduction

Viral respiratory illness (VRI) such as that caused by influenza, coronavirus, respiratory syncytial virus (RSV), and 'common cold' viruses are widespread across the globe. VRIs are most often transmitted across a spectrum of small (aerosols) and large-sized respiratory droplets expelled when an infected person coughs or sneezes, and when aerosol generating medical procedures (AGMP) are done.[3,4] Multiple factors may influence transmission and infection with VRI (e.g., transmissibility of the virus, enclosed spaces, relative humidity, ventilation). Viruses in respiratory droplets can land on the recipient's eyes, nose, or mouth, or are inhaled when close to an infected person. Because microorganisms in droplets can often survive on surfaces, infections can also be spread indirectly when people touch contaminated hands, surfaces, and objects and then touch their mouth, nose, or eyes.

Individuals aged 70 years and older, especially those with underlying chronic health conditions, are at higher risk of a serious or fatal illness after contracting a VRI. COVID-19 and influenza viruses continue to be an important cause of morbidity and mortality in patients and residents in health care facilities, including people who are immune compromised, frail, and elderly individuals. Preventing transmission of VRIs is essential in minimizing the risks for residents, health care workers (HCWs), and staff working in long-term care (LTC) and seniors' assisted living (AL) homes. VRIs have similar routes of transmission, which means that infection prevention and control (IPC) measures to prevent and control transmission in these health care settings can be highly effective against all of them.

1.1. Purpose and Scope

This document is intended to provide infection prevention and control (IPC) guidance for the operators of all licensed Long-Term Care (LTC) facilities and registered seniors' Assisted Living (AL) residences in B.C., including health authority owned, operated, and/or funded facilities, as well as contracted affiliates and fully private operators, to mitigate the impact of VRIs that spread primarily through close range respiratory droplets, such as SARS-CoV-2, influenza, and respiratory syncytial virus (RSV). This guidance does not apply to correctional centres/facilities, mental health and supportive recovery AL facilities, or independent living facilities. The guidance outlines the IPC measures intended for providing care safely in these settings when interacting with residents.

This guidance is based on the current available best practices and scientific evidence and may change as new information becomes available. Due to the very broad range of health care services and settings in British Columbia, this guideline may need adapting for specific contexts.

Operators are responsible for ensuring adequate training and ongoing engagement for HCWs and staff on updated IPC requirements as outlined in this document. HCWs and staff (including all contractors and volunteers) are responsible for taking reasonable steps to protect their own health and safety and the health and safety of all other people in their workplace. In the context of VRIs, this means HCWs and staff are responsible for their own personal health measures: rigorous and frequent hand hygiene, staying home when sick, respecting personal space, practicing respiratory etiquette, wearing masks when appropriate, and ensuring immunizations are up-to-date. Recognizing that seniors' AL residences may have a regulatory level of care and service that differs from LTC homes, operators are advised to apply the measures outlined in this document to their facilities to the greatest extent possible.

All HCWs **must** follow current provincial and organizational policies, including orders from the Provincial Health Officer (PHO) and their local Medical Health Officer (MHO).

Note: There **may** be circumstances that exist where additional Ministry of Health policy directives will be in place in addition to or instead of these guidelines. Please follow the current and applicable provincial policy for IPC measures in health care settings, regulations, and Public Health Orders.

Further Information/Resources:

- Refer to the Provincial Outbreak Guidance for Viral Respiratory Illness in Long-Term Care Settings in British Columbia.
- Refer to Appendix B: Provincial IPC Preparedness Checklist for VRI in LTC and seniors' AL settings to assist in implementing the guidance in this document.
- For viral respiratory pathogens of concern, refer to the BC Centre for Disease Control's (BCCDC) Respiratory Diseases webpage for more information.

2. Viral Respiratory Illness Case Definitions

Early detection of VRI symptoms will facilitate the rapid implementation of effective control measures to limit the spread of VRIs.

2.1. Probable Case of Viral Respiratory Illness

A resident is suspected to have a VRI when they have acute onset of signs and symptoms based on clinical judgement* **AND** test results maybe pending.

VRI signs and symptoms include a new or worsening cough and/or fever** and any one or more of the following (not listed in any particular order of significance):

- Shortness of breath
- Runny or stuffy nose (i.e., congestion) or sneezing
- Sore throat or hoarseness or difficulty swallowing
- Other non-specific symptoms may include tiredness, malaise, muscle aches (i.e., myalgia), headache, and nausea, vomiting, or diarrhea (maybe present in some residents).

***Note**: Clinical judgement is required to assess probable VRI. Other etiologies including non-infectious causes must be considered and ruled out (e.g., side effect of medication or chronic health conditions).

** Fever may or may not be present, particularly in young children, the elderly, the immuno-compromised, or those taking medications such as steroids, Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), or Acetylsalicylic Acid (ASA). A temperature <35.6ºC or > 37.4ºC in the elderly may be an indication of infection.

2.2. Confirmed Case of Viral Respiratory Illness

A confirmed case of VRI is a resident with:

- Signs and symptoms of acute respiratory infection;
  AND

- Confirmation of infection with the pathogen causing VRI, (i.e., influenza, SARS-CoV-2, parainfluenza, RSV, adenovirus, rhinovirus, metapneumovirus)* by validated laboratory testing.

Note: Once initial testing has identified the causative agent within a select group of symptomatic residents, further testing of symptomatic residents may be suspended at the discretion of the MHO/official designate.

*** Further Information/Resources:** Refer to Appendix C: Common VRI Pathogens for organism-specific information, including incubation and communicability periods.

3. Immunization for Health Care Workers, Residents, and Visitors

- HCWs and staff in LTC facilities and seniors' AL residences **must** meet immunization requirements in accordance with Ministry of Health and employer policies, and when directed by a medical health officer.
- Residents and visitors are not required to be vaccinated, nor do they need to provide proof of their vaccination.
- Settings **should** confirm resident's immunization status on admission, interfacility transfer to an LTC or seniors' AL residence, and on an annual basis.
- Settings **should** offer appropriate vaccination(s) as indicated at the earliest opportunity (e.g., influenza, pneumococcal, and COVID-19).
- People (e.g., visitors, support persons) are **not to** visit a health care facility if they are sick and/or have symptoms of an infectious disease (e.g., active respiratory or gastrointestinal symptoms).

4. Infection Prevention and Exposure Control Measures

Implementation of infection prevention and exposure control measures helps to create a safe environment for LTC and seniors' AL residents, HCWs, staff, and visitors.

Further Information/Resources: Refer to the Hierarchy of Controls for Infection Prevention and Exposure Measures for Communicable diseases for information on IPC measures that can be implemented to reduce and eliminate the transmission of infectious diseases.

