Continuing Care and COVID-19
Frequently Asked Questions

April 7, 2020

Disclaimer: As information related to COVID-19 is evolving the information in this document can only be confirmed as of the date created. Links to resources are included throughout and those should be utilized to verify current practice information.
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Introduction

Information related to the global coronavirus (COVID-19) pandemic is evolving moment to moment. It is essential that leaders, educators, staff, clients and the public are keeping up to date by accessing the most recent information. For quick access, bookmark relevant resources by accessing the AHS and Government of Alberta (GOA) website. This FAQ is applicable to home care, lodge, retirement residences and designated living options.

AHS is providing a toll-free line for Congregate Living Setting Operators. Use this line to reach AHS directly if:
- you have a resident with influenza-like or COVID symptoms,
- you need assistance or guidance in managing symptomatic residents, or
- if you have any COVID-related questions or concerns


Visitation - Screening and Restrictions

The most recent information related to visitation, screening and restrictions can be located on the AHS external website under Information for People Visiting Clients. Self-assessments and screening questionnaires are available for use. Social distancing shall be maintained as individuals may have been in contact with the virus without experiencing symptoms. Signage to support notification of restrictions to visitors has been developed for use in multiple languages. Facilities are also required to have visitors greeted at designated entrances to ensure applicable screening and information can be shared.

Key principles related to point of care risk assessment prior to care provision and routine practices shall always be adhered to. Additional precautions may be necessary to provide care safely.

Additional questions:

What is the definition of ‘essential visitor’?

The definition of essential visitor is located on the AHS website. An essential visitor is defined as family, friends or paid companions attending to a resident who is dying. Hours of visitation may be restricted based on local, operator or site decisions.
Who decides who is an essential visitor?

The term essential visitor is defined by the Chief Medical Officer of Health (CMOH) and is included in the CMOH directive. The client in collaboration with their family/caregivers/friends and care team would make the determination related to essential visitors.

Who determines who needs an essential visitor?

The client in collaboration with their family/caregivers/friends and care team would make the determination related to who meets the criteria for permitting an essential visitor.

Are we required to take temperatures for essential visitors? Can we take temperatures as a part of the screening process and what should we do if we are questioned or when we ask visitors to return at a later date?

Taking temperatures is an integral component of assessment for all staff and visitors to any congregate setting. Essential visitors must complete a self-assessment prior to entering the setting. Your site must use temperature as a tool for screening. If visitors have any questions they should be encouraged to review information on the GOA website.

We have several families who have paid for private agencies to provide care. Should we restrict them?

Private care givers, who meet the definition of essential visitor, can be permitted entrance to facilities. All screening protocols still apply. Paid companions must still practice social distancing and employ good hygiene habits such as washing their hands with soap for 20 seconds and not visiting if they have any signs of illness.

Is it absolutely necessary to have a log book for visitors to sign in and out?

Yes, this is required for tracking purposes in the case that public health needs to follow up. Tracking must include everyone who enters the setting including physicians, AHS case managers, contractors, movers etc.

Home Care - If a client has a family member (or visitor) in the home who is symptomatic and/or has said yes to a self-assessment screening question, should home care staff include those people in their screening process?

Yes. All individuals that live in or are visiting the home at the time of the client visit, should be screened. Contact and droplet precautions, if deemed necessary based on
the **point of care risk assessment**, should be followed. If anyone in the home is on self-isolation for suspected, presumed or confirmed COVID-19, then follow contact and droplet precautions during visit.

**Are all congregate settings, who do not provide any health supports (managed through AHS & contracted homecare providers), expected to implement daily temperature checks for all residents?**

There is no expectation that daily temperature check are completed on all individuals living at a congregate setting. Care staff must complete a point of care risk assessment with all clients prior to contact. If the client is experiencing any symptoms that are different from the normal for that client, including a change in behaviour or new onset cough, then further contact and droplet precautions should be put into place until further assessment occurs.

**What are the expectations around resident daily symptom checks in facility living (DSL and LTC)?**

Most recent information around assessment and symptom review expectations can be found in the [CMOH Directives](#). The expectation is to complete a point of care risk assessment on all clients prior to every interaction. New onset or changes in client condition or behaviour should be reported to a regulated health care provider and a comprehensive health assessment completed.