4.1. Routine Practices

- Routine practices **should** be in place at all times in all LTC facilities and seniors' AL residences. They are fundamental to preventing transmission of microorganisms among residents, HCWs, staff, and visitors in these settings.
- Routine practices and other risk reduction strategies include conducting a PCRA **before every** resident interaction, practicing hand hygiene, respiratory hygiene, cleaning and disinfection, and appropriate use of PPE.

4.1.1. Point-of-Care Risk Assessment (PCRA)

The PCRA helps HCWs select the appropriate actions and PPE required to minimize their risk of exposure to known and unknown health risks for a specific interaction, a specific task, with a specific resident and in a specific environment. The PCRA is based on judgment about the clinical situation, as well as up-to-

date information on how the specific health care facility has designed and implemented appropriate physical (engineering) and administrative controls, and the use and availability of PPE. The PCRA can be adapted for specific-care settings, roles, and suspected or confirmed VRI infectious agent (e.g., influenza SAR-CoV-2, and RSV).

- Prior to every resident interaction, all HCWs and staff **must** complete a PCRA to assess any occupational health risks posed by a resident, situation, or procedure to themselves, other HCWs, staff and other residents and visitors.
- The PCRA tool **should** be used in assessing exposure risks and identifying appropriate measures to prevent and control exposure, such as use of PPE.

4.1.2. Hand Hygiene

- All HCWs, staff, residents, and visitors **must** rigorously practice hand hygiene with plain soap and warm water or at least 70% alcohol-based hand-rub (ABHR) as this is the most effective way to reduce the spread of illness.
- Strategies to ensure diligent hand hygiene are as follows:
  - Ensure dedicated hand hygiene sinks are well-stocked with plain soap and paper towels for hand washing. Antibacterial soap is not required for VRI prevention.
  - Ensure 70% ABHR is readily available to residents, HCWs, staff and visitors at all facility entry and exit points, common areas, resident units and at the point-of-care of each resident room.
  - Ensure other supplies, including disinfecting wipes, tissues, and waste bins are available as required at point-of-use.
  - Post signage to promote and reinforce the importance of diligent hand hygiene and proper hand hygiene technique with HCWs, staff, residents, and visitors on an ongoing basis.
  - Encourage all residents to perform hand hygiene where physically and cognitively feasible. Assist residents with performing hand hygiene if they are unable to do so by themselves.
- Instruct HCWs, staff, residents, and visitors on diligent hand hygiene which **must** be performed at the following moments:
  - When entering and exiting the building;
  - When hands are soiled;
  - Before and after touching others;
  - After using the washroom;
  - Before and after handling food and eating;
  - After performing personal hygiene routines, such as oral care;
  - Before and after handling medications;
  - After sneezing or coughing; and
  - When entering and exiting resident rooms.
- Where applicable, HCWs and staff **must** also perform hand hygiene at these times:
  - At the beginning of the workday;
  - Before preparing or serving food;
  - Before putting on new PPE and after removing each individual piece of PPE;
  - Before and after contact with a resident or their environment, even while wearing gloves;
  - Before performing an aseptic or sterile procedure;
  - Before moving from a contaminated site to a clean body site during the care of the same resident;
  - Before assisting residents with feeding or medications; and
  - After contact with body fluids.

4.1.3. Respiratory Etiquette

- Post signs in the home/residence to encourage and guide residents, HCWs, staff and visitors to follow proper respiratory etiquette.
- Ensure an adequate supply of tissues and waste baskets are available for use by residents, HCWs, staff, and visitors.
- Reinforce the importance of diligent respiratory etiquette with residents, HCWs, staff, and visitors on an ongoing basis, including:
  - Using tissues to contain coughs and sneezes; or coughing or sneezing into one's upper sleeve or elbow if tissues are not available;
  - Disposing of used tissues in a proper waste bin and performing hand hygiene immediately after; and
  - Refraining from touching their eyes, nose, or mouth with unclean hands.

4.2. Administrative Measures

4.2.1. Passive and Active Screening for VRI Symptoms and Risk Factors

- Follow current and applicable Ministry of Health policy directives, regulations, and Public Health Orders.

Passive Screening

Passive screening means that all HCWs, staff, and visitors will self-monitor for respiratory signs and symptoms and assess their own risk factors to determine if they should enter a site. Passive screening includes the following actions by operators:

- Post signage at appropriate locations around the facility for foundational IPC measures, including self-screening for symptoms by reviewing the signage, hand hygiene, respiratory etiquette, respecting personal space, and staying home when sick. Additionally, ensure the availability of masks and ABHR at all entry point(s) for those who wish or/need to use them.
- Post signs in multiple languages at all entry point(s) reminding people not to enter if they are sick or if they are required to self-isolate in accordance with public health directives.

Further Information/Resources: Please refer to the following IPC posters on the PICNet website:

- VRI Transmission poster.
- How to Clean your Hands poster.
- Respect Personal Space poster.
- How to Wear a Medical Mask poster.
- Staff and Visitors Screening poster for VRI and other communicable diseases *(outside VRI season).*
- All Patients/Residents Screening poster for VRI and other communicable diseases *(outside VRI season).*

Active Screening

Active screening means screening of individuals to determine their risk of having VRI and guide measures to prevent exposure of VRI to others in the facility or residence.

- Active screening **may** be in place when indicated by provincial or organizational direction (e.g., during VRI season, emergency department screening). This may include:
  - Active screening of visitors for VRI symptoms upon entry;
  - Directing all individuals to perform hand hygiene upon entry; and

    - Providing medical masks.
- As part of a PCRA and a clinical assessment, HCWs **should** assess and monitor residents for VRI symptoms and take appropriate measures to prevent and minimize the risk of exposures.

Further Information/Resources: During the VRI season, please refer to following IPC posters for additional guidance:
- VRI Entrance Screening Tool for Health Care Facilities poster.
- Medical Mask is Required poster.

Screening of Health Care Workers and Staff

- Before each shift and prior to leaving for work, HCWs, and staff **must** follow:
    - All applicable employer communicable disease prevention protocols, including practicing rigorous hand hygiene and respiratory etiquette, passively self-screening for symptoms by reviewing the signage, and staying home if they are ill or have symptoms of illness.
    - Measures outlined in the VRI HCW Self-Check and Safety Checklist.
- HCWs and staff who have any questions or concerns regarding possible exposures or symptoms are advised to call their supervisor/workplace health and safety department for assessment and advice.
- Additionally, LTC/AL sites operators are to adopt occupational health policies and exposure guidance for returning to work following any serious respiratory illness.

Screening of Residents

- Resident screening can be limited to an assessment of general wellness as part of the daily staff check in with each resident. Residents who are unwell will require a clinical assessment.
- Residents **must** be supported to practice hand hygiene, practice respiratory etiquette, self-screen for symptoms in accordance with posted signage, and undergo testing in accordance with local, regional, or provincial testing guidelines.

Screening of Visitors

- Visitors **must** practice hand hygiene, practice respiratory etiquette, and self-screen for symptoms in accordance with posted signage prior to their visit.

4.2.2. Specimen Collection and Testing for VRI

- Review the latest viral testing guidelines prior to any testing.
- All HCWs **must** follow institutional process and procedures for specimen collection, transport, and testing.
- Follow droplet and contact precautions during specimen collection. These precautions include wearing a gown, gloves, medical mask, and eye protection (e.g., face shield/goggles).

Further Information/Resources:
- Refer to the BCCDC's Viral Testing and Laboratory Services webpages.
- Refer to the 4.2.3. Guidance for Personal Protective Equipment (PPE) outlined below in this document.
- Refer to the video for instructions on how to perform a nasopharyngeal swab.

If a Resident is Suspected for VRI

LTC facilities

- If a resident is identified or suspected with a VRI (e.g., resident reports fever and/or new/worsening cough and another symptom (Refer to Section 2 for VRI case definition):
  - Follow public health guidance regarding testing and notification requirements.
  - All residents suspected of having VRI **should** be reassessed at a minimum of twice daily to detect additional signs or worsening symptoms.
  - Implement droplet and contact precautions, which includes wearing a medical mask, eye protection, gloves, and gown (refer to the Additional Precautions section) and perform a PCRA prior to any interaction with the unwell resident.
  - Place the resident in a single bedroom, if possible (see the Placement and Accommodation of Residents with Suspected or Confirmed VRI in this document), and post droplet and contact precautions signs on the door of the resident's room.
  - Notify the designate at the facility/residence (e.g., director of care, medical director, site manager) and test the resident for VRI in accordance with provincial testing guidelines.
  - Inform environmental services of the need for enhanced cleaning in the resident's room and provide meals within the resident's room while awaiting test results, if possible.
  - Set up a PPE station/cart outside the resident's room.
  - Ensure all staff entering the resident's room follow routine practices and droplet and contact precautions, including using appropriate PPE and practicing rigorous hand hygiene.
  - Maintain an increased level of surveillance of other residents and for any staff with symptoms consistent with VRI.

Seniors' Assisted Living Residences

- If a resident develops VRI symptoms, they **should** do the following:
  - Self-isolate in their suite.
  - Staff **should** try to interact directly with residents if feasible. If this is not feasible, staff can follow up with residents via phone or through the facility intercom system.
  - Where applicable, follow the criteria from the Resident Management with Suspected or Confirmed VRI section in this document.

4.2.3. Guidance for Personal Protective Equipment (PPE)

- HCWs and non-clinical staff **must** follow provincial policy for IPC measures in health care settings, as applicable, for example, during VRI season.
- Additionally, HCWs and staff **must** follow their health authority/organizational guidelines for PPE and use PPE that is approved by their organization.
- HCWs **must** perform a PCRA to determine if additional PPE or IPC measures are required.
- When in contact with residents deemed as a VRI risk, implement droplet and contact precautions, which includes wearing a medical mask, eye protection, gloves, and gown.
- Access to additional PPE, such as respirators **must** be provided by the facility in circumstances where a HCW or organization determines there is an elevated risk of transmission through resident interactions based on a PCRA or an organizational risk assessment.
- Where PPE is used, the employer **must** train, test and monitor staff compliance to ensure vigilant donning (putting on) and doffing (removing) of PPE.
- Monitor and safely secure PPE stock, while still ensuring staff can access PPE when needed.
- Whenever possible, PPE **should** be accessible and available at the point-of-care for each resident.

- Unless, directed otherwise, visitors and support persons of a resident with symptoms or a diagnosis of a VRI **should** wear a medical mask.
  - Visitors and support persons assisting with resident care or based on a PCRA by the HCW, they **must** follow droplet and contact precautions (wear gown, gloves, eye protection, and medical mask).
  - Visitors and support persons **should not** visit an LTC/AL facility if they themselves are sick and/or have symptoms of an infectious disease (e.g., active respiratory or gastrointestinal symptoms).
- When using PPE always:
  - Use PPE in combination with frequent hand washing using plain soap and water or ABHR with a minimum of 70% alcohol content.
  - Change gloves between residents, accompanied by hand hygiene between each glove change.
  - Change medical mask if the mask becomes wet, damaged, or soiled or when leaving the facility.
  - Practice hand hygiene after removing each individual piece of PPE and before putting on new PPE.
- Extended use of PPE considerations:
  - HCWs **must** follow provincial policies, and health-authority or organizational guidance for extended use of PPE.
  - A medical mask can have extended use for repeated, close contact encounters, unless damaged or visibly soiled.
  - Medical mask, respirator, and eye protection use can be extended for repeated, close encounters with residents where there is a known diagnosis of VRI and no other infectious pathogen is present (e.g., MRSA, CPO). In this context, medical masks **must** be removed, and hand hygiene **must** be performed:
    - If the mask becomes soiled, wet, or damaged;
    - When leaving the resident care area; and
    - After exiting the room or bed space of a resident on additional precautions.
  - Medical mask and eye protection **should** be removed, and hand hygiene **must** be performed at least two metres away or outside the room of residents on droplet and contact precautions. The PPE **must** also be removed and replaced if they become soiled, wet, damaged during use.
  - Respirators **must** be removed outside the resident room and hand hygiene **must** be performed. Respirators **must** also be removed and replaced if it becomes soiled, wet, or damaged during use.
  - Change PPE if moving from residents with the same confirmed VRI to residents without confirmed VRI or different VRI pathogen.
  - Change PPE if moving between residents on additional precautions for non-VRI reasons (e.g., airborne, droplet or contact precautions).
  - Properly doff and dispose/clean and disinfect PPE when leaving a resident care area (e.g., at end of shift, during breaks, or mealtimes).
  - Clean and disinfect eye/facial protection when visibly soiled and when leaving a resident care area (e.g., at the end of each shift, during breaks, or mealtimes).
- Don and doff PPE safely.
  - Hand hygiene **must** be performed before donning and after doffing PPE.
  - Ensure PPE instructions on how to put on (don) and how to take off (doff) PPE are readily available for HCWs.
- Signage to guide PPE use:
  - Post signage for droplet and contact precautions outside the room/space of residents who are suspected of having or have been diagnosed with a VRI.
  - Post signs for appropriate use of PPE in health care settings.