**What screening tool should be used for non-employee Health workers entering a lodge setting? For example AHS case manager coming to see their clients in a lodge.**

AHS case managers are required to complete an employee symptom screening with temperature check at the start of their shift prior to attending to any appointments with clients in the community. All visitors, including AHS staff, must again be screened prior to entering any building as designated in the CMOH directive. Follow the screening criteria as outlined by the most current CMOH criteria for screening.

**If I’ve already been screened at another facility do I need to be screened again?**

Yes, to ensure the safety of those living at the congregate setting, all visitors and staff must be screened prior to each entry into a building.

**Are clients allowed to leave continuing care sites with families?**

For information related to leaves of absence refer to the [Resident Leave of Absence for Congregate Living Sites](#) resource.
Testing

Local testing centers are being set up throughout the province. In addition, public health and home care are coordinating efforts to provide additional assessment and testing when deemed necessary to reduce risk to the public and reduce spread. Public is encouraged to complete the self-assessment tools and contact Health Link for additional information on testing. Health care professionals can access information on clinical management through local lab bulletins and updates on testing and self-isolation criteria.

Call 1-844-343-0971 immediately if you have a client or staff with suspected symptoms. Notify Public Health/Center for Disease Control immediately to ensure that early detection and outbreak measures occur to contain any possible spread. If testing confirms a positive result for COVID-19 the zone Medical Officer of Health (MOH) will receive all positive results, will notify the site, will declare an outbreak and the site will be instructed to implement appropriate outbreak management. Contact and droplet precautions should be put in place immediately for any client with suspected symptoms.

Additional questions:

**How will senior apartments and/or private lodges be notified or provided information on testing that is going on for clients in their sites?**

All positive results are immediately reported to the zone MOH who follows established protocols to notify public health and the setting. Resources will be mobilized to establish an outbreak team at the site and ensure appropriate precautions are in place. All staff at congregate settings must be aware to report any symptoms, in staff or clients, to their site designate. Notification to Public Health/Center for Disease Control must occur to ensure outbreak measures are taken early to prevent potential spread.

**How do we access more swabs if we need them?**

Access additional swabs for COVID-19 testing through local lab services.

**Any thoughts of allowing long-term care (LTC) sites to swab clients/staff/families? Does it change if they are in hospital or in the community?**

Refer to the Quick Reference and Guidelines for COVID-19. Follow Zone specific protocols for reporting of cases of ILI or GI illness to Public Health. Individuals that
meet the criteria for further assessment should contact the area advised for their need (e.g. WHS, Health Link, public assessment center or Public Health).

If nasopharyngeal (NP) swabs are only being tested for COVID (as per lab) what are we doing about regular influenza screening?

Follow usual processes for influenza-like illness (ILI) screening and outbreak management. Access the most recent lab bulletins for information.

If swabs are ordered due to respiratory symptoms, does 1 symptom or 2 symptoms warrant NP specimen collection?

Please review the current COVID-19 testing and self-isolation criteria and Novel Coronavirus Nasopharyngeal Swab Collection directive.

What are the guidelines for asymptomatic clients who may have had contact with family/visitors with ILI symptoms? Is there any work being done on a decision-making tool for discontinuing isolation for clients who, after consideration, may not meet criteria? Current suggestion is for us to continue 14 days once started.

Under public health order, you are legally required to self-isolate for:

- 14 days if you returned from international travel or are a close contact of a person with COVID-19, plus an additional 10 days from the onset of symptoms, should they occur
- 10 days if you have a cough, fever, shortness of breath, runny nose, or sore throat that is not related to a pre-existing illness or health condition

Client Movement and Isolation

The Addendum to Outbreak Management and Pandemic Planning Resources for COVID-19 provides additional information related to transfers of clients, isolation and cohorting. Local zone transition services in collaboration with zone emergency operation center leaders are collaborating to ensure the care needs of each client are met in the right place by the right providers. The CMOH Directive also provides information related to admissions, transfer and provision of care.

Additional questions:

If a number of clients are affected, should staff be coming and going from the building or should sites be preparing for having staff stay at the site?
Refer to **Outbreak Management Guidelines** (section 2.5 and 5.4) and follow the direction of the **CMOH**. Additional resources specific to COVID-19 have also been developed including a **Quick Reference** and **Guidelines for COVID-19**.