- Post signs at appropriate locations with instructions on how to put on (don) and how to take off (doff) PPE.
- Post signs at appropriate locations on how to wear a medical mask.
- Post instructions at appropriate locations on how to clean and disinfect eye and facial protection.
- Post signage to inform HCWs about skin protection from PPE use.

Further Information/Resources: For up-to-date information on PPE, please refer to BCCDC's personal protective equipment webpage and PICNet website for PPE donning and doffing videos.

Mask Use for HCWs (clinical and non-clinical staff), Visitors, and Residents

Medical masks provide protection from respiratory droplets and other blood and body fluids by covering the mouth and nose and include the following:

- HCWs and non-clinical staff **must** follow provincial policy for IPC measures in health care settings, as applicable.
- Visitors and support persons **must** wear a medical mask or other PPE when directed by a health care worker and/or based on a PCRA.
- Residents **must** wear a medical mask or other PPE when directed by a health care worker during direct resident care and/or based on a PCRA, if tolerated.
- Unless directed otherwise, HCWs (clinical and non-clinical staff), residents, and visitors **may choose** to wear a medical mask based on personal choice.
- Ensure masks are available at all entry points to those who wish or need to use them.
- Medical masks **should** be changed if the mask becomes wet, damaged, or visibly soiled.

Further Information/Resources:

- For signage, please refer to the How to Wear a Medical Mask poster on PICNet website.
- During the VRI reason or during outbreaks, refer to the Medical Mask is Required poster for signage.

4.2.4. Additional Precautions

Droplet and Contact Precautions

- Staff **must** follow additional precautions when entering units or rooms on droplet and contact precautions (e.g., rooms where residents diagnosed with confirmed or suspected VRI have been admitted).
- Visitors and support persons **must** follow all additional precautions (e.g., donning eye protection, gown, gloves, and/or medical mask) identified by a PCRA, as directed by a health care worker.
- PPE for droplet and contact precautions includes gloves, gown, eye protection and a medical mask.
- For AGMPs performed on residents with suspected or confirmed VRI, use an N95 respirator or equivalent, eye protection (e.g., goggles or face shield), gloves, and a gown.
- AGMPs on residents with suspected or confirmed VRI **should** only be performed when medically necessary.
- If an AGMP is performed, ensure the fewest number of staff necessary to perform the procedure are present.
- Follow and implement all additional measures ordered by an MHO or outlined in health authority guidelines to minimize risk.
- Access to additional PPE, such as respirators, will be provided in circumstances where a HCW determines there is elevated risk of VRI transmission through resident interaction, as indicated by the PCRA tool.

- Use precaution signs from your organization or available on the PICNet website.

Discontinuation of Droplet and Contact Precautions

Duration of additional precautions can vary depending on the communicable period of the suspected or confirmed VRI infectious agent.

- Consult with health authority IPC or MHO guidance as needed or refer to Appendix C: Common VRI Pathogens.
- Additional precautions **should** only be discontinued when there are no other remaining infectious diseases or pathogens requiring additional precautions (e.g., a resident with an antibiotic-resistant infection **should** be placed on contact precautions).
- Residents diagnosed with COVID-19 **should** be placed on droplet and contact precautions for five days following the symptom onset date or based on local health authority IPC or MHO guidance.
    - Droplet and contact precautions for residents with COVID-19 **should** remain in place until improvement in symptoms AND resolution of fever for 24 hours without the use of fever reducing medication.
    - A decision to modify the duration of droplet and contact precautions may be made at the discretion of the MHO or their official designate. Consideration should be given to the severity of illness and immunocompromised status of the resident. Please see the public health case and contact management guidance for more information.
    - Requirements for additional measures after the droplet and contact precautions period is over (e.g., continued masking and/or avoidance of group settings until 10 days following symptom onset date) are at the discretion of the MHO or their official designate.
- A health care professional, such as a physician or a nurse, **should** assess the clinical status of the resident for resolution and improvement of symptoms related to VRI and follow the criteria below to determine if discontinuation of droplet and contact precautions is indicated. These decisions **should** be made in consultation with the resident's most responsible care provider, IPC professional and/or the MHO.

Resident Management with Suspected or Confirmed VRI

Placement and Accommodation of Residents with Suspected or Confirmed VRI

- Immediately place any resident with suspected or confirmed VRI in a single room with a private toilet and sink for hand washing, where possible.
- If a single room is not available, maintain a physical separation of two metres between the bed space of the ill resident and all roommates. Close the privacy curtains between the beds.
- Provide a designated commode chair for the resident's use, if required.
- Only if necessary, restrict the resident to their room or bed space, including during meals and any other clinical or social activities.
- Provide the resident(s) with their individual supply of reusable equipment, if possible.
- Set up a PPE station/cart outside of the door of the resident's room/space and implement droplet and contact precautions. Please see the PCRA tool for health care facilities for more information.
- Post signage outside the resident's room/space indicating required additional precautions and giving instructions on how to don (put on) and doff (take off) PPE.
- For LTC facilities with residents in shared rooms, if practical and possible, place any resident with suspected or confirmed VRI in a single room with a private toilet and sink for hand washing, where possible, and monitor the roommates for symptoms.

- If a separate private room is not available, maintain a physical separation of two metres between all beds in the current room and close any privacy curtains.
- Cohorting of residents with suspected or confirmed VRI may be used, where practical, and **should** only be considered once other infectious causes have been ruled out and upon consultation with IPC and/or MHO. Designated VRI rooms/units **should not** be located close to vulnerable residents (e.g., residents with compromised immune systems or those with underlying health conditions).
- Decisions regarding cohorting **should** be made in consultation with the facility/residence director/administrator, an MHO or designate and client care leader.

Flow and Activity of Residents with Suspected or Confirmed VRI

- Residents with suspected or confirmed VRI **should** remain in their rooms unless there is an essential need for movement and/or transport.
- Transfers within and between facilities **should** be avoided unless medically indicated.
- When leaving the room, residents with suspected or confirmed VRI, when physically able, **should** wear a medical mask, perform hand hygiene, and minimize touching surfaces or items while outside their room.
- Residents with suspected or confirmed VRI who require urgent medical attention and transfer to an acute care facility **should** wear a medical mask during transport through the facility and during the transfer to hospital (as tolerated).
- Staff **must**:
    - Contact the receiving treatment facility/unit (e.g., dialysis clinic) and the transferring service ahead of time to review and discuss the transfer.
    - Notify the ambulance dispatch and the receiving institution about the resident's known or suspected VRI status ahead of transport.
    - Clean and disinfect any surfaces touched by the resident while outside of their room.
    - Maintain routine practices, droplet, and contact precautions during resident transfer.
    - Assist residents in performing hand hygiene, if necessary.
    - Encourage residents to practice respiratory etiquette.
    - Moving residents requiring continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) machine within a facility **should** be avoided.