**What would we do for clients that do not adhere with Covid-19 isolation requirements?**

Clients must adhere to public health requirements for isolation. Contact local public health to discuss any concerns. For clients with a diagnosis of dementia additional resources can be located on the **AUA toolkit** page and by reaching out to **continuingcare@ahs.ca**.

**Should very ill clients and clients positive for COVID-19 be “treated in place”?**

During an outbreak response, continuing care facilities are required to enhance care in place rather than sending clients to acute care hospitals except when acute episodic illness requires surgical intervention and/or other urgent acute care services. (See **Continuing Care Pandemic Operational Guide for COVID-19** Appendix F)

**Are there recommendations to limit non-essential medical appointments for clients living in facility?**

Unless the appointment is deemed "essential", medical appointments will be cancelled. Clinics are to contact clients regarding these appointments to reschedule. Additional options for virtual health are coming out regularly. Please contact your local primary care network or family physician to determine if these services are available in your area.

**We were anticipating a new admission this week from another facility. Should new admissions be put on hold?** Admissions involve families and moving companies that could be potential carriers of the virus.

Sites should work closely with the zone continuing care transition services team to ensure a comprehensive client health history is obtained prior to admission which includes **screening for COVID-19**. Sites should coordinate admissions in a manner that follows outbreak guidelines including social distancing, promotion of routine practices and completion of self-assessment for all essential visitors. Additional information can be obtained from the zone transition services staff.

**Should new clients be put in isolation or tested upon admission?**

**New admissions** will be screened as part of the risk assessment prior to admission. Completing the self-assessment again at time of arrival is required and self-isolation for
14 days should be initiated where deemed necessary based on the results of the self-assessment or point of care risk assessment.

**Independent/congregate living sites are also having difficulties enforcing self-isolation and distancing requirements among residents do to the lack of credible health care staff to deliver messaging and monitor clients.**

Lodges and retirement residences can reach out to environmental public health in their area for support and guidance on how to share messaging and enforce social distancing requirements. The social distancing video could also be shared.

**For lodges and supportive living who do not have health care staff on site, what is going to happen if they have clients with symptoms and/or testing positive?**

Public health will be in contact to discuss the required protocols if a client tests positive. If a client identifies as having symptoms and has answered yes to any of the self-assessment tools online then contact and droplet precautions should be put in place and that client should self-isolate. Site administrators can contact their local public health office to receive additional support related to the required response.

**How do we ensure residents with dementia comply with Isolation requirements? We are having trouble getting them to understand that they need to stay in their room?**

Review the AUA toolkit for resources to support reducing responsive behaviours. Tips such as doorway signage, reminders and collaboration with family to provide an essential visitor to support the clients’ needs may be beneficial. Reach out to continuingcare@ahs.ca for additional resource support.

**Can you clarify the difference between a preadmission screen and a screen on arrival?**

**Preadmission screening** occurs prior to the decision to transfer/admit to a new facility. This ensures that at the time prior to/close to transfer that the client screened for COVID-19 symptoms. Another screening including temperature check shall also occur at time of arrival and the client shall be placed on contact and droplet precautions if any screening questions are answered YES. ADT resource

**What do we do if a client who is COVID+ gets admitted to our facility?**

Each admission is reviewed on a case by case basis in collaboration with the MOH, public health, site leadership and transition services. Risk algorithms have been developed to assist care teams when making these decisions. A sample algorithm has
been provided in the *Addendum to Outbreak Management and Pandemic Planning Resources for COVID-19*.

**One of our large designated supportive living/long-term care sites just notified us that they will no longer be accepting any new admissions due to COVID-19. How should we respond?**

Zones should work with transition services and AHS leaders to discuss concerns on a case by case basis. Under the authority of the Public Health Act the MOH is able to make decisions related to client movement to ensure appropriate resource allocation for the entire health care system.

**Should we expect an influx of clients arriving from acute care?**

At this time, we are expecting an influx of patients from acute care as we make room for the surge of COVID-19 positive individuals into acute care. Modelling suggests we have sufficient capacity in acute care as long as we make use of every available space in continuing care and congregate living settings. Please refer to the *Continuing Care Pandemic Operational Guide Appendix G* for additional information on surge capacity.

**Are we required to continue to offer respite care to families in the community? Our respite room could be used for isolation if needed but we would need to potentially not accept respite clients.**

Respite services will be suspended to ensure surge capacity and private room availability. Once waitlist management processes are suspended in your zone you will be notified and respite admissions will halt. Clients currently admitted to a respite bed will be assessed to see if it is safe for them to return home.

**Is blocking beds an option to prevent the spread of the virus?**

The most important strategy to block spread includes good prevention practices such as frequent handwashing, and social distancing. Acute care capacity and flow will be a very important element of managing a response. Generally, blocking beds will not be an option. Please reach out to zone operations designates if any concerns arise.

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**Operations - Maintaining Services**

Operators are encouraged to try and maintain normal routine and structure for individuals in their care. As with all outbreak situations, there is a need to ensure only essential services and personal, including essential visitors, are entering the building. Operators shall endeavor to ensure that clients are receiving the care that they need for their health and wellbeing while
recognizing the importance of emotional, intellectual, spiritual and mental health in our day to day lives. Additional information related to service level recommendations is available in the Continuing Care Pandemic Operational Guide.

Social distancing will require that activities to support these areas of health are modified. Clinicians will need to collaborate with clients to determine which aspects of their care are deemed essential to reduce the risk of adverse outcomes and hospitalizations. As each client’s needs are different, on advisement of the Chief MOH, all steps should be taken at this time to minimize risk of exposure especially to our most vulnerable population and essential services to maintain or improve health status should continue.

Additional questions:

**Are we able to force residents to use our pharmacy in supportive living?**

Clients are able to choose their own pharmacy provider in designated supportive living as per section 5.3 in the Medication Management in Continuing Care policy. If operational needs, including availability of pharmacy services and the safety of clients dictate, then operators should consider utilizing consistent pharmacy services during this pandemic.

**Can clients still order take-out?**

According to the medical officer of health, food delivery is still permitted. Delivery personnel shall drop food off at the door. Staff going out for food need to observe routine practices specifically hand hygiene.

**Can care home owned/based pets remain in the facility?**

There are no restrictions on pets that live in a facility. Visiting pets are restricted.

**Are we still able to bring home care clients into a long-term care facility for shower/bath assist?**

Only essential visitors are permitted at all licensed supportive living (including group homes, lodges and including Indigenous supportive living settings) and long-term care (nursing homes and auxiliary hospitals). Alternative arrangements will need to be made.

**Is there a guideline or decision making tool that can be used by physicians and clinical staff to determine essential and non-essential clinic appointments and at what point in the pandemic plan should we put this into practice?** At this time there are still RCTP and Chronic Complex Care clients (especially respiratory)
being moved back and forth to acute care for follow up appointments and diagnostics?

During an outbreak prevention response, continuing care facilities will be required to enhance care in place rather than sending clients to acute care hospitals except when acute episodic illness requires surgical intervention and/or other urgent acute care services. (See Continuing Care Pandemic Operational Guide Appendix G). Many non-essential ambulatory clinics are already adjusting how and when patients are seen.

What is the current recommendation for managing Acute Bipap in continuing care sites? How are zones resourcing this?

Supports to establish new CPAP and BPAP services may be impacted during the pandemic. Existing clients will continue to access services through their Registered Respiratory Therapist or vendor. CPAP/BPAP and heated high flow oxygen are not clinically indicated treatments for a client in acute respiratory failure.

Are contract providers able to access daycare services for their staff?

The Alberta Government has reopened select licensed child care centres to provide child care for core service workers.

Comprehensive Assessments and Care Conferences

Comprehensive assessments and care conferences are essential steps in the development of accurate care plans that meet client goals and address health care needs. AHS zone clinical informatics and RAI leads continue to evaluate the impacts to current required practices as they relate to care planning to determine what steps are crucial to ensuring that client care is accurate, timely and effective. Based on key factors, including staffing demands and client movement through the system, decisions related to comprehensive assessments and care planning should be made in collaboration with clients, families, operational and zone leadership.

Additional questions:

Should we suspend resident and family council meetings?

Due to restrictions on social gatherings and essential visitors, on-site meetings should be suspended and alternatives considered including virtual meeting rooms and teleconference.
Personal Protective Equipment (PPE)

Access the most current resources and signage related to PPE on the AHS website. AHS IPC has developed COVID-19 specific resources to help inform staff, residents, family members, and the public. These resources are updated on a regular basis and available on the public AHS website on the emerging issues page under COVID-19. Key practice principles, including performing a point of care risk assessment to determine routine practice requirements, will be important to protect staff and clients. Leadership in the zones will be disseminating additional information related to access to PPE and cleaning supplies to ensure that all operators have access to the supplies that they need. Connect with zone designate for additional information.