HCW and Staff Cohorting

- Where practical, consider dedicating teams of staff to care for residents with suspected or confirmed VRI.
- During events of VRI clusters or outbreak scenarios, to minimize the risk of the transmission of infection in the building, consider re-organizing the workflow to limit the movement of staff between units/floors.
- Where possible, maximize the number of services delivered during a single resident interaction and minimize the number of times staff enter/leave the resident area during their shift.
- Where possible, minimize the number of staff who care for residents with confirmed or suspected VRI.
- Designate staff to specific units or cohorts of residents, whenever feasible.
- If it is not an option to have dedicated teams or staff providing care to ill residents in designated areas, HCWs and staff **must** take additional care to follow all IPC guidelines when providing care to residents who are VRI confirmed, symptomatic, or well.
- Train staff, families, visitors, and residents on appropriate IPC measures. Monitor for compliance and take immediate corrective action when needed.

Admissions and Transfers

- Vaccination status **should** be determined prior to any admission, or interfacility transfer to a LTC or seniors' AL residence.
- Screen residents for new respiratory and gastrointestinal signs and symptoms upon admission and continue regular clinical assessment. This includes admissions from acute care, community, transfer from other facilities and those receiving in-facility respite care.

Further Information/Resources: Please see the PCRA tool for health care facilities for screening of residents upon admissions.

Contact Management

- All residents who share a room with an ill resident with suspected/confirmed VRI **should** be considered exposed and monitored for symptoms at least twice a day for 5 days from the last date of exposure.
- Testing of contacts **should** be guided by the provincial testing guidance.

Further Information/Resources: For further information on management of resident close contacts, refer to the Provincial Outbreak Guidance for Viral Respiratory Illness in Long-Term Care Settings in British Columbia.

Management of Deceased Persons

- Refer to the Public Health Agency of Canada's Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings for management of deceased persons on additional precautions.

4.2.5. Visitation Guidelines and Social Events

Safe, meaningful visits in LTC and seniors' AL settings while adhering to IPC requirements are fundamental to preventing transmission of microorganisms among residents, HCWs, staff and visitors in these settings.

- Residents are free to receive visitors of their choice at any time, to the greatest extent possible, according to the Residential Care Regulation and Assisted Living Regulation. Visitation is under section 32(2)(b)(ii) of the Public Health Act.
- Unless directed by a Medical Health Officer, limits on the number of visitors are **not** required. Health and safety **should** be maintained while allowing visitors.
- Any limitations on visiting **must** be for health and safety reason(s).

Requirements for Visitors and support persons includes:

- Indoor and outdoor events, gatherings, and activities of any size, including social/recreational activities that are part of a resident's regular routine, and special events can include any number of visitors.
- Visitors and support persons are **not required** to provide their vaccination status and those who are unvaccinated can visit freely at LTC/AL sites.
- Unless directed by a Medical Health Officer, visitors and support persons are **not required** to undergo testing nor confirm a recent negative VRI test prior to visiting.

- Visitors and support persons **must** practice hand hygiene, practice respiratory etiquette, respect personal space, and self-screen for symptoms during their visit in accordance with posted signage.
- Visitors and support persons who are ill or experiencing symptoms of illness **should not** be visiting a health care facility including LTC/AL sites.
- Visitors and support persons **must** wear a medical mask or other PPE when directed by a health care worker, and/or based on a point-of-care risk assessment.
- Visitors, and support persons **should** wear a medical mask based on personal choice in common areas, non-clinical, and administrative areas.
- Visitors and support persons **must** follow all additional precautions (e.g., donning eye protection, gown, gloves, and/or medical mask) identified by a PCRA, as directed by a health care worker.
- At all entry points, provide ABHR and have medical masks available for those who choose to use them.
- During VRI season and outbreaks, the IPC guidance may change:
  - Facilities **should** make masks available for visitors who choose to use them.
  - Visitors entering the facility **may be required** to wear a medical mask in certain circumstances, as determined by an MHO or the PHO.
  - Other measures **may be required** based on emerging scientific evidence.

Social Events, Gatherings, and Activities

- LTC and seniors' AL residents residing within a campus of care may participate together in joint events, gatherings, and activities.
- Residents may also leave the facility for outings and family visits. There is no requirement for residents to isolate or undergo testing upon return.

Hairdressing and Other Personal Services

- All service providers **must** follow all applicable WorkSafeBC communicable disease prevention protocols, including rigorous hand hygiene, practicing respiratory etiquette, and the cancellation of services if the service provider or resident has symptoms.
- Hairdressers and other service providers working onsite will develop and submit communicable disease prevention plans, as described in WorkSafeBC's guide, to the director of the facility, who will confirm the feasibility of the plan and work to determine the starting date. These plans will need to follow the guidelines within this document.

4.2.6. Notification & Reporting

- Clinical staff **must** notify the IPC lead or designate at the LTC facility/seniors' AL residence regarding laboratory-confirmed VRI in residents, HCWs, staff, volunteers, or visitors.
- Inform environmental services of the need for enhanced cleaning in the resident's room and provide meals within the resident's room while awaiting test results, if possible.
- Notify the resident's primary care provider to determine if further assessment or treatment is required and the resident's family, substitute decision maker, or next-of-kin about the potential need to set or modify orders from the primary care provider.
- Ensure the facility's medical director or site manager is aware of the pending test result and the resident's goals of care.
- The IPC or designate at LTC home/seniors' AL residence **must** notify Public Health of all residents, HCWs, staff, volunteers, or visitors confirmed to have VRI or follow direction for reporting from the

local MHO or their official designate. The director of care or site manager **should** call the communicable disease unit at their local public health unit.

4.2.7. Outbreak Management

- An outbreak **may** be declared at the direction of the MHO or their official designate. Considerations for declaring an outbreak can be found in the BC Communicable Disease Control Manual and the Provincial Outbreak Guidance for Viral Respiratory Illness in Long-Term Care Settings in British Columbia.
- There **may** be circumstances where the cases of VRI at an LTC facility and seniors' AL residence do not meet the threshold for an outbreak but enhanced monitoring/surveillance and implementation of additional measures to prevent transmission are deemed appropriate by the MHO (e.g., severity of illness amongst vaccinated residents suggests circulation of a variant that causes more severe illness or a facility with low vaccination coverage amongst residents).
- **If an outbreak has been declared at a LTC facility, operators must implement the** Provincial Outbreak Guidance for Viral Respiratory Illness in Long-Term Care Settings in British Columbia **immediately.**

Further Resources: Refer to the Outbreak poster available on the PICNet website.