Additional questions:

If a resident has chosen to self isolate and is asymptomatic, what is the recommendation for the use of PPE when entering that resident’s space?

If a resident is self-isolating due to a positive self-assessment screening which may include new onset symptoms or potential contact with someone that is positive then adhere to contact and droplet precautions for the duration of the isolation. If the individual is self-isolating to reduce risk of infection then complete a point of care risk assessment and follow routine precautions.

How do we have conversations regarding unnecessary interventions when discussing goals of care? Continuing care is also limited in ability to run a full code and doing so exposes staff to body fluids, droplets, etc.

Refer to AHS policy on goals of care designation orders and advanced care planning discussions. Health care providers should don appropriate PPE during resuscitation, including wearing N95 respirators/masks while performing CPR.

Should we be requiring staff bring a change of clothing/uniform for each shift in an effort to prevent introduction of the virus to our sites?

Follow IPC healthcare attire recommendations for wearing or laundering of uniforms or work attire. If attire is soiled during care, remove and replace attire, and place soiled items in plastic bag to launder at home. Staff working at sites in a suspected or probable outbreak must immediately change into a new set of clothes/uniforms and if possible change shoes before going to work at another site and ideally before returning home.
The guidelines state CPR is an Aerosol Generating Medical Procedure (AGMP) when provided to those with ILI symptoms; thereby necessitating use of N95 masks. If an Ambubag is used, is a N95 mask still necessary? We have been informed by our vendors that we have no access to ordering any more N95 masks and are very concerned about our diminishing supply due to mask fitting for RNs & LPNs who may be required to perform AGMPs.

Operators should collaborate with physicians and pharmacists to move clients away from medications and treatments that require AGMPs when at all possible. CPR is an AGMP and appropriate PPE including an N95 respirator/mask will be required. Please contact your organizations WHS department or AHS leadership in your zone to discuss needs related to FIT testing and supply management.

Many clients/families of clients that are immunocompromised are asking home care staff to wear full PPE even if the staff and client have passed screening questions. What is the direction, for home care in particular, as we attempt to manage PPE inventories?

Reassure clients and families that each interaction requires a point of care risk assessment and that risk of transmission from one client’s home to another is reduced by ensuring proper PPE where required and handwashing between visits. Staff schedules shall be arranged to ensure that clients who have tested positive for COVID-19 are receiving care from a separate cohort of staff or at the end of shift.

Is the Respiratory Illness Algorithm applicable to continuing care, or is it only for use in acute care settings?

The Respiratory Illness Algorithm applies to all care areas and is utilized in conjunction with the additional precautions for individuals that are positive for COVID-19.

According to the Respiratory Illness Algorithm for PPE selection, when a surgical mask is donned, eye protection should be worn as well. Is there a certain certification or specification for eye protection worn while providing care to clients with ILI symptoms?

Approved medical supplies are able to be ordered through current supply chains Additional information related to PPE for contact and droplet precautions can be located on the AHS website.

Documents linked in the continuing care communication memo refer to putting symptomatic clients in a private or a negative pressure room when undertaking AGMP’s. In continuing care we often do not have single or negative pressure rooms. Can these documents be amended for continuing care?
As per the contact and droplet precautions for continuing care the recommendation is to close the room door. Please see the Addendum to the Outbreak Management and Pandemic Planning Resources for additional information related to placement and transition of clients as well as the guideline for cohorting clients.

**What should we do if we run out of hand sanitizer?**

Handwashing is still considered the gold standard for hand hygiene. Where feasible, handwashing should be the preferred option with hand sanitizer reserved for situations where handwashing is not practical.

**What is the process if operators require additional PPE supplies? We have put in a request for some additional PPE, but have not heard back. Why?**

AHS' PPE Taskforce is now operational, considering critical and emerging needs of our staff, physicians and partners in the community, as well as evidence and guidance of national and international bodies.

For a provider that is a contracted AHS provider, please contact AHS for access to supplies of personal protective equipment (PPE): AHS.ECC@albertahealthservices.ca. For a provider that is not a contracted AHS provider, please contact Provincial Emergency Social Services, to advise them of your PPE needs: PESSECC-LOGISTICS@gov.ab.ca. Supply requests are being accommodated based on the urgency of the need, outbreak status, and ensuring all sites have access to some of every supply.