4.2.8. Health Care Worker Management and Safety

- Ensure that all HCWs have sound knowledge of IPC practices required in the workplace and with residents.
- Ensure there is a process for reporting health and safety concerns.
- HCWs are encouraged to keep all recommended immunizations up-to-date to protect themselves, residents, and others.
- Provide appropriate education and training, monitor for compliance, and take immediate corrective action when needed, on the following topics:
  - Hand hygiene
  - Environmental cleaning and disinfection
  - How to conduct a PCRA prior to each resident interaction.
  - Appropriate handling of HCW work clothing/uniforms. Work clothes **should** be laundered after each shift.
  - Respiratory protection, proper selection, and use of PPE, and putting on and removing PPE.

Health Care Worker Illness

- Develop a contingency plan for staff illnesses and shortages, with consideration given to staff scheduling:
  - Consider adjusting clinic hours to accommodate resident and staffing needs, while supporting IPC measures.
  - Assess employee availability when greater staffing needs and employee absences for family or self-care are expected.

Further Information/Resources:

- For up-to-date information on what to do if a staff member becomes ill, how long to stay away from work, and criteria for return to work for those with symptoms, refer to the Provincial Guidance on Return to Work and Exposure Management for HCWs with VRI.
- Please see the VRI HCW Self Check and Safety Checklist for more information.

4.2.9. Education for Health Care Workers, Residents, Families, and Visitors

- All HCWs and volunteers require IPC education on health authority or organizational policies, which includes information regarding the principles of IPC, such as routine practices and additional precautions. Yearly review of all infection control principles enhances and reinforces good practices.
- Additionally, HCWs are also responsible for:
  - Educating residents about hand and respiratory etiquette. If the resident has an infection, provide education on practices necessary to reduce the risk of spread.
  - Educating visitors about respiratory etiquette, hand hygiene, and any other situationally appropriate practices (e.g., how to use PPE).
  - Providing a demonstration or illustrated visuals to residents and visitors especially where language barriers exist.

4.3. Environmental Measures

4.3.1. Cleaning and Disinfection

Requirements for enhanced cleaning and disinfection in health care environments, including in resident rooms, will continue as follows:

Handling, Cleaning, and Disinfection of Resident Care Equipment

- Have cleaning and disinfecting wipes available for cleaning and disinfection of non-critical resident care equipment close to point-of-use.
- Identify which staff are responsible for cleaning resident care equipment and inform them about all required duties.
- Provide the resident with suspected or confirmed VRI with their individual supply of reusable equipment and supplies.
- If dedicating equipment and supplies to an individual resident is not possible, all reusable equipment that is shared between multiple residents **must** be cleaned and disinfected with a hospital-grade disinfectant after each use.
- Always follow the manufacturer's instructions for dilution, contact times, safe use, and materials compatibility of all cleaning products.
- Items that cannot be easily cleaned and disinfected **should** not be shared among residents.
- Discard all single-use items into waste bins after use.
- Remove personal care items left behind by the resident after their discharge.

Environmental Cleaning, Waste Management, and Laundry

- Regularly use cleaning products and disinfectants that are effective against VRIs.

Further Information/Resources: Please see the Quick Reference Guide on Environmental Cleaning and Disinfection in Clinic settings available on the PICNet website.

4.3.2. Food Handling, Delivery, and Pick-Up

Food Delivery and Pick-up

- All food service providers, delivery and staff **must** follow food safety requirements, including practicing diligent hand hygiene.
- Use regular, reusable food trays, dishes, and utensils for all residents. Disposable dishes are **not** required.
- All food service providers, delivery and staff **must** clean their hands prior to delivering meal trays, and after leaving resident areas, units or floors when delivering and picking up meal trays.
- Gloves are not required when delivering or picking up meal trays. However, if gloves are being worn, staff **must** change gloves prior to leaving units with VRI, as well as any time hand hygiene is indicated. Proper hand hygiene **must** be performed after removing gloves.
- Where possible, if there are suspected or confirmed cases of VRIs, serve those residents individual meals in their rooms while ensuring adequate monitoring and supervision. If in-room meal service is not possible, serve asymptomatic residents first, clean the dining area, and then serve symptomatic residents.
- Food service providers and delivery staff **should not** enter dedicated VRI cohort units or rooms with residents with suspected or confirmed VRI. Food service providers and delivery staff **should** leave meal trays outside units or rooms with residents with a VRI and notify resident care staff.

Food Carts

- Food service providers and delivery staff **should not** bring food carts into resident rooms.
- Food service providers and delivery staff **should not** transport food on carts that have used dishes on them (e.g., carts used to deliver meals cannot be used to pick up used dishes at the same time).
- Regularly clean and disinfect carts used for transporting food between meal service and after picking up used dishes.
- Clean and disinfect cart handles before entering and after leaving each resident area, unit, or floor.

Food Sharing

- HCWs and staff **may** share individually packaged food items (e.g., creamer cups, sugar packets, crackers, pre-packaged granola bars) with others.
- Unpackaged shared food items (e.g., candy, cookies, chocolate, nuts, fruit) **should not** be in the staffing workspace.
- HCWs and staff are discouraged from taking part in any food sharing in units/facilities undergoing enhanced monitoring and during an outbreak.
- Visitors **may** bring in the favorite food for their loved one. Food **should** be individually packaged for consumption by the resident.
- Visitors **must** confirm with facility staff regarding any dietary considerations before bringing in food for the resident (e.g., allergies, diabetes, choking hazard, or swallowing difficulties).
- Remind visitors and residents to perform hand hygiene before and after handling or eating food.
- Provide visitors with appropriate information on safe food practices, such as protecting foods from contamination, minimizing direct handling of food, preventing cross-contamination of foods, and discarding food that may have been contaminated with coughs or sneezes.

Communal Dining

Communal dining is an important part of many homes' social environment. Residents, staff, and visitors **may** participate in communal dining with the following precautions:

- Utensils and cutlery **should** be pre-placed prior to seating.
- Food **must** be served on individually portioned plates prepared by the staff. If food is to be shared from a communal dish, one staff member **must** be designated to serve.
- Provide single-use condiment packages (e.g., salt, pepper, sugar, ketchup and mustard) directly.
- Visitors seeking to participate in communal dining with a resident **should** contact the facility and request permission ahead of time.
- Visitors dining with a resident **should** attempt to sit at a separate table from other residents and follow the same IPC practices as residents and staff.
- Ensure ABHR with at least 70% alcohol content is available in communal dining rooms.
- Residents, staff, and visitors **must** perform hand hygiene before handling or eating food.

Further Information: Please see the BCCDC's Food Safety page for information related to food safety.

4.3.3. Indoor Ventilation

- Heating, ventilation, and air conditioning (HVAC) systems **should** be properly installed and regularly inspected and maintained according to HVAC standards and other building code requirements.
- Where feasible, optimize HVAC systems in resident care areas and rooms, especially where residents presenting with communicable respiratory illnesses are cared for.
- Consult with HVAC specialists/professionals prior to making adjustments to ensure appropriate procedures are undertaken and intended parameters are met.

Further Information: Refer to resources for optimizing indoor ventilation found on the PICNet website.

5. Organization Management

5.1. Facility Response Planning and Organization

- Develop or update a facility preparedness plan and response strategy to ensure readiness for managing surges in VRIs and prevent future pandemics.
- Conduct an organizational risk assessment (ORA) to identify the effectiveness of present control measures in the facility, and the breadth of the hierarchy of controls to prevent transmission of the VRIs. Considerations for an ORA include:
  - Identifying where residents are likely to present for care;
  - Identifying how multiple residents will be handled at once for screening or treatment; and
  - Reviewing and maintaining ventilation systems. Measures to improve indoor air quality and ventilation are important to decrease risk of aerosol transmission. See indoor ventilation resources for more information.
- Establish clearly defined roles and responsibilities for all staff, balanced by cross training of staff and planning for backfilling positions if staff are unable to work.
- Establish clear communication channels.
- Ensure that information and decision-making pathways are identified.
- Designate a qualified staff member(s) as the lead(s) for coordinating surge/pandemic response at the residence, including staff responsibilities and information gathering and dissemination.
- Consider developing a standard operating procedure that outlines setting-specific processes and established roles and responsibilities.

Further Information/Resources: Please see Appendix B: Provincial IPC Preparedness Checklist for VRI in LTC and seniors' AL settings to aid in planning.

5.2. Psychosocial Supports for Residents, Health Care Workers, and Staff

Support for Residents

The implementation of IPC measures may adversely affect the mental health, psychological well-being, and physical health of residents. Prevention measures may lead to behavioral and non-compliance issues. Some residents may become more agitated, stressed, and withdrawn during an outbreak or while under additional precautions, and may require mental health and psychological support.

- Settings **should** support and facilitate social connections, including virtual and phone options with friends, family, and other carers.

Support for HCWs and Staff

- Settings **should** support the psychosocial well-being and resilience of staff.
- Advise and assist staff who have any questions or concerns regarding their possible exposure or symptoms, including contacting their workplace health and safety department for further information.

Further Information/Resources:

- BCCDC has guidance on the adoption and implementation of health care provider support.
- Mental health support for health care providers is available through Care for Caregivers.
- An ethical analysis of the duty of HCWs to provide care in circumstances where there is a risk of harm to their own person is available online.

Appendix A: Additional Tools and Resources

Provincial guidance and information specific to VRIs can be found at:

- Provincial Outbreak Guidance for Viral Respiratory Illness in Long-Term Care Settings in British Columbia
- Provincial Outbreak Guidance for Viral Respiratory Illness in Acute Care Settings in British Columbia
- Provincial Infection Prevention and Control Guidance for Viral Respiratory Illness in Acute Care and Ambulatory Health Care Settings in British Columbia
- BCCDC Respiratory Diseases
- Office of the Provincial Health Officer – Orders, Notices and Guidance
- Government of British Columbia – Respiratory Illness Provincial Support and Information
- BCCDC getting a vaccine
- Health care Worker Exposure and Illness Resources
  - Provincial Guidance on Return to Work and Exposure Management for HCWs with VRI
  - VRI HCW Self-Check and Safety Checklist

Facility/Unit Entrance VRI posters:

- Staff and Visitors Screening *(outside VRI season)*
- All Patients/Residents Screening poster *(outside VRI season)*
- VRI Entrance Screening Tool for Health Care Facilities *(during VRI season)*
- Medical Mask is Required *(during VRI season)*
- How to Wear a Medical Mask
- Respect Personal Space

Hand Hygiene resources:

- How to Clean your Hands poster
- Hand hygiene videos
- BC Guidelines and Resources
- BC Ministry of Health Best Practices for Hand Hygiene

Point-of-Care Risk Assessment Tool (PCRA)

Personal Protective Equipment (PPE) Use resources:

- PPE Audit Tool
- PPE Donning and Doffing posters
- PPE Donning and Doffing videos
- Appropriate Use of PPE in Health Care Settings
- Cleaning and Disinfection Instructions for Reusable Eye and Facial Protection
- Eye and Facial Protection Selection Fit Tool
- Prescription Eye Protection Selection Requirements
- Skin Protection for PPE Use for Health Care Workers
- Respirator donning and doffing instructions.
- Donning instructions for elastomeric half facepiece respirator (EHFR) without an exhalation valve filter

- Position Statement to Address Double Masking and Mask Modifications for Medical Masks in Health Care Settings

VRI Transmission and Chain of Infection posters:

- VRI Transmission
- VRI chain of infection

Environmental Cleaning and Disinfection resources:

- Quick Reference Guide on Environmental Cleaning and Disinfection in Clinic settings
- PICNet's British Columbia Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Healthcare Settings and Programs

Ventilation resources:

- Indoor Ventilation resources
- Provincial IPC Guidance on Portable Fans in Health Care Settings in BC

Other IPC Resources:

- Public Health Agency of Canada's Routine practices and additional precautions for preventing the transmission of infection in healthcare settings
- Hierarchy of Controls for Infection Prevention and Exposure Measures for Communicable diseases
- For up-to-date IPC resources, please refer to the PICNet website.

Appendix B: Provincial Infection Prevention and Control (IPC) Preparedness Checklist for Viral Respiratory Illness (VRI) in Long-Term Care (LTC) and Seniors' Assisted Living (AL) Settings

Provincial IPC Preparedness Checklist for VRI in LTC and Seniors' AL Settings in BC

General IPC Measures

- ☐ Follow current provincial policy directives and the PHO orders.
- ☐ Educate all staff about VRIs.
- ☐ Provide HCW IPC education (e.g., hand hygiene, PCRA, PPE donning and doffing).
- ☐ Develop a contingency plan for staff illness and shortages.
- ☐ Assign a staff member(s) to coordinate VRI planning and monitor public health advisories.
- ☐ Place VRI posters and signage (e.g., hand hygiene, cough etiquette) at all entrances and in all common areas.
- ☐ Ensure ABHR with at least 70% alcohol, medical masks, tissues, no-touch waste receptacles and disinfectant wipes are available at multiple locations (e.g. entrances, reception counter, common areas, and exits).
- ☐ When available, provide staff with small bottles of ABHR with at least 70% alcohol.
- ☐ Provide disposable tissues and no-touch waste receptacles in appropriate areas.
- ☐ Provide plain soap and paper towels in resident washrooms and at staff sinks.
- ☐ In consultation with IPC and WHS, maintain existing physical barrier(s) where initial screening or triaging for infectious diseases occurs (e.g., at reception stations).
- ☐ Removal of barrier(s), e.g., between desks in offices, **should** also be done based on consultation with IPC and WHS.