The perspectives of our frontline staff, unions and other experts are essential to our planning for the anticipated surge in demand and needed capacity. We understand that our staff, physicians and partners in the community need more information about PPE guidelines, availability and accessibility, across our system. To support communications and transparency, the taskforce has set-up a dedicated PPE email at ppe@ahs.ca. AHS staff, physicians and partners are encouraged to send their questions on PPE in Alberta to this email account.

**Do home care staff need to wear PPE when entering any lodge setting?**

No, PPE is only required when entering an area that requires contact and droplet precautions such as an isolation room or on a secured unit where a suspected or confirmed outbreak is occurring. All staff will complete a point of care risk assessment prior to any client interaction.
Policy, Practice, Access and Case Management  
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**Staff**

Efforts are being taken by all health care operators in the province to build capacity for staffing needs in the system. Regulatory bodies, including CARNA, CLPNA and CPSA, are reaching out to recently retired health care professionals to assess competency and provide licensure. Contract staffing agencies are providing capacity support. Health professionals in leadership and other roles are being asked to submit skills inventories so that they can be deployed to areas in need. At this time it is important to review fan out lists and ensure that pandemic plans and emergency preparedness plans have up to date staff lists with contact information. Zone transition services staff are prepared to discuss staffing needs when considering admissions, transfers, discharges and cohorting of clients. Provincial and zone emergency operations centers are prepared to address the need to establish alternative care centres (ACC) to provide additional capacity as required within Zone(s).

Additional questions:

**What are the guidelines for staff travelling between communities to provide care?**

Staff should only travel between communities/zones to provide care if absolutely necessary and if approved by their manager to do so.

**Will staff who work at multiple sites be prevented from working at their other places of employment? What guidance is available for staff in these roles?**

It is mandatory for staff working in multiple sites to inform their employer. If there is a suspected, probable or confirmed COVID-19 outbreak at one of their sites the employee must contact all of their employers to determine whether or not they are permitted to work at the alternate site.

In all circumstances, staff working at multiple sites should change uniforms and practice personal hygiene when moving between sites to prevent the spread of illness. Movement between facilities will be limited especially if one of the sites is on a declared outbreak. IPC has developed a [Best Practice Guideline](#) pertaining to uniforms and scrubs. Additional information regarding uniforms has been added to the bottom of the AHS IPC COVID-19 [Interim recommendations](#) sheet. Please consult OHS/WHS/designate, IPC or Public Health for further recommendations.

**What should you do if an outbreak occurs at your site and your workforce is severely depleted?**

Zones are currently determining contingency plans with staff shortages being a major focus of those efforts. Numerous health care professionals, businesses and providers have come forward to offer their assistance during this pandemic. Ensure to reach out
to your zone designate to discuss any staffing concerns so that a collaborative plan can be put in place to resolve shortages. Ensure that consideration is given for security screening for all new employees and volunteers.

**Staff Health**

An online tool is available for all healthcare workers who think they may have or may have been exposed to COVID-19. The targeted approach to testing for COVID-19 in those most at risk, including healthcare workers with respiratory symptoms, is consistent with the approach happening across Canada. Continuing care operators can access the fitness to work resources and Return to Work Guide on the AHS website and align or adopt these resources if deemed appropriate.

**Additional questions:**

**How do we differentiate between symptoms of Covid-19 and seasonal allergies when screening staff?**

We understand that people may have seasonal or environmental allergies. The screening process for COVID-19 is meant to keep people out of the workplace if they are ill with ILL. Chronic conditions such as allergies etc. are not intended to “qualify” as exclusion criteria.

COVID-19 and seasonal allergies typically have different symptoms. Where there is overlap is symptoms of sore throat and coughing.

**Symptoms included in the staff COVID-19 screening:**

- Fever (greater than 38 degrees Celsius)
- New onset of (or exacerbation of chronic) cough
- Shortness of breath
- Difficulty breathing
- Sore throat
- Runny nose

**Symptoms of seasonal allergies:**

- Itchy, watery eyes
- Sneezing
- Runny, stuffy, or itchy nose
- Temporary loss of smell
- Headache and fatigue
- Dark circles under the eyes ("allergic shiners")
- Drainage from the nose down the back of the throat (post-nasal drip)
- Sore throat or coughing
• Snoring

Until further clarification comes please use clinical judgement based on the above approved symptom criteria to guide decision making.

**Can I still return because my cough is persisting?**

It’s okay for people with a chronic cough or reactive airway disease to go back to work after they’ve been sick if they’re still coughing, as long as it’s not worse and they don’t have any other symptoms.

**Update on Staff Screening? What is the process, does the screener require PPE, who can be a screener?**

The [PPE for Facility Screening Tasks](#) provides additional detail.

**Does a manager need to be present for staff screening?**

A manager or leader needs to be available.

**Does the staff member need to sign the screening form?**

Yes, to ensure that contact tracing can occur accurately by public health.

**Are there special precautions for employees who are currently pregnant?**

Pregnant staff should reach out to their WHS or HR department if they have any questions related to transmission and risk.

**If staff have only one symptom (cough, fever, sore throat, etc.), do they need to self-isolate, contact Workplace Health and Safety and wait for clearance before returning to work?**

WHS uses a set of criteria to provide direction on self isolation and testing. This includes a combination of [criteria and symptoms](#).

**Do we use COVID coding for payroll?**

Contact your HR advisor or payroll/timekeeper for the latest information related to coding staff leaves appropriately.

**If staff exhibit respiratory symptoms but have no history of travel nor any direct contact with someone who tested positive for COVID-19, is there a hot line that
we call to request a test swab so the staff member can continue to work? Or should they immediately self-quarantine?

All individuals experiencing symptoms are required to self-isolate and to contact WHS or Health Link as appropriate. As this is an evolving situation, please check the AHS website for updated information related to recommendations on continuing or returning to work.

Education

Pandemic direct patient care education materials, to support rapid training of individuals without a health background or to refresh those who have been away from clinical practice for some time, have been developed. This training is structured, but abbreviated. Pandemic Direct Patient Care Education is located on:

- Insite: https://insite.albertahealthservices.ca/hpsp/Page9766.aspx
- Continuing Care Connection: Resources>Business Resources> General & Pandemic Planning

Additional questions:

Can sites train non HCA staff to provide medication assistance if they are having problems with staffing?

Yes, medication assistance is not a restricted activity, unless the delivery route of that medication is considered a restricted activity (e.g., injection). The employee or volunteer will have a job description which includes this task (likely classifying them as an unregulated health care provider). A regulated health care provider must assign the task and provide the required supervision. Supportive Living Accommodation Standards and the CCHSS require unregulated health care providers to be trained in medication assistance.

Medication Assistance Program materials accessible here:

- Insite: https://insite.albertahealthservices.ca/sh/Page12068.aspx
- Continuing Care Connection: Resources>Practice Resources>Medication Management

Will N95 fit testing train the trainer education be available soon?

Check with WHS to prioritize staff that requires FIT testing.

Is there a contingency plan for updating CPR certification in lieu of suspension of in-person education? Will nurses have flexibility in renewing annual CPR
certification if it is soon to be expired? Has CARNA provided recommendation or guidelines to AHS in this regard?

CARNA and CLPNA have agreed to the AHS recommendation to extend BLS certification past the expiry date. Full courses and other opportunities for re-certification will be considered in the coming months.

Funding

Can we collectively request a suspension of the proposed AHS funding changes in light of the additional financial and operational changes facing continuing care operators due to COVID-19?

All changes to funding models have been put on hold for the interim and will be reconsidered in 3 months.

What additional funding can we receive to assist with extraordinary costs such as equipment, supplies, and security?

AHS is working with AH to assess availability of funding for extraordinary costs related to the continuing care sector and will provide information when available.

If we experience workforce shortage issues (e.g. staff illness/quarantine, childcare issues), will operators be at-risk for funding recoveries during this time period?

The matter is being examined on a case by case basis. AHS assures fairness in the consideration of this difficult situation.

Will there be recovery funding for staff that are off for either self-isolation, mandatory isolation or because of daycare coverage?

This is an unprecedented situation that is evolving quickly. There is a role for both federal and provincial governments to support this. Further information will come as available.
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This resource has been prepared by AHS Seniors Health, CSAMH in collaboration with Infection Prevention Control, Environmental Public Health and Capacity Planning.

Contact

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