Symptom Screening

- ☐ Encourage HCWs, staff, contractors, visitors, and others to self-screen for VRI symptoms and **not** come to work or visit if experiencing acute respiratory or gastrointestinal symptoms.
- ☐ Have processes in place to monitor residents for VRI signs and symptoms and place them on additional precautions as needed.
- ☐ Post signage at building entry points to support self-screening process.

Personal Protective Equipment (PPE)

- ☐ Follow institutional IPC policies and procedures including conducting a PCRA prior to any interaction with a resident or visitor.
- ☐ Ensure masks are available if a resident or a visitor chooses to wear one.
- ☐ Implement droplet and contact precautions for direct care of residents with suspected/confirmed VRI.
- ☐ Ensure PPE, hand hygiene, and cleaning and disinfection supplies are readily available for HCWs.
- ☐ Ensure PPE donning and doffing instructions are readily available for HCWs.
- ☐ Train, test, and monitor staff compliance by operators to ensure vigilant donning, wearing, and doffing of PPE.

Continued…….

Provincial IPC Preparedness Checklist for VRI in LTC and Seniors' AL Settings in BC
☐ If an airborne precautions sign is posted or an AGMP is being performed, ensure staff wear an N95 respirator, in addition to a gown, gloves and eye protection. ☐ Where respirators (e.g., N95 respirator or equivalent) are worn or anticipated to be required based on a point-of-care risk assessment (PCRA), provide fit-testing to ensure appropriate size and style of a respirator is selected and worn. ☐ Assess HCW hand hygiene and PPE compliance (e.g., PPE Audit Tool). ☐ Monitor and safely secure PPE supplies to prevent theft and loss, while still ensuring staff and residents can access PPE when needed.
Environmental Measures
☐ Have cleaning and hospital-grade disinfectant supplies (e.g., disinfectant wipes) readily available in appropriate locations to facilitate environmental and equipment cleaning and disinfection. ☐ Identify which staff are responsible for cleaning resident care equipment and inform them about all required duties. ☐ Provide the resident(s) with suspected or confirmed VRIs with their own supply of reusable equipment. ☐ If dedicating equipment and supplies is not possible, clean and disinfect reusable equipment that is shared between multiple residents with a hospital grade disinfectant after each use. ☐ Store clean equipment and supplies in a clean room/drawer/cupboard and physically separated from used or dirty equipment to protect from moisture, contamination, and damage. ☐ **Do not** share items among residents that cannot be easily cleaned and disinfected. ☐ Discard all single-use items into waste bins after use. ☐ Replace cloth-covered furnishings with easy-to-clean furniture, where possible. ☐ Where permitted by fire regulations, keep frequently used interior doors open to avoid recurrent door handle contamination. ☐ Heating, ventilation, and air conditioning (HVAC) systems **should** be properly installed, regularly inspected, and maintained according to HVAC standards and other building code requirements. Refer to the indoor ventilation resources.

Appendix C: Common Viral Respiratory Illness Pathogens

Viral Organism	Epidemiology	Incubation period	Symptoms and symptom duration	Period of communicability*
Adenovirus [5]	Usually fall and winter Causes infection in all ages	Range 1-10 days	Conjunctivitis, sore throat, croup, fever, and other respiratory symptoms	Shortly before symptom onset and until symptoms cease. Symptoms may be prolonged in immune-compromised people.
COVID-19 [6,7,8]	Epidemiology is evolving at the time of writing.	2-14 days	Cough and fever, loss of smell or taste, sore throat, fatigue, headache	Generally, 48hrs before symptom onset to 10 days after (for acute care settings). Communicable period may be longer than 10 days in immune compromised patients or patients with severe/critical COVID-19 illness.
Influenza A [9, 10, 11, 12]	Typically, November to April Causes mild to severe symptoms. Causes infection in all age groups with highest incidence in children; highest mortality in elderly and those with comorbidity. Can infect animals and humans.	1-4 days	Fever*, cough (often severe and may last longer than other symptoms), headache, muscle/joint pain, sore throat, prostration, and exhaustion. Gastro-intestinal symptoms may occur in children. Duration: 2-7 days	1 day **before** symptoms onset and up to 5-7 days **after** clinical onset in adults; Young children and people with immune compromise may be > 7 days. People with asymptomatic infections may also be infectious.
Influenza B [13]	Historically November-April Causes milder infection. Mostly affects children.	1-4 days	Cough, fatigue, fever—though everyone does not have a fever—or chills, gastrointestinal symptoms like vomiting and diarrhea—which are more common in children, headaches, muscle or body aches, runny nose, sore throat. Duration: 3-7 days, although cough and malaise can persist > 2 weeks.	1 day **before** symptoms onset and up to 5-7 days **after** clinical onset in adults; People with asymptomatic infections may also be contagious.
Parainfluenza virus[14]	Entire year (little seasonal pattern). Predominantly causes infection & outbreaks in young children and the elderly.	2-6 days	Fever, cough, bronchiolitis, bronchitis, pneumonia Croup. Duration: 1-3 weeks	Duration of active symptoms.
Respiratory Syncytial virus (RSV)[15]	Usually seasonal: winter and early spring. Predominantly causes infection & outbreaks in young children and the elderly.	2-8 days	Fever, cough, wheezing Bronchiolitis in children Pneumonia in adults	Shortly before clinical onset and duration of active disease. Viral shedding may persist for several weeks or longer after symptoms have subsided, especially in children.
Common respiratory viruses such as:[16] **- Rhinovirus** **- Coronavirus** **- Metapneumo-virus** **- Echovirus** **- Coxsackie-virus** **- other entero-viruses.**	Throughout the year with peaks in the spring and fall	Usually 2-3 days, but may be longer	'Common cold' type illness: Sneezing, runny nose, cough, sore throat, sinus congestion malaise, headache, myalgia and/or low-grade fever	Viral shedding usually most abundant during the first 2-3 days of clinical illness. Shedding usually ceases by 7-10 days but may continue for up to 3 weeks in young children.

** In general, communicability is greatest in pre-symptomatic and early symptomatic stage of illness.*

